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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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

evidence that his idea is incomplete (Tuckett, 1976); perhaps doctors are not quite so good at seeing life as they think they are. Balint said that too!

JOHN D. WILLIAMSON
12 Westville Road
Barnsley
Yorks S75 2TR.

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INDEPENDENT CONTRACTOR STATUS

Sir,

It is not only how, or even how much, we are paid, as Tudor Hart suggests (April *Journal,* p.237), but for how long. We can bemoan the loss to our NHS patients of years of experience when great consultants are pensioned off at 65: we also sigh with relief that we can carry on. What to do with our status is a question of political attitude, for revolution or evolution.

The introduction of the NHS 30 years ago was a revolution. Evolutionary modifications have followed (although the 1966 Charter might be described as part of a continuing revolution).

Evolutionary changes in the independent contractor status have, as Tudor Hart rightly says, increased our dependence on the DHSS. On the salaried side, some 45 per cent of consultants have chosen to be whole-time salaried employees. In Exeter these consultants may be impersonal and lackluster; in Central London most, in my experience, are the reverse.

No, the main difference at present between salaried and independent contractor status is the possibility of the independent contractor continuing to earn a full income past 65. Even here, however, increasing misgivings are felt, especially in local medical committees where cases are heard against elderly general practitioners in breach of their terms of services. The General Medical Council is toying with annual review of registration of those over 65 involving some form of audit.

My argument is that the two kinds of status are moving so close together that they vary only in detail. The details are important but if we chose, or were forced to choose, to be salaried, our negotiators should be able to protect our needs in the new contracts. I have no doubt that we would continue to practise past 65, but I suspect that there would be some form of assurance of competence, and this would not be such a terrible thing.

Dr Pereira Gray is to be congratulated on opening this discussion (December *Journal,* p.746). The clarification of issues that is following can only help to question dogma, and this is vital to that very British form of revolution—evolution.

RICHARD STONE
50 St Petersburgh Place
London W2 4LD.

PRACTICE ACTIVITY ANALYSIS

Sir,

We have enjoyed taking part in the Practice Activity Analysis published in the *Journal* in the past few months. However, the published results do not take account of consultation rates, size of practice, type of practice or age-sex distribution which are obviously relevant to the results, and we wonder if there are any other practices which would be interested in pursuing these variable factors.

D. K. FAIRWEATHER
J. E. SCRIVEN
19 Jerdan Place
London SW6 1BG.

BOOK REVIEWS

THE SI FOR THE HEALTH PROFESSIONS

World Health Organization
75 pages. Price £1.20

SI units are not exactly popular! Indeed they can be said to inspire bewilderment, contempt, or anger among most practising doctors who in any case are usually rather shaky about exactly how they are derived.

Nevertheless SI units are here to stay and they are being used increasingly in medical journals and books throughout the world. The 'I' stands for international and this is their first main advantage. If eventually they do become universal it will greatly aid communication between doctors in different continents.

Secondly, and perhaps more important in the long run, is that they do provide a rational basis for calculating units which is logical and consistent at the very least. Almost any uniform system was bound to be better than the hotch-potch of units which has grown up over the years.

Fundamentally there are seven base units which are precisely defined and include, for example, a unit of length (the metre), a unit of mass (the kilogram), a unit of time (the second), and a unit of substance (the mole). From these there are a series of derived units such as the square metre or cubic metre.

This little booklet, in only 75 pages, makes a fair attempt at explaining in simple language what SI units are all about. As they will soon be adopted as the standard unit in this *Journal,* this would be a useful book to buy.

D. J. PEREIRA GRAY

OBESITY AND ITS MANAGEMENT 3RD EDITION

Denis Craddock

Churchill Livingstone
London (1978)
194 pages. Price £5.50

Shame on those of us who have not read this book! By a generalist, for generalists, and written, perhaps, on the most general topic one could find, it is one of the few volumes that can be unreservedly recommended for, if not every consulting room bookshelf, then certainly every practice library.

Like a good deal of important literature, its message is not new. We already know much about the causes of obesity, of its hazards and its implications, and no one who did not have a fair grasp of the principles of its