Correspondence

Letters to the Editor should not exceed 500 words.

General-practitioner Hospital Beds

SIR,—Arguing along lines extremely similar to those of Dr. G. N. Marsh (6 March, p. 644), we set out in October 1964 to determine very roughly how much of the medical ward work in a large district hospital could be undertaken by general practitioners. One of us (R. D. W.) is a young general practitioner in the neighbourhood of Whipps Cross Hospital, and the other (H. W. B.), not quite so young, taught him as a student in Bart's and as his house-physician in Whipps Cross Hospital a few years ago. Each week R. D. W. went round two acute general medical wards, and imagined himself to be in charge of the patients there (who were in fact under the care of three general physicians, Dr. J. T. Wright, Dr. A. E. Dormer, and H. W. B., of a dermatologist, Dr. R. E. A. Price, and a neurologist, Dr. K. W. G. Heathfield). He tried to make up his mind whether, using the hospital facilities in the normal way, he would be able to look after the patient entirely by himself (Group I); whether, after appropriate investigation, he would like a consultant opinion at some stage (Group II); whether he would like consultant guidance fairly early on but thereafter could continue happily on his own (Group III); or whether he felt the patient ought to be entirely under the care of a consultant and his team (Group IV). Each week the assessment was reviewed, and, to be fair, the patient was allotted to the "too difficult" group if there was any doubt rather than to the "soldier on" lot.

Two hundred and thirty new cases were reviewed during an eighteen-week period, and proved to be grouped as follows:

Group I	155	68%
Group II	44	19%
Group III	21	9%
Group IV	10	4%

We were surprised to find that very similar proportions were obtained if one merely grouped all the patients in the wards each week, thus inevitably counting some of them several times over. In this way, 932 assessments made, the grouping worked out as follows:

Group I	610	65%
Group II	174	19%
Group III	81	9%
Group IV	67	7%

These results surprised us, and add so much weight to Dr. Marsh's argument that we thought they ought to be published now rather than be delayed in order to have a possibly fairer assessment at the end of a whole year. We had anticipated having to write an essay to discuss them, but finding one ready-made for us—and indeed much better than if we had tailored it ourselves—we hope Dr. Marsh will allow us to make use of it and thus save ourselves extra literary work.

We believe that our results indicate that well-trained young general practitioners could

supervise the great majority of patients admitted to ordinary acute medical wards in regional board hospitals, assuming consultant opinions to be readily available. We believe that if they worked in such places they would have a much better chance of keeping up with the flood of medical advance than they at present do, would have better facilities for consultation with other general practitioners and with specialists, would enjoy the work, would respect the privileges attached, would if anything request fewer unnecessary investigations than most hospital registrars, and would be interesting people to have about. We thought it probable that the extra administrative work involved if they were on the staff would be cancelled out by the work saved (for instance, the duplication of social investigations, the writing of discharge letters, the acquisition of vital information about the patient's previous care, and so on).

Dr. Marsh's article did not, we think, lay sufficient stress on the patient who is in hospital purely as a "disposal problem." A distressingly large proportion of the longer-stay patients were in the ward because their landladies or relatives would not have them back again, and the geriatric hospital was full.

We would like to associate ourselves very strongly with Dr. Marsh's plea for general-practitioner beds in district hospitals, but do not wish to imply that cottage hospital facilities should in any way be reduced. There are very many reasons why they should be retained, and indeed it could be argued that if district hospital facilities were open to general practitioners at the same time some of the disadvantages of the cottage hospital would be greatly lessened.—We are, etc.,

R. D. WINCH.

H. WYKHAM BALME.

Whipps Cross Hospital,
London E.11.

Treatment of Cystinuria

SIR,—We note with considerable interest the article by Professor C. E. Dent and his colleagues entitled "Treatment of Cystinuria" (13 February, p. 403). It is reassuring to have such careful documentation of the beneficial effects of round-the-clock fluid therapy in the 12 out of 18 patients who were able to endure the discipline of the programme. In particular, we are impressed by the evidence of stone dissolution in six of the patients so treated. It is clear, however, that one-third of the patients did not respond to simple fluid therapy because of inadequate motivation, poor self-discipline, or for reasons quite unknown.

Our experience in cystinuria is based on observations extending over four years in 10 patients who were referred to us because of continued stone formation despite reasonable adherence to the standard regimen of low-methionine diet, alkali, and forced fluids.

Over the last two years we have treated these patients with D-penicillamine (usually 2 g./day) in addition to their standard therapeutic regimen, which had, of course, proved ineffective. Particulars of this therapy are published elsewhere.¹⁻⁴ Briefly, we have observed evidence of significant stone dissolution in three of these patients. In one the stone disappeared entirely. The remaining seven patients were rendered stone-free either as a result of surgery or by spontaneous passage of calculi. In these patients D-penicillamine, when added to their usual programme, resulted in a complete cessation of stone formation. In two instances small stones were formed and passed during periods when the patients became careless and neglected to take their medication. Toxicity to date has been negligible in all ten of our patients and in four other patients who are only indirectly under our guidance. Pyridoxine (50 mg./day) was given to all patients to avert the mild antipyridoxine effect of D-penicillamine.⁵ Our D-penicillamine has been supplied without cost through the kindness of Merck, Sharp, and Dohme; on the market the cost to the patient of 2 g. a day would be £200 a year.

We are somewhat mystified by Professor Dent's stated disbelief (in the instruction to patients) in the effectiveness of a low-methionine diet in this disease. Surely there is more than ample evidence to support the view that a low-methionine diet can indeed produce a significant reduction in urinary cystine.⁶ Perhaps he would care to comment more fully on this aspect of therapy.—We are, etc.,

MYRON LOTZ.

FREDERIC C. BARTTER.

National Institutes of Health,
Bethesda, Md, U.S.A.

REFERENCES

- Lotz, M., and Potts, J. T., jun., *J. clin. Invest.*, 1964, **43**, 1293.
- , and Bartter, F. C., *Milit. Med.*, in press.
- , Holland, J., Kiser, W., and Bartter, F. C., *J. Urol.*, in press.
- Bartter, F. C., Lotz, M., Thier, S., Rosenberg, L. E., and Potts, J. T., jun., *Ann. intern. Med.*, in press.
- Jaffe, I. A., Altman, K., and Merryman, P., *J. clin. Invest.*, 1964, **43**, 1869.
- Brand, E., Cahill, G. F., and Harris, M. M., *J. biol. Chem.*, 1935, **109**, 69.
- Lotz, M., Potts, J. T., jun., and Bartter, F. C., personal observations.

Plasma Renin in Primary Aldosteronism

SIR,—We reply to the letter from Professor J. W. Conn (6 March, p. 656) in order to correct errors of fact additional to those which some of us had previously criticized elsewhere.¹

Professor Conn is incorrect when he claims² to have improved the method of Boucher *et al.*³ and mistaken when he says this was "pointed out" in his previous paper.⁴ He now gives² the lower limit of sensitivity for his method. This, at 50 ng./100 ml. is inferior to that of the originators, who record a value of 35 ng./100 ml.⁵ The potentiometric chart recorder seems irrelevant in this context.