LETTERS TO THE EDITOR

COELIAC ARTERY COMPRESSION SYNDROME

Sir,

The comments made by Dr Peppiatt (April *Journal,* p.237) on the first case quoted to exemplify my article on coeliac artery compression syndrome (November *Journal,* p.684) are both reasonable and pertinent. However, nothing he has said detracts in any way from my conclusions and he should consider the following points.

First, coeliac artery compression syndrome is a vascular disorder, as its very title suggests, and not a disease of the small bowel.

Secondly, malabsorption as a consequence of intestinal ischaemia is a well recognized entity and is a problem often encountered in general practice.

Thirdly, while this patient cured her diarrhoea by following a gluten free diet, it was surgical decompression of her coeliac trunk which relieved her intractable abdominal pain.

Finally, were I able to produce convincing case reports, there would be no need for this discussion. The whole point about coeliac artery compression is that it produces an enigmatic range of symptoms while really having only one cardinal diagnostic feature, the epigastric bruit. Even that is non-specific and can be present in large numbers of healthy persons, although showing a distinct peak of incidence in young women.

J. A. McSHERRY

Carruthers Clinic
1150 Pontiac Drive
Sarnia
Ontario
Canada.

DIAGNOSIS OF GONORRHOEA

Sir,

Raphael and Levy (1977) claim an accuracy of 84 per cent in the diagnosis of gonorrhoea by means of cultures taken from the vagina alone. What of the remaining 16 per cent of women who have gonorrhoea and remain undiagnosed by this method and consequently go untreated until further symptoms or signs develop? Oriel (1976) emphasized that a "high vaginal swab" alone is not adequate. Gonorrhoea is often symptomless in the early stages of the disease in women.

Rees and Annels (1969) consider that an increase in the incidence of gonococcal salpingitis is an indication of failure to treat the primary infection early and effectively. Accurate diagnosis must precede treatment. This has become more important with the recognition of gonococci with decreased sensitivity to penicillin in many parts of the world, and the threat this poses to the control of the disease. But this must be kept in perspective, as has been pointed out by the *British Medical Journal* (1977).

It is suggested in the current issue of the *British National Formulary* (1976-1978) that venereal diseases should be treated in special clinics to ensure adequate bacteriological control, follow up, and treatment of contacts. It seems unlikely that this recommendation will be accepted generally, but it is mandatory for all who undertake the management of women suspected of having a sexually transmitted disease to obtain urethral and cervical, as well as vaginal, smears and cultures. To do otherwise might be considered negligent.

G. D. REES

78 Eaton Crescent
Swansea SA1 4QN.

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Raphael, M. & Levy, B. (1977). *Journal of the Royal College of General Practitioners,* **27**, 349-351.

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NUMBER 15 PRINCES GATE

Sir,

I heartily agree with Dr Sheldon (July *Journal,* p.442): a large country house should be bought and turned into a conference centre and regular week-end courses held.

These would be open to *all* general practitioners but members would have some slight concessions. Topics might include sigmoidoscopy, ECGs, manipulation, hypnosis, intra-articular steroid injections, sexual counselling, but of course the list is endless.

Here would be a real and tangible contribution to general practice and an answer to the often asked question, "What does the Royal College of General Practitioners do for me?"

DAVID HOGG

192 High Street
Oldland Common
Bristol.

AETIOLOGY OF CONSULTATION

Sir,

I must congratulate Dr H. J. Wright (July *Journal,* p.400) on his attempt to stimulate general practitioners to think about what patients do before, or instead of, consulting a doctor. However, I must also chide him for encouraging us to keep our sociological insights rooted in the 1960s.

As Dr Wright said, "In recent years a number of conceptual models . . . have been suggested" and it is all the more distressing that he should have ignored these in favour of Suchman's primitive and over-simplistic one. There are many more recent contributions to the literature which readers will find both more realistic and more practical (Friedson, 1971; Stimson and Webb, 1975; Williamson and Danaher, 1978). All of these show that a straightforward flow-chart model is misleading. Indeed, if it were not so it could be argued that it would not need a doctor's skills to unravel the psychological and social factors influencing the patient's behaviour. But 'sickness' is complicated and because this has been recognized by our profession, new techniques, such as those introduced by Michael Balint, have become an accepted part of general medical practice.

Similarly, it is rather short-sighted to endorse Parsons' view (1951) of the 'sick role' without considering recent amendments (and denials) of his theory. This can best be illustrated with reference to the 'privileges' mentioned by Dr Wright. Do people consider that a person 'sick' with syphilis is 'not actively responsible' for his disease? Are the disabled 'exempted' from responsibilities or merely 'thrown away'? If it is true that the sick role describes how doctors see their patients then Parsons may have said something of supreme importance, for there is increasing