conclusions he draws from his study. In addition he fails to mention whether he uses the fourth or fifth sounds to determine diastolic pressure, there being on average a difference of five mm Hg mercury between the two.

ANDREW HAINES

Glyncorrwg Health Centre,
Near Port Talbot,
Glamorgan,
Wales.

REFERENCE

Fry, J. (1975). *Journal of the Royal College of General Practitioners*, **25**, 481–94.

USING GLOVES

Sir,

In my description of *A labour-saving manoeuvre* (June *Journal*) I wrote that "when the cervix is very thin and closely applied to the fetal scalp it is easier to employ an ungloved hand." (In such occasional cases dilatation is completed rapidly with a minimum of force). My attention has been drawn to the recommendation of the Medical Defence Union that the hand should be gloved for all vaginal examinations or procedures.

K. D. SALZMAN

Western Elms Lodge,
317 Oxford Road,
Rading, RG3 1AX.

REFERENCE

Salzmann, K. D. (1975). *Journal of the Royal College of General Practitioners*, **25**, 401–16.

GENERAL PRACTITIONERS' REFERRAL LETTERS

Sir,

The interesting article in the July *Journal* notices that about half of a series of patients referred to hospital and subsequently admitted did not have a general practitioner's letter in the in-patient notes.

The reasons for this were touched on only lightly. It was suggested that in the case of casualty admissions the patients had probably referred themselves.

There are many reasons why a letter might be absent from hospital inpatient notes. Among the less obvious possibilities, but each within my personal experience, are the following:

(1) The letter was forgotten and remained at home

(2) The letter was opened by an unauthorised person who found that he could not reseal it without revealing that it had been opened. It was therefore discarded

(3) As in (2) above but the unauthorised person considered that the contents were best withheld from the hospital and the letter was therefore discarded.

(4) The letter remained in the patient's personal belongings throughout the hospital admission. Nobody asked him for it and he did not think to produce it.

The conclusion of the authors that patients often refer themselves is certainly true. There are cases in which the patient has referred himself with the knowledge, but against the expressed advice, of his general practitioner.

D. A. FURNISS

Windmill Health Centre,
Mill Green,
Seacroft,
Leeds, LS14 5JS.

REFERENCE

Durkin, C. J. and Edwards, A. (1965). *Journal of the Royal College of General Practitioners*, **25**, 532–536.

DIAGNOSIS OF PREGNANCY

Sir,

I wish hospital diagnosis of pregnancy was as quick in my area as it was in the survey reported in the July *Journal*. The authors, Professor Barber and Dr Robinson, regarded the average delay of three days as unacceptable, though Dr Cargil, writing in *Doctor* disagreed with them.

My nearest hospital, at Loughborough, will send urine for pregnancy testing providing a fully labelled sample is delivered to the hospital with a request slip not later than 09.30 hours on a Monday or Tuesday. The results have usually taken 4–7 days to reach the surgery. If Monday or Tuesday happen to be holidays or if there is any imperfection in the labelling of the sample or request form, there is likely to be a further delay of at least a week. Thus someone attending surgery on a Tuesday would be lucky to have the result of a hospital pregnancy test within ten days. For these reasons I do my own pregnancy testing. Incidentally the return journey to the hospital by public transport may cost 50p or more.

A. P. K. JOHN

116 Charnwood Road,
Shepshed,
Loughborough,
Leicester LE12 9NP.

REFERENCE

Barber, J. H. & Robinson, E. T. (1975). *Journal of the Royal College of General Practitioners*, **25**, 511–19.

CHOICE OF PRACTICE LOCATION

Sir,

I was interested to read the article by J. R. Butler and R. Knight on *The Choice of Practice Location* (July *Journal*). I suppose that I would come into the category of doctors aged between 40 and 49 years at the time of survey. He remarks that one might have expected more of these doctors to have moved when vacancies outnumbered applicants, but did he ask any of these doctors what the size of their overdraft was at the material time?

Having started with a 'negative' profit in my first years in the National Health Service, I had to buy a house and a share of the practice property, at an inflated value, etc. and I eventually had an overdraft of some £15,000 to £20,000 before I was able to start paying this off, mostly by inherited "monies". I think that this was the anchor to my practice and not laziness or disinclination to uproot.

D.HUTCHISON

REFERENCE

Butler, J. R. & Knight, Rose (1975). *Journal of the Royal College of General Practitioners*, **25**, 496–509.

MYALGIC ENCEPHALOMYELITIS

Sir,

I and some fellow doctor-sufferers of myalgic encephalomyelitis would like to form a group with the aims of furthering research into this unusual illness and providing help and support for fellow-sufferers.

Acheson (1959) wrote the classical description of this illness. We have no doubt that the disease is not hysterical, but an organic entity, but because of the protean nature of the clinical picture difficulty in diagnosis remains our chief problem. In other virus diseases like glandular fever or infective hepatitis two or more attacks can occur, but myalgic encephalomyelitis is unique in my experience in relapsing ten or more years after the original attack.

Permanent damage to the central nervous system may be sustained with slow deterioration and a feature of the 'relapses' which distinguishes them from multiple sclerosis is the severity of the pain unresponsive to the usual analgesics, and the malaise and weakness which apart from a low fever, show very little in the way of positive physical signs to account for them.

We would like to establish some criteria for diagnosis, such as a typical history in chronic relapsing cases and a preceding sore throat or attack of diarrhoea and vomiting in acute ones. An extreme pallor, enlarged glands, generalised muscle weakness with tenderness in some cases, increased jerks, giddiness and a history of conjunctivitis are other features.

Fluctuation of symptoms from day to day and at different times of the day is almost diagnostic, but may mistakenly be assumed to be hysterical. The association of neurological signs and symptoms such as difficulty in walking with evidence of gastrointestinal disturbance, e.g. nausea, anorexia and abdominal pain should make one suspect the diagnosis.

In my experience, symptoms are characteristically worse on lying down and pain is frequently so severe at night it wakes the patient in the early hours of the morning. Fatiguability is a constant feature and rest is essential in the early stages as aggravation of symptoms after exertion is responsible for the frequent relapses during convalescence.

At present there is no definitive diagnostic test, but a serum pyruvic acid or lactate or muscle biopsy have been suggested as possible lines of research.

The cause of the illness is unknown, but in a chapter on the central nervous system in the April 1975 issue of *The Practitioner* devoted to autoimmunity, disseminated encephalomyelitis was linked with multiple sclerosis, myasthenia gravis, and lupus erythematosis. It is interesting that it has features in common with all three and in my opinion could be either a slow virus infection of the CNS like multiple sclerosis, but producing more signs of encephalitis than myelitis, a multisystem auto-immune disease like lupus erythematosus, or a myopathy like myasthenia gravis.

It is our impression that the disease now largely goes unrecognised, unless it erupts in an outbreak at an institution. But sporadic cases do occur and we would like your help in identifying them. General practitioners see more cases than hospital consultants particularly in the less severe forms and can see the different ways members of the same family are affected. This therefore seems a piece of research which the R.C.G.P. is particularly well qualified to undertake.

CELIA WOOKEY

51 Lake View,
Edgware,
Middlesex.

REFERENCE

Acheson, E. D. (1959). *American Journal of Medicine*, 569.

HOURS ON CALL

Sir,

Surely Dr Dermot Lynch was joking in his letter in the May *Journal* when he said that after a 40-hour week 20 hours of standby, with two attendances created a tension state leading to fatigue.

This seems to me to be general practice at its leisurely best. A five-day week, each day of eight hours, work, and, after two emergency consultations taking perhaps half an hour each, 19 nail biting hours of on call!

I. D. KERR

Clare House,
Tiverton,
Devon, EX1 6NJ.

REFERENCE

Lynch, D. (1975). *Journal of the Royal College of General Practitioners*, **25**, 396.

THIRD INTERNATIONAL CONGRESS ON GROUP MEDICINE

Sir,

The third International Congress on Group Medicine is to be held in Paris next June. I am