pregnancy was probably not caused by incest or rape.

Even though the rate of late abortion was lower than the national average (4% v 6% in 1986), in one third of our patients there was a delay of two weeks or more between referral by the general practitioner and the operation. The underfinancing of the NHS has led to bed shortages and closure of the out-patient clinic over holiday periods. In two thirds of the women there was a discrepancy of more than two weeks between the woman's dates and gestation shown by ultrasound, a quarter had continued to menstruate for one or two months while taking the pill, and three women had irregular periods and did not realise they were pregnant until late.

Ignorance about the system, cultural change, poverty, homelessness, drug addiction, mental illness, violence from the male partner, youth and inexperience, and failed contraception in older women are associated with late presentation. These women would not be helped by any restrictive changes in the 1967 Abortion Act, which while not ideal, has helped many women, reduced the death toll and morbidity from illegal abortion, and allowed women and their doctors to discuss openly what was secret and hidden and thus deal with the problem safely.

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1 Savage W. Requests for late abortion—Tower Hamlets 1983. *Br Med J* 1983;290:621-3.

Strongyloidiasis

SIR,—Dr J A Hill (12 March, p 753) discusses the screening programme for *Strongyloides stercoralis* infection in ex-Far East prisoners of war. These patients are known to be at increased risk,¹ but *S. stercoralis* is endemic in several parts of the world.²⁻⁶ I present three cases of hyperinfestation occurring in patients of West Indian origin.

A 64 year old Jamaican man presented with a four year history of abdominal pain and weight loss. Stool parasitology had never been done. His eosinophil count was normal. Gastroscopy and colonoscopy showed lesions suggestive of Crohn's disease, and he was started on oral prednisolone. The biopsy reports, however, confirmed the presence of *S. stercoralis*. The steroids were stopped and he was started on thiabendazole. Twelve hours later he developed an *Escherichia coli* septicaemia and meningitis. He developed a cough, and live worms were isolated from his sputum. His treatment was changed to mebendazole and chloramphenicol, and he made a slow but uneventful recovery.

An 18 year old girl was admitted for investigation of weight loss and a low serum concentration of albumin. She developed clinical evidence of septicaemia and died. A postmortem examination showed hyperinfestation with *S. stercoralis*, and filariform larvae were found in the brain.

A 50 year old man was treated with thiabendazole after the organism was isolated from his stool. Within 12 hours he developed the clinical features of septicaemic shock and died.

S. stercoralis may be endemic among patients in Britain who have previously lived in the West Indies, and they are at risk of hyperinfestation. Other cases of hyperinfestation have been reported in Britain. Smallman and others reported two fatal cases in patients from the West Indies.⁷ A 29 year

old Jamaican woman was successfully treated,⁸ and two other fatal cases have been reported from the West Indies. These patients were all previously fit and three of them had not been back to the West Indies for more than 10 years.

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Sulphonylureas and hypoglycaemia

SIR,—The leading article by Drs R E Femeer and H A W Neil (2 April, p 949) omitted one aspect of hypoglycaemia developing with sulphonylureas—namely, this complication occurring with high dose sulphonamides, which are chemically related to the sulphonylureas. This has been observed in the last four cases of pneumocystis pneumonia we have treated by such therapy; we present here our most florid case. The other cases were less severe, but the patients did not have renal failure.

A 64 year old man was admitted with a five month history of general debility. Investigation showed renal failure (sodium 131 mmol/l, potassium 5.4 mmol/l, total carbon dioxide 12 mmol/l, urea 45 mmol/l, creatinine 837 µmol/l, creatinine clearance 3 ml/min). Biopsy showed active focal segmental glomerulonephritis. He was treated with cyclophosphamide 150 mg and prednisolone 60 mg orally per day. His condition deteriorated and he required haemodialysis and blood transfusion.

His chest radiograph showed progressive confluent shadowing of the left upper lobe. Suspected *Pneumocystis carinii* pneumonia was confirmed from bronchial washings. Treatment with co-trimoxazole 1920 mg intravenously four times a day was started, as recommended by Winston et al.² After initial improvement he relapsed and suffered an unexpected cardiac arrest, from which he was resuscitated.

At this time he developed hypoglycaemia and for the subsequent 48 hours his blood glucose concentration remained at 2.4 mmol/l despite an infusion of 10 g of dextrose per hour, repeated 20 g dextrose boluses, and on one occasion 100 g of dextrose in two hours. He recovered consciousness, but the response to treatment was not sustained and he died 48 hours later. The patient had received prednisolone 30 g, propranolol 120 mg, indomethacin 75 mg, flucloxacillin 2 g, calcium carbonate (Titalac 6 tablets), and danthron (Dorbanex 60 ml) daily. There was no evidence of liver or adrenal failure.

Necropsy showed an organising pneumonia, a quiescent glomerulonephritis, renal scarring, and patchy pancreatic necrosis. There was no evidence of an insulinoma.

We believe that accumulation of the sulphamethoxazole contained in the co-trimoxazole caused the hypoglycaemia. Hypoglycaemia has been recorded in cases of renal failure after much more modest doses of co-trimoxazole.^{3,4} This is clearly a rare complication but it is important to be aware of such a possibility in the increasing cohort of immunocompromised patients developing problems such as pneumocystis infection and requiring high dose sulphonamide treatment.

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Drug addicts and the GP

SIR,—The report from the Advisory Council on the Misuse of Drugs discussed by Dr Tessa Richards (16 April, p 1082) recognises the rapid spread of human immunodeficiency virus (HIV) among drug misusers which has overwhelmed the present arrangements for coping with them.

Among the proposals to contain misuse and combat the spread of AIDS are ones which affect the whole of general practice. For example, one proposal says: "We conclude that the advent of HIV makes it essential that all GPs should provide care and advice for drug misusing patients to help move them away from behaviour which may result in them acquiring and spreading the virus. Health authorities should ensure that appropriate support is available and that GPs are made aware of it."

As a result of this report considerable pressure will be put on all general practitioners to participate in combating drug misuse. Many, however, are reluctant to do so, although their response is based on practical reasons rather than the prejudice implied by Dr Richards. Their reluctance will be founded on lack of training; the expectation of lack of support, based on past experience of dealing with dependent groups; concern about demands on their time; and worries about their staff being exposed to patients who will bring manipulation and violence into the waiting room, where there is greater danger to staff than in hospital.

If any progress is to be made it will not come from rhetoric, reports, or the simple transfer of problems to general practice. Success can come only from a programme designed to train general practitioners and their staff to deal with this group and from effective support in the hospital and community.

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Early detection of visual defects in infancy

SIR,—Drs D M B Hall and Susan M Hall (19 March, p 823) do not analyse which visual defects screening programmes are likely to uncover. No claim to detect severe visual defects in the first weeks of life has ever been made. Myopia and refractive errors, by far the most common

problems, will not be discovered at the neonatal examination and are rarely noticed by parents of preschool children. They are some of the most important *raison d'être* of screening programmes. They are rarely diagnosed under 2 years of age,¹⁻³ although the yield between 3 years and school age is high.^{3,4}

If you are a member of a family with an inheritable visual disorder it is likely that you will worry about the visual acuity of your offspring. Furthermore, having one handicap doubles the likelihood of another. This explains the high percentage of children in the study whose initial diagnosis was made by their parents or a paediatrician examining a second major handicap. There is a difference in "ophthalmic health" in metropolitan areas and inner city and rural areas of the world⁵ and thus a need for vigilance even if "families of low socioeconomic state are perfectly capable of making relevant observations about defective vision."

It is wrong to conclude that because most of the children studied were not diagnosed at clinics for developmental screening such clinics make little contribution to the diagnosis of visual problems. After all, maternal suspicion of deafness is an important pointer to early diagnosis,⁶ but no one has suggested that screening for hearing loss should be abandoned.

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AUTHORS' REPLY.—The early detection of severe visual defects should be one of the aims of a surveillance programme. In our study most of these were diagnosed by the age of 6 months. We are not, however, making a plea for more accurate screening tests for disabling defects since they are detected by other means.

Suitable tests do exist for screening 3 year old children, but we do not agree that myopia and other refractive errors are "the most important targets." The discovery of a refractive error uncomplicated by amblyopia at the age of 3 years instead of at school entry is of uncertain, but probably marginal, benefit. Detection of amblyopia is more important. We cannot prevent it, so detection and treatment are the best we can offer.

The existence of a suitable test does not guarantee that the screening programme is effective.¹ Screening 3 year olds produces many referrals, but the true yield (the number of new cases requiring treatment) is much smaller. Elementary errors of technique are frequent. For instance, the single letter test is still used, although it has been known for years that it misses or underestimates amblyopia.

The analogy with screening for deafness is unfortunate. The distraction test for deafness at 7-8 months is hardly a success story. Unlike visual screening tests for infants, it is potentially sensitive and specific, but the quality of testing in many places is so low that some authorities are suggesting that it should be discontinued. A badly performed screening test does more harm than good because it

provides false reassurance to worried parents. The traditional skills of taking an accurate history and listening carefully to what parents have to say will contribute more to the early diagnosis of visual defects and other developmental problems than the continued use of unsatisfactory screening tests.

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- 1 Stewart-Brown SL, Haslum MN, Howlett B. Pre-school vision screening; a service in need of rationalisation. *Arch Dis Child* 1988;63:356-9.

Editorial freedom

SIR,—There are few editors who would quarrel with the cogent points put forward by Dr Stephen Lock (12 March, p 733). From a South African viewpoint there was also a certain wry pleasure in reading that "outsiders who interfere in the internal affairs of others risk rebuke for their presumption and for exacerbating difficulties."

However, his article contains one important error, where he states, "The editor of the *South African Medical Journal* is forbidden to publish letters or articles from members of the National Medical and Dental Association." As the current editor I wish to put the record straight.

The executive committee of the Medical Association of South Africa did pass a resolution advising the editor of the *South African Medical Journal* not to accept any material from the National Medical and Dental Association. The rationale was that as the National Medical and Dental Association appeared to be losing no opportunity to try to discredit the Medical Association of South Africa, both in South Africa and overseas, it made little sense to give free publicity to it in the Medical Association of South Africa's own journal.

This decision, which was originally intended to cover only advertising, was reversed when the threat to editorial independence was perceived. Last year I stated clearly and unequivocally in an editorial¹ that contributions to the *South African Medical Journal* would be judged and accepted at the editor's discretion solely on the basis of their quality and relevance and not on the source from which they emanated. I would like to reassure Dr Lock and the readers of the *BMJ* that that policy has not changed.

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- 1 Anonymous. Serving the Truth [Editorial]. *S Afr Med J* 1987;72:371.

**This letter is substantially the same as one published in the *Lancet* of 23 April (p 941). We publish it, with the *Lancet's* permission, to give Dr Lee the chance to reply to a criticism made in the *BMJ*.—ED, *BMJ*.

Risk of upper respiratory tract infection and malaria prophylaxis

SIR,—Drs Pheng Soon Lee and Edwin Y L Lau (26 March, p 893) conclude that differences in the risk of upper respiratory tract infection in the military recruits described was due mainly to the malaria prophylaxis given to one group. This is based on the false presumption that other factors have been compensated for adequately.

Despite the geographical similarity and proximity of the two camps there remains a sufficiently great environmental difference between them for malaria prophylaxis to be required at only one. Surely risks for other infections might also differ.

Other variables which are unaccounted for may be important. Psychological stress is a well recognised cause of immune suppression.¹ Examination students under stress have been shown to have impaired cellular immunity² and reduced production of IgA.³ In the latter study there was a higher incidence of respiratory disease during the period of stress. The impact of personality factors was also assessed. Students exhibiting a "high inhibited need for power" had concentrations of IgA that continued to fall even when the amount of stress decreased. Officer recruits undergoing greater physical and psychological stress than other recruits might be affected similarly.

Greater physical activity has not been excluded as the cause for a higher risk in the officer cadet group. The reasoning that if it were related the increased risk of sprains and of upper respiratory tract infections should be identical is flawed. This is no more logical than saying that jogging should increase the risk of ankle injuries by exactly the same percentage as it increases the risks of being run over by a car. I would be reluctant to draw any conclusion about the relevance of dapsone-pyrimethamine as a cause of immunosuppression on the basis of the authors' findings, and I hope that prescribing practices are not altered.

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Postviral fatigue syndrome

SIR,—Dr A V Mark Hughson (9 April, p 1067) suggests that our arguments have been overtaken by a report which was published after our paper was accepted.¹

In that paper enteroviral infection was found in 17 of the 76 (22%) subjects with postviral fatigue syndrome, and it persisted in only five (7%) at one year. In a second sample of 87 people with postviral fatigue syndrome an enteroviral antigen was detected in 44 (51%), and this remained in 39 (45%) at four months. Despite the detailed virological studies, we think that this investigation exemplifies some of the shortcomings in "the old approach" to this condition. There are scant details on diagnostic criteria and no information on case selection or why there were two samples. Using volunteer control subjects, enlisted by the cases, may have led to biases that could account for the differences. The importance of these results will emerge only with precise information about the population from which cases were drawn and the methods by which they were selected.

One of the main aims of our paper was to encourage discussion of the definition of cases. Dr Hughson points out that we risk underdiagnosing the disorder. This caution is appropriate for research purposes but it does not mean that patients with some features suggesting the syndrome need be denied the best care in clinical settings. This may include prescribing rest for all suspected cases, but such instructions, which have anecdotal support, must be weighed against the potentially severe complications of prolonged inactivity.² The role of controlled exercise in the