"It is no longer justifiable for one physician to spend twice as much money as another on treating patients with similar diseases," yet it is almost embarrassing to report that only the private sector seems to be using well researched, humane, and acceptable techniques which reduce the duration of opiate withdrawal from the usual two to three weeks to two to three days or less.^{4,6}

COLIN BREWER

Stapleford Unit,
London Road,
Stapleford Tawney,
Essex RM4 1SR

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Fibre and patients with diabetes

SIR,—Ms V A Beattie and others (23 April, p 1147) state that viscous fibres have no therapeutic benefit for type II diabetic patients when added to a low energy, high carbohydrate, low fat diet. In their study the lack of washout periods between different treatments is unwise and could lead to misleading results, especially of concentrations of glycated haemoglobin. The method of giving the guar gum is not clear. Was it added to the main meals or given otherwise? Fasting blood glucose concentrations at the end of the run in periods were not grossly raised, an important factor for a beneficial effect from guar.

We have recently conducted an eight week randomised, non-crossover study of 15 g of guar mini tablets given daily before meals compared with placebo in 20 overweight non-insulin dependent (type II) diabetic patients who failed to respond to diet. Guar was well tolerated, although eight of 12 patients receiving guar experienced mild gastrointestinal upsets, which settled in one to two weeks in all but one patient.

Guar significantly reduced the fasting plasma glucose concentration (14.05 (SD 2.61) before treatment v 11.01 (2.02) mmol/l after treatment), postprandial glucose concentrations (17.50 (3.10) v 14.32 (3.60) mmol/l), glycated haemoglobin concentrations (9.96 (1.17) v 7.86 (1.00)), total cholesterol concentrations (7.44 (1.90) v 6.78 (2.20) mmol/l), and triglyceride concentrations (3.8 (2.18) v 2.99 (1.47) mmol/l) (in each case $p < 0.05$). No changes were observed in these variables with placebo.

Six out of nine patients in the guar group lost their symptoms of hyperglycaemia during the study compared with one of eight in the placebo group. Our results show a therapeutic benefit conferred by guar gum, and we conclude that it is effective in patients whose blood glucose concentrations remain high despite dietary measures.

A LAKHDAR
E FARISH
E H McLAREN

Stobhill General Hospital,
Glasgow G21 3UW

SIR,—Non-viscous, non-digestible materials in the diet have no important influence on the meta-

bolic control of diabetes. In contrast, viscous fibre, when intimately mixed with food, has been shown to delay carbohydrate absorption and lower serum concentrations of cholesterol. Many papers have been published to this effect.¹ Ms V A Beattie and others (23 April, p 1147) do not contribute usefully to them.

It is well recognised, for example, that guar, like many other treatments, must be started slowly. We prescribe half a satchet (2.5 g) with the evening meal for the first week of treatment and increase this slowly to a maximum of 10 or 15 g daily. If this is done over three to six weeks minimal bowel symptoms result and compliance is good. In contrast, a high proportion of patients begun on 15 g a day all at once will suffer from severe bowel symptoms.

For the best effect the gum needs to be mixed with the food.^{2,4} This is presumably because its effect is achieved through increasing the viscosity of the gastric chyme, preventing ingress of digestive enzymes and increasing the unstirred layer in the small intestine, both effects being likely to delay the absorption of nutriment. Indeed, drinking guar with a glass of water before the meal seems designed to frustrate its effective action by reducing mixing of guar with the food. The authors did not describe their mode of giving guar—a surprising omission.

If the optimal fasting blood glucose concentration is taken as 5 mmol/l the two groups on high fibre diets at 20 weeks were above this target by 1.8 and 1.5 mmol/l, while the low fibre group was above it by 2.8 mmol/l. This difference could be biologically important, and the lack of statistical significance might reflect the design of the trial and the small numbers of patients studied rather than a true lack of effect.

S R BLOOM

Royal Postgraduate Medical School,
Hammersmith Hospital,
London W12 0HS

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Neisseria gonorrhoeae resistant to tetracycline

SIR,—Dr M A Waugh and others (26 March, p 898) discuss the isolation of tetracycline resistant *Neisseria gonorrhoeae* in the United Kingdom. We have also encountered infections caused by these organisms in patients attending the Praed Street Clinic at St Mary's Hospital. Since our original report of eight such infections¹ we have isolated a further six strains of tetracycline resistant gonococci, all from heterosexual patients.

Recently we have encountered a strain of *Neisseria meningitidis* that also has high resistance to tetracycline (minimum inhibitory concentration > 8 mg/l). This was isolated from the pharynx of a homosexual man during screening for pharyngeal gonorrhoea. Analysis showed the presence of a plasmid of approximately 25.2 megadalton. A similar isolate of *N. meningitidis* (received from Dr M S Sprott at the Newcastle Public Health Laboratory) showed a plasmid of identical size. In gonococci the determinant for high level resistance

to tetracycline is integrated into the conjugal plasmid to give a plasmid of 25.2 megadalton.²

Plasmids are unusual in meningococci, although low molecular weight cryptic plasmids have been described.^{3,4} To our knowledge there has been only one report of plasmid mediated antibiotic resistance in a clinical isolate.⁵ This strain carried both a penicillinase encoding plasmid of 4.5 megadalton and a conjugal plasmid of 24.5 megadalton. Transfer of penicillinase plasmids between gonococci and meningococci has been achieved in vitro, but acceptance of the conjugal plasmid by the meningococci has not been shown.^{6,7}

The presence of a 25.2 megadalton plasmid in these two isolates of meningococci, which both exhibit high level resistance to tetracycline, is alarming. This plasmid may have been acquired from gonococci. If this is true the plasmid will be capable of self transfer,² allowing further dissemination of tetracycline resistance. Both of these isolates were associated with asymptomatic carriage. This means that the presence of the 25.2 megadalton plasmid could easily remain undetected. While tetracycline resistance is not of concern in meningococcal disease, the presence in the pharynx of meningococci that carry self transmissible plasmids is worrying. Meningococci should be screened for tetracycline resistance, particularly in areas where the 25.2 megadalton plasmid has been found in gonococci.^{1,8}

CATHERINE A ISON
KHALID BINDAYNA
NEIL WOODFORD

Department of Medical Microbiology,
St Mary's Hospital Medical School,
London W2 1PG

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- 8 Anonymous. *Tetracycline resistant Neisseria gonorrhoeae*. Collingbourne: Public Health Laboratory Service, 1987. (Communicable Disease Report No 46.)

Meningococcal meningitis

SIR,—Dr G Venkat Raman (23 April, p 1141) stated that rifampicin is the prophylactic drug of choice for meningococcal meningitis. A 14 year old girl was admitted in the last week of March 1988 with what proved to be meningococcal meningitis. Rifampicin prophylaxis was given to all of her close contacts. It was shown subsequently by disc diffusion tests that this isolate was resistant to the sulphonamides and rifampicin, and these results were confirmed by the Meningococcal Reference Laboratory.

This strain was sensitive to the tetracyclines and ciprofloxacin, and ciprofloxacin was given prophylactically to the home contacts. We were told that this had been used successfully at a naval establishment (N Gaunt, personal communication) to protect adolescents. No adverse effects were reported, and so far no evidence of secondary meningococcal disease has occurred.

Although, fortunately, rifampicin resistant meningococcus is rare in the United Kingdom, we believe that doctors should be aware that these strains do exist.

A S SOHAL
V R RAO

Wakefield Health Authority,
West Yorkshire WF1 4DH

Other health services

SIR,—What an interesting view of different health care systems was offered by Dr Helga Rheim (9 April, p 1063). The grass is evidently greener in Edinburgh than in West Germany and, judging from her report, much greener than it was when I left the National Health Service in 1965.

For nearly 20 years I worked in various hospitals in Scotland and England, and I have revisited them from time to time since I left. There are many good things to be said about the NHS, but I remember the long waiting lists, overcrowded waiting rooms, lack of privacy in open wards, grossly overworked junior staff, too few consultants, and consultants with no incentive to show courtesy to patients or their general practitioners. I take my hat off to the many consultants I knew who were courteous, because it served only to increase their workload and their waiting lists.

For the past 23 years I have been in specialist practice in Australia, working in both public and private hospitals. My experience is limited to the smallest capital city of the smallest state, but I have no reason to believe it to be unique in Australia.

Points

After the horror

Dr RITA HENRY-GUTT (Shenley Hospital, Radlett, Hertfordshire WD7 9HB) writes: Professor Beverley Raphael and Dr Warwick Middleton (23 April, p 1142) draw attention to the difficulty that sometimes occurs in diagnosing post-traumatic stress as a cause of psychological distress. There is now evidence that the effects of such trauma may extend to the children of the victims, and this needs to be recognised when they experience psychological problems in adult life. The work on this relates in particular to the children of survivors of the Holocaust.^{1,2} Some of the problems relate to disturbed family relationships resulting directly from the psychological symptoms of the parent. There is also the difficulty the second generation experiences in accepting the victim as "a good enough parent."³ This seems to produce a feeling of the world as dangerous and life as insecure, leading to depression and anxiety requiring treatment. This problem of the second generation is not generally recognised by doctors in Britain, and this may preclude correct diagnosis and appropriate treatment.

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- 3 Bettelheim B. *A good enough parent*. London: Thames and Hudson, 1987.

Cervical cytology screening

Dr DAVID SLATER (Department of Histopathology, Rotherham District General Hospital, Rotherham S60 2UD) writes: The organisation and results of the British Columbia programme described by Dr George H Anderson and others (2 April, p 975) are impressive and invite comparison with the British programme.

British Columbia and other countries, including Iceland,¹ with broadly similar programmes provide further evidence that high compliance (80%) and frequent recall (every one to three years) will achieve a

There is a strong commitment to medical ethics and to a compassionate profession. I have never experienced refusal of cooperation between hospitals or "rival" doctors. There certainly are competing medical insurance companies, but they compete in the services they offer. They rebate money to patients, rather than paying doctors, so companies cannot interfere in medical decision making.

The great advantage of our system is freedom to practise medicine as I wish to practise it and to compete against my fellows in the quality of service I offer. This is an incentive to keeping waiting time to a minimum; to keep wards, consulting rooms, and waiting rooms clean, cheerful, and comfortable; and to communicate clearly and courteously with patients and the general practitioners who refer them.

The patients, most of whom are insured for private hospital care, have freedom to choose their general practitioner and their specialist, which hospital they prefer, and the date on which admission would be convenient. The biggest blot on our system is that not everyone can afford to be fully insured. They must accept what the public hospital system provides, which does not offer freedom of choice. If freedom of choice is the hallmark of a truly democratic society the most obvious way to improve our system would be to extend full medical and hospital insurance to all, regardless of income, so that even the poorest have the same choices as everyone else.

JOHN LARGE

Hobart 7000,
Tasmania

Training in obstetrics and gynaecology

SIR,—Mr J D Hamlett (30 April, p 1256) is concerned about the "decline in number and quality of junior staff" in obstetrics and gynaecology and the excessive workload and antisocial hours in the specialty. I think I may be one of the "inadequate" junior staff whom he describes as I have many "faults in the basic human material available for training." Let me describe my experience of working in a department of obstetrics and gynaecology as a senior house officer on a vocational training scheme.

One of my "faults" is that I need to sleep at night. Nevertheless, I was expected to work for three days and two nights with little sleep during weekends on call. There was a gross imbalance between the service and training components of my job. I spent 84 hours each week on call and got 15 minutes of formal teaching. The consultants showed little interest in theoretical teaching and none at all in bedside teaching. Nobody ever watched me examine a patient. Is it surprising that I was less "adequate" than I should have been? And I was not unique: senior house officers are abused in this way all over Britain.

Most of Mr Hamlett's suggestions are sensible. Of course the job should be structured to provide sensible hours of duty, workload, and sleep. I particularly like his idea of a one in five on call rota and a day off after a night on, but I hope that his proposal applies to junior staff as well as to consultants.

PETER GRAY

Workington,
Cumbria CA14 1LW

large reduction (72-78%) in mortality from cervical cancer. The continuing laissez faire British policy² will have some effect but, tragically, substantially less than in Canada. Patient compliance and recall frequency are independent factors in the equation of success, and it is illogical for the government to resist mandatory increased frequency of recall because of variable compliance. The Canadian policy of concentrating cytological skill in large central laboratories has advantages. This opportunity was lost in Britain with devolution to health districts. The computer is the central pivot in the Canadian laboratory and there is extensive and adequate technical and clerical help. In Britain, although computerised call and recall are now mandatory, laboratory computerisation for adequate follow up and fail safe mechanisms remains desirable but optional.³ The British Society for Clinical Cytology recommendations on laboratory staffing³ are comparable to those for Canada—even down to screening one slide every eight or nine minutes. Sadly, however, these recommendations fall well short of practice in most British laboratories.

- 1 Laara E, Day NE, Hakama M. Trends in mortality from cervical cancer in nordic countries association with organised screening programme. *Lancet* 1987;i:1247-9.
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- 3 British Society for Clinical Cytology. *Recommended code of practice for laboratories providing a cytopathology service*. London: BSCC Publication, 1986.

malignant oral conditions. What evidence supports Dr Osborne's contention that dental examinations are less essential than sight tests? Furthermore, although water fluoridation is of undoubted benefit in reducing dental caries, fluoridated water is available to only a minority of the population of the United Kingdom. The decline in the prevalence of caries in recent years cannot, therefore, be attributable to this single cause. Given the government's declared commitment to prevention of disease, it seems paradoxical that charges for any screening examinations should be proposed. Are cervical smears to be the next item to attract a charge?

Disabled living centres

Professor W A WALLACE (Department of Orthopaedic and Accident Surgery, Queen's Medical Centre, Nottingham NG7 2UH) writes: Dr M A Chamberlain discusses the development of disabled living centres and their value in providing a display of "tools for living" and valuable information of all types for the disabled. There is, however, an error in her map of the location of disabled living centres as a number of newer ones are now being opened. In particular, a resource centre for the disabled was opened in Nottingham in 1987, and Nottingham should be recorded on the map as having a full disabled living centre.

Correction

Urinary catheters

We regret that an error occurred in this letter by Dr D J Vaughan and others (30 April, p 1258). The first sentence of the second paragraph should have read: "Chlorhexidine may not only be inhibited or inactivated by urine itself; up to half of all catheter specimens of urine may contain organisms resistant to this antiseptic."

Charges for dental examinations

Dr M J ALDRED and Mr P J M CRAWFORD (Department of Oral Surgery, Medicine, and Pathology, Dental School, Heath Park, Cardiff CF4 4XY) write: We are concerned by the comments attributed to Dr L Osborne regarding dental examinations and their effect on dental health (23 April, p 1207). Dental examinations should not be regarded solely in relation to caries. They are important in the recognition and referral of, among other things, premalignant and