BRITISH MEDICAL JOURNAL

SATURDAY 6 JULY 1985

LEADING ARTICLES

What's new about hay fever? STEPHEN T HOLGATE, PETER H HOWARTH 1
Epilepsy and employment DAPHNE GLOAG 2
Quinine for night cramps JOHN HENRY 3
Regular Review: Rh(D) haemolytic disease of the newborn: the changing scene S J URBANIAK 4

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Failure of acyclovir cream in treatment of recurrent herpes labialis
MARCIA SHAW, MARY KING, JENNIFER M BEST, J E BANATVALA, JOHN R GIBSON, MICHAEL R KLABER 7
Relation of gene expression (allotypes) of the fourth component of complement to insulin dependent diabetes and its microangiopathic complications C MIJOVIC, J FLETCHER, A R BRADWELL, T HARVEY, A H BARNETT 9
Effect of vegetarianism on development of gall stones in women FIONA PIXLEY, DAVID WILSON, KLIM McPHERSON, JIM MANN 11
A somatic component to myocardial infarction ALEXANDER S NICHOLAS, DOMENIC A DeBIAS, WALTER EHRENFEUCHTER, KATHERINE M ENGLAND, ROBERT W ENGLAND, CHARLOTTE H GREENE, DAVID HEILIG, MICHAEL KIRSCHBAUM 13
Deaths from rhesus haemolytic disease in England and Wales in 1982 and 1983 CYRIL A CLARKE, P L MOLLISON, A G W WHITFIELD 17
Relief of pain by infusion of morphine after operation: does tolerance develop?
HUW MARSHALL, COLIN PORTEOUS, IAN McMILLAN, STUART G MacPHERSON, WALTER S NIMMO 19
Intravascular haemolysis induced by pentachlorophenol A B HASSAN, H SELIGMANN, H M BASSAN 21
Changes in serum thiocyanate concentration on stopping smoking BURCKHARD JUNGE 22
Thrombocytopenia in hypothermia: a common but poorly recognised complication P J EASTERBROOK, H P DAVIS 23
Mixed malarial infection due to Plasmodium falciparum and P vivax
LORENZO SAVIOLI, ANNAPAOLA DE FELICI, MARIA GRAZIA PAGLIA, GIUSEPPE VISCO 23
Increased serum pancreatic enzymes after treatment with methylprednisolone: possible evidence of subclinical pancreatitis
P DANDONA, D JUNGLEE, A KATRAK, V FONSECA, C W H HAVARD 24
Psoriasis, alcohol, and liver disease JEAN-CLAUDE CHAPUT, THIERRY POYNARD, SYLVIE NAVEAU, DOMINIQUE PENSO, OLIVIER DURRMEYER, DENIS SUPLISSON 25
Hyperosmolar non-ketotic diabetes mellitus associated with metolazone PETER A ROWE, H G MATHER 25
Pituitary apoplexy after combined test of anterior pituitary function A J CHAPMAN, G WILLIAMS, A D HOCKLEY, D R LONDON 26
Practice Organisation: How safe is your surgery? ANNE PAINE 27
Respiratory consultations in asthmatic compared with non-asthmatic children in general practice
MARK LEVY, MOHINI PARMAR, DAVID COETZEE, STEPHEN W DUFFY 29

MEDICAL PRACTICE

Death and blindness due to overdose of quinine E H DYSON, A T PROUDFOOT, L F PRESCOTT, R HEYWORTH 31
ABC of Nutrition: Reducing the risk of coronary heart disease A STEWART TRUSWELL 34
For Debate: Over the counter sale of topical corticosteroids: the need for debate SAM SHUSTER 38
Communicable Diseases: National Congenital Rubella Surveillance Programme 1 July 1971-30 June 1984
R W SMITHELLS, S SHEPPARD, HELEN HOLZEL, ANN DICKSON 40
CDSC Report: Outbreak of poliomyelitis in Finland 41
Lesson of the Week: Apparent portosystemic encephalopathy in patients with chronic liver disease
C C KIBBLER, G P JEFFREY, O EPSTEIN, N McINTYRE 42
Philosophical Medical Ethics: Beneficence: doing good for others RAANAN GILLON 44
CSM Update 46
Any Questions? 33, 37, 39
Materia Non Medica—Contribution from K G HEYMANN 43
Medicine and Books 47
Personal View NELL O'CONOR 50

CORRESPONDENCE—List of Contents 51

OBITUARY 61

NEWS AND NOTES

Views 58
Medical News 59
BMA Notices 59
One Man's Burden MICHAEL O'DONNELL 60

SUPPLEMENT

The Week in Plymouth 64
Presidential address: Politics is good medicine 86
Deterioration in relations between profession and government, warns chairman of council 88

NO 6487 BRITISH MEDICAL JOURNAL 1985 VOLUME 291 1-88
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 291 (6487) 1-88 (1985)

CORRESPONDENCE

Audit for all
T P C Schofield, FRCGP 51

Simultaneously acquired hepatitis B and hepatitis D virus infections
F Caredda, MD, and others 51

Epidemic hypochlorhydria
P I Reed, FRCP, and C L Walters, PHD; B J Rathbone, MRCP, and others; R H Hunt, FRCP, and D Darkin, BSC 52

Non-cemented hip prostheses
R N Villar, FRCS 53

Acute respiratory insufficiency from psittacosis
T Wheatley, MRCP, and G R Park, FFARCS; J H Winter and others 53

Intranasal calcitonin and plasma calcium concentrations
J C Stevenson, MRCP; A E Pontiroli, MD 54

Numbers of immature livebirths
R R Gordon, FRCP; D Field, MRCP 55

Two different mechanisms in patients with venous thrombosis and defective fibrinolysis
G T Layer, FRCS, and K G Burnand, FRCS 56

Vitamin B_{12} injections
R Berlin, MD 56

Where are the unemployed doctors?
N E Scholes, FRCSED 56

Malaria at high altitudes in Africa
Monica Fisher, MB 56

Points Infective endocarditis: a preventable disease? (P Lyn); Sutures or adhesive tapes for primary closure of pretibial lacerations (F Dudley Hart); Ovariectomy and breast cancer: did Schinzinger beat Beatson? (H Vorherr); Accidental digitalis poisoning due to drinking herbal tea (G P Spickett); Chest physiotherapy in primary pneumonia (J Sim and others); Is peritoneal dialysis a good long term treatment? (D G Oreopoulos); Acute appendicitis and dietary fibre (R G Benians); Fenclofenac induced interstitial nephritis (L Sellars and others); Review body proposes 6·3% rise (A J Macdonald) 57

Correction: Delayed puberty (Zondek and Zondek) 57

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Audit for all

SIR,—I read the Audit Reports (15 June, p 1792) and admired the authors for both their honesty in publishing their results and their determination to improve their practices still further.

The next article, surveying the treatment of primary breast cancer in Great Britain (p 1793), paints a similar picture of suboptimal care and variable organisation. The conclusion, however, that "the time has come to encourage treatment by specialist breast units" is very different.

The leading article by Professor L E Hughes and Mr S P Courtney on the follow up of patients with the same condition (27 April, p 1229) also argues the case for rigorous organised care but again concludes, without any evidence, that this should take place in hospital clinics rather than in general practice. Where such evidence does exist, as, for example, with the measurement of blood glucose and detection of complications in diabetes, the outcomes of care in well organised general practice are comparable with those in hospital clinics, while both are better than disorganised or random care.[1]

Our criteria for good quality care should not concentrate solely on technical indices but should include interpersonal factors such as accessibility, continuity, and patient satisfaction. We must remember that the obstetricians who have led the profession by reviewing their performance in terms of maternal and perinatal mortality have also been on the receiving end of the most vociferous criticism from patients for their relative neglect of these other dimensions of quality. Finally, as we have seen in the United States, the economic implications for transferring more patient care to specialist units can be horrendous.

You may feel that all I am doing is making my special case for undertaking the care of patients as the authors to which I refer are making theirs. The conclusion I would prefer to draw, however, is that all doctors should be involved as part of their normal professional activities in setting criteria for their own work and monitoring the level of performance in achieving them. It is only by this method that we can guarantee good quality care for our patients wherever they receive it.

T P C SCHOFIELD

Oxford Regional Committee for Postgraduate Medical Education and Training,
John Radcliffe Hospital,
Oxford OX3 9DU

1 Dornan C, Fowler G, Mann JI, Markus C. A community study of diabetes in Oxfordshire. *J R Coll Gen Pract* 1983;**33**:151-5.

Simultaneously acquired hepatitis B and hepatitis D virus infections

SIR,—We would like to refer to a few of the issues raised by Dr Alan G Shattock and colleagues (11 May, p 1377). In contrast to their previous reports,[1,2] the data reported in this paper suggest a strong association between hepatitis B and hepatitis D virus coinfection and the severity of hepatitis in drug abusers in Dublin. This association has been reported in a group of drug addicts in Milan.[3] These observations make unlikely the hypothesis of Dr Shattock about the possible role of ethnic (genetic) factors in the severity of delta coinfection.[1,2]

We agree with the authors that a high proportion of drug abusers with acute HBsAg positive hepatitis have serological evidence of simultaneously acquired hepatitis D infection and that a significant proportion of these patients have a more severe disease than patients with classical hepatitis B.[3,4] Nevertheless, we would like to make several points.

The acute (primary) hepatitis B infection might be shown serologically in all the patients by testing the acute sera for IgM anti-HBc. Moreover, the titration of IgM anti-HBc might be used to distinguish individuals simultaneously infected by both agents from carriers of HBsAg (still positive for IgM anti-HBc at a borderline level) superinfected by hepatitis D,[5] a condition often observed in drug abusers,[4] whose carrier state is generally of recent onset.

Since anti-δ antibody in patients previously negative for serological delta markers is sometimes detectable only 4-6 weeks after the onset of disease,[3] the incidence of hepatitis D infection may be underestimated if serial serum samples are not tested.

Concerning the clinical and biochemical characteristics of the patients with acute hepatitis studied by Dr Shattock and colleagues, it is surprising that most of them had either an asymptomatic disease (29/267) (alanine aminotransferase values less than twice normal) or a mild or moderate illness (223/267) (values <10 times normal). It would be interesting to know if all the first serum samples tested were taken during the acute phase of the disease. Unfortunately there are no indications about the diagnostic criteria since no symptoms were reported and alanine aminotransferase values, in most of the cases studied, were not consistent with clinically acute hepatitis, so the possibility that some of the patients might have been observed after the acute phase of the disease cannot be excluded. Such data are also important for establishing the persistence of hepatitis D antigenaemia.

We agree with Dr Shattock and colleagues that the detection of HDAg in serum is not uncommon in drug abusers with hepatitis B and D coinfection, since we also have found HDAg by radioimmunoassay in 19·6% (49/250) of the drug abusers with delta infection. Delta antigenaemia is always associated with the presence of hepatitis D RNA in serum and it is detectable until the first or second week after the onset of symptoms (FC, unpublished data). In contrast, and with the same technique, delta antigenaemia is only rarely observed in non-addicts so that this phenomenon could not be explained simply by a lower sensitivity of radioimmunoassay.