

RUBELLA IN EARLY PREGNANCY

Sir,
May I comment on your editorial (November *Journal*) on the management of rubella in early pregnancy?

You state that some practitioners will prefer to wait for the result of a pregnancy test before investigating a woman who has missed a period and been in contact with rubella. This delay is unwise for two reasons, firstly because subsequent failure to collect a blood specimen within the incubation period will add greatly to the difficulty of making a laboratory diagnosis of rubella, and secondly because an HAI screening test on a woman of child-bearing age, pregnant or not, will anyway be worthwhile.

The use of normal immunoglobulin to prevent fetal rubella in the way you suggest has little to recommend it. The doses you mention are large and painful for the recipient, and if, as you say, their administration is delayed until it has been shown that the patient is susceptible, any benefit may well have been lost. The alternative of offering immunoglobulin to all women in contact with a rubelliform illness in early pregnancy will entail giving it to many who are immune and some whose contact has not been with rubella at all.

For practical purposes, therefore, the use of immunoglobulin can be limited to those patients who would not agree to a termination of pregnancy if they contracted rubella and must be offered the chance of any protection it may give. Other women, knowing that the value of immunoglobulin is unproven, will probably prefer to await the outcome of clinical and laboratory observations, and decide whether they wish to continue their pregnancy accordingly.

The diagnosis of viraemic infection in the mother, with its implications for the health of the fetus, depends on a full clinical and laboratory assessment of each case. A decision to terminate pregnancy cannot be based solely on a fourfold rise in titre because these rises also occur in "re-infections" in which the fetus does not seem to be at risk (Boué *et al.*, 1971). Seroconversions from antibody negative to positive, the presence of specific IgM in the mother's serum, and of course a rubella-like illness in the mother two to three weeks after contact with a known case of rubella are all firmer grounds for deciding that the fetus is threatened.

Congenital rubella and the anxiety which it causes in pregnancy can now be prevented by seeking out and vaccinating susceptible women. Laboratories have made great efforts to provide rubella HAI tests for patients attending antenatal clinics as well as for vulnerable groups such as teachers and nurses, and last year the Public Health Laboratory Service carried out over 300,000 of these tests. Many additional tests were per-

formed by other hospital laboratories. This work will have been fruitless unless those shown to be susceptible are vaccinated, and this, as you rightly say, represents a challenge to the general practitioners, obstetricians, and other clinicians involved.

For unless the screening programme in our laboratories is complemented in surgeries and postnatal clinics by vaccination of susceptible women much effort will have been wasted, and rubella in pregnancy will continue to be a problem perplexing both doctors and patients.

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REFERENCES

- Boué, A., Nicolas, A & Montagnon, B., (1971). *Lancet*, **1**, 1251.
Journal of the Royal College of General Practitioners (1975). Editorial, **25**, 783-784.

HYPERTENSION IN GENERAL PRACTICE

Sir,

We would be grateful if we could use your *Journal* to seek help in the expansion of the Medical Research Council's treatment trial for mild hypertension. The pilot phase of this trial, as many of your readers will know, has been in progress for almost three years and has already shown that a full national trial is both scientifically and ethically justifiable. The 22 clinics at present collaborating have together entered and followed-up about 1,200 patients in the 35-64 age range with sustained diastolic (V) pressures of 90-109. The full scale trial is estimated to require a five-year follow-up of 18,000 patients and therefore a total of about 200 such clinics. We believe that a necessary part of the pilot phase of the trial should include a demonstration that this is feasible.

Recently all area medical officers, the secretaries of local medical committees and the administrators of family practitioner committees have been asked to provide lists of suitably sized practices. From such lists we hope, at this stage, to assemble at least 200 practices which would be willing to take part in this work, and, at that time, a random sample of 10 or 15 would be selected. By this means the practicability of full-scale expansion would be assessed.

If any of your readers feel that their own practices—whether general practices or industrial—could contribute we should be glad to hear from them. We are seeking practices with total lists of about 7,500 or more—i.e. 2,500 in the 35-64 age range. Three to five per cent of such patients would probably be eligible for the trial.

The Medical Research Council has usually

provided additional nursing help, and sometimes medical assistance, to cope with the added load of screening and recruitment and all costs of participation are covered. The workload, once screening is complete, is relatively light and can be largely covered by a competent part-time nurse provided she has ready access to medical advice.

Further details, and a copy of the trial protocol, can be obtained from: The Secretary, M.R.C. Treatment Trial for Mild Hypertension, MRC/DHSS Epidemiology & Medical Care Unit, Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.

The Medical Unit,
St. Mary's Hospital,
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W. S. PEART
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FINANCIAL DEFICIT FOR THE COLLEGE

Sir,

As you will know from the Honorary Treasurer's Report in the Annual Report, we are now forecasting a deficit of the order of £20,000 in the present financial year (ending 31 March 1976), owing to the effects of inflation. The increase in subscription which was approved at the Annual General Meeting on 15 November will not take effect until 1 July 1976, i.e. after the end of the present financial year when this deficit is expected.

In order therefore to try to balance the books this year, Dr Ian Watson, who is a Past President of the College, proposed at the AGM that all members be asked to make a voluntary contribution to bring the level of their subscriptions for 1 July 1975 up to that approved at the AGM for next year. This means that we are now asking those who paid £25 to contribute a further £10 now, and those who are on reduced subscriptions to contribute whatever they can.

This proposal was unanimously endorsed by the meeting and a considerable sum was collected on the day from those Fellows, Members and Associates who were present. To economise on postage, we do not intend to thank each one individually, but I should like those who have already subscribed to know how much we value their contribution and to ask them to discuss the contents of this letter with their colleagues,, confirming the support given at the Annual General Meeting.

For those who have not already subscribed the additional amount, I ask them now to send their cheque to the Finance Officer at 14 Princes Gate. I should also like to thank those who have

responded so generously in support of all the work our College does for general practice.

It would also be very helpful to let the Finance Officer have a variable direct debit form, sent to you with the AGM papers; this method of payment does help us make great economies in administrative expenses.

P. S. BYRNE
President

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ARE REFERENCES REALLY NECESSARY?

Sir,

In your Editorial (December *Journal*), you ask *Are References Really Necessary?*, and then make out a very good case for their retention. I am sure that all would agree that, despite the expense involved, they provide essential information and cannot be omitted. If the purpose of your editorial was to explore the possibility of omitting references as an economy measure, I would not approve such a step. Indeed, I would suggest that, despite any extra cost involved, they should be made even more useful and informative by including the title of each article referred to, in addition to the names of the authors and location, as is now the practice in many scientific journals.

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REFERENCE

Journal of the Royal College of General Practitioners (1975). Editorial, 25, 861-2.

Readers' opinions would be much appreciated.—Ed.

SPECIALIST RECOGNITION IN THE EUROPEAN ECONOMIC COMMUNITY

Sir,

The Council for Postgraduate Medical Education in England and Wales has proposed the following paper on the relationship between specialist recognition as determined by the EEC medical directives and accreditation which marks the end point of training as laid down by the Joint Higher Training Committees.

Specialist Recognition in The European Economic Community

An EEC Directive of 16 June 1975 (75/363/EEC) deals *inter alia* with the minimum postgraduate training to be required by Member States before doctors can be recognised as specialists for Community purposes. To facilitate freedom of movement Member States will issue a certificate or other evidence of formal qualifications in