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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Treatment of tuberculosis

SIR,—I have recently learnt that it is the custom of some orthopaedic surgeons in Britain to give one month of chemotherapy to a patient with a tuberculous fistula. Fistulae may initially close with such treatment, at least temporally. But, of course, these lesions arise from the haematogenous spread of tubercle bacilli. Very short course chemotherapy exposes the patient to an avoidable risk of later relapse, either locally or with tuberculous lesions elsewhere. I am further told that this and other deviations from the well-established rules of antituberculosis chemotherapy are still not too uncommon in some areas of Britain, especially among orthopaedic surgeons, urologists, and gynaecologists.

Thirty years after the introduction of chemotherapy for tuberculosis and at least 18 years after the establishment of its modern principles, which should guarantee the patient against relapse and are the same for all forms of tuberculosis, such treatment shows a degree of ignorance and a neglect of the patient's interests which might well expose the consultant to a suit for damages should the patient later relapse. None of us, of course, can know all about all branches of medicine and I am as ignorant as any outside my own field, but we do have an obligation to seek specialist advice when we are faced with a problem beyond our expert knowledge. Nowadays virtually every chest consultant in these islands knows how to treat tuberculosis and his advice should normally be sought in such cases.

I feel ashamed to have to write this letter, which must sound arrogant and emotional, but I do so in the hope that its publication may help to reduce the pockets of Dark Age treatment of tuberculosis which until recently I had thought were now confined to more backward countries.

JOHN CROFTON

Edinburgh

Return of whooping cough

SIR,—In a recent debate in the House of Lords on the Public Health Laboratory Service Bill it was revealed by a distinguished medically qualified speaker that in England and Wales there had been 50 000 cases and 12 deaths from whooping cough this year.[1] Cases of brain damage have occurred also from the disease. What arrangements are proposed for compensation for these children?

T S WILSON

Glasgow

[1] *Hansard*, House of Lords, 30 November 1978, col 1437.

SIR,—A medical student and a general practitioner, using whooping cough as an example, warn of the dangers of failure of the immunisation programme (9 December, p 1639).

Vaccination and immunisation have been controversial since Lady Montagu popularised mild case infection and Dr Dimsdale took it to the Russian court, well knowing the penalty for failure. Jenner's vaccine had to replace the old method. Diphtheria antitoxin survived Dr Hadwin and the antivivisectionists.

The progress of vaccination and immunisation during the past 40 years is one of the exciting advances in medicine—smallpox virtually eradicated, diphtheria and polio rare, and whooping cough was in retreat in the western world. That the whooping cough controversy, a scientific dispute conducted in public without all the facts or agreed criteria, has sapped the confidence of the public cannot be denied. The Joint Committee on Vaccination and Immunisation has consistently said that whooping-cough immunisation should continue and recent studies support this contention.

However, the single incidence of whooping cough is not the only issue: the whole immunisation programme is at stake. In the past unless parents objected their children were vaccinated, troops were lined up and inoculated, and only the strongest protested. In civil life doctors and health visitors pressurised, the public complied, and there are now several previously killing and debilitating diseases which many doctors have not seen. The success of the programme and its artificial herd immunity is taken for granted; publicity relating to complications causes a proper questioning attitude in people's minds, and to cater for this and to assess and advise on each case more time must be given by doctors and nurses, and of course this costs money. If rubella immunisation is to be extended to seronegative women of child-bearing age the extra work load of the laboratory service must be allowed for.

There is a communication gap between the Joint Committee on Vaccination and Im-