

cal infection in women with gonorrhoea. Such patients represent a challenge to the medical profession in that they have progressed from early, completely curable, gonorrhoea to a later stage in which permanent structural damage to the body is often unavoidable.

Routine screening has often been proposed but Felton (1971) has shown that it would require 26,450 examinations to increase the discovery of female gonorrhoea by one per cent, and Rees and Hamlett (1972) found only two cases (both symptomatic) on screening 319 antenatal patients.

If the majority of women are asymptomatic, complications represent a medical failure, and screening is unhelpful, how are we to find the cases that are occurring? The answer is in screening women with symptomatic sexually transmissible disease (STD) for associated asymptomatic gonorrhoea.

Gonorrhoea is found in 46 per cent of women with trichomoniasis (Nielsen *et al.*, 1974), 12 per cent of women with warts (Kinghorn, 1978), one per cent of all patients with syphilis (Woodcock, 1971), 11.1 per cent of women with candidosis (Eriksson and Wanger, 1975), 12 per cent of female scabietics (Nielsen *et al.*, 1976), 28 per cent of all patients with pubic lice (Fisher and Morton, 1970), and 13 per cent of patients with herpes (Beilby *et al.*, 1968).

Barlow and Phillips (1978) reported 571 female patients with gonorrhoea, of whom 200 also had trichomoniasis, 107 also had candida albicans, 31 also had chlamydia trachomatis, 19 also had warts, 12 also had herpes, six also had phthiriasis, and four also had syphilis.

The message of these studies should be clear: if a woman had a symptomatic sexually transmitted disease she must be screened for asymptomatic gonorrhoea.

Investigation of women must include urethral, cervical, and rectal sampling. If only urethral samples are tested, 23.4 per cent of cases will remain undiagnosed, if only cervical samples are tested 10.3 per cent of cases, and if only rectal samples are tested, 61.6 per cent of cases will remain undiagnosed (Barlow and Phillips, 1978). If the rectal smear is omitted, 5.6 per cent of cases will remain undiagnosed (Bhattacharya and Jephcott, 1974).

Dr Timson is correct in stating that it would be logistically impossible to refer all cases of vaginitis to a special clinic, and many women would probably refuse to attend. This problem can be readily overcome. No responsible clinic would refuse to analyse properly collected material on behalf of interested family practitioners. An air-dried smear on a microscope slide and a transport

medium should be prepared from each of the three sites. The most suitable transport medium for general practice is the Vi-Pak transport swab system which can be obtained from Exogen, 1967 Dumbarton Road, Glasgow G14 0HZ.

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NIGHT CALLS IN GROUP PRACTICE

Sir,  
Dr Morton (*May Journal*, p. 305) asks

for a comparison of night calls from an urban area with his figures from a small town in Scotland. We are a three-doctor training practice half a mile from a major accident unit in a teaching hospital. We have a small list; in 1978 it was 4,904 (average of the four quarterly counts), with 405 joining and 378 leaving (turnover eight per cent). In that year 19 per cent of the patients were over 65 years old. We do all our own night calls and try hard not to admit patients with terminal illness to hospital. Nearly all the patients have occupations classified by the Registrar General in social classes three, four and five, and 99 per cent live in houses rented from the local council. Not surprisingly there are very few holiday-makers and temporary residents.

We keep a list of all night calls in order to check that the Family Practitioner Committee are paying us for all we do (they are). Using this list, I have made a retrospective analysis of the 102 night calls the three partners and the trainees made between 23.00 and 07.00 hours from 1 January to 31 December 1978. I divided the visits into the three groups used by Lockstone (1978) and Morton, adding two categories necessitated by incompleteness of retrospection. The results are shown in Table 1.

Table 1. Analysis of 102 night calls.

	Number	Percentage
Genuine emergencies	36	35.3
Irresponsible calls	0	0
Unnecessary but reasonable	34	33.3
No record in the notes	2	2.0
Died or left the list	30	29.4
	102	100

The rate of calls per 1,000 patients was 20.8 (Morton 15.9/1,000 and Lockstone 10.7/1,000).

I found it difficult to distinguish, in retrospect, a genuine emergency from an unnecessary but reasonable call. The complete lack of calls I would now deem irresponsible reflects more than anything my belief that exceedingly few patients are so malign that they will insist on getting their own doctor out of bed for something which they are sure is trivial (that being my interpretation of 'irresponsible').

The main conclusions I draw from these figures are that there is a high rate of illness in our patients and that—like workload in general—the smaller the

number of patients on a doctor's list the more attention they get.

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## TRANQUILLIZERS AND ROAD ACCIDENTS

Sir,

Having read and heard a great deal of evidence on the association of tranquillizers and road accidents (September *Journal*, p. 533), I have looked in vain for any reference to the conditions requiring the tranquillizers.

My own casual observations of drivers makes me believe that tension and anxiety may often be the cause. Inappropriate, rather than slow, reaction may well be the more dangerous of the two.

I am not referring to the increasing numbers who can no longer face life except through a benzodiazepine haze—only to those who are going through a time of considerable anxiety.

It is easy enough to gather statistics about the percentage of tranquillized drivers involved in accidents but very difficult to find out their degree of anxiety at the time.

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## HAY FEVER

Sir,

I read with some interest the prize-winning essay on hay fever by Dr Harland (*May Journal*, p. 265) and was somewhat surprised to read Dr Fields' letter (*August Journal*, p. 498). May I take issue with Dr Fields on a few points?

1. The author of the essay did *not* state that cell-mediated immunity is mediated by IgE; he indicated that, because IgE binds firmly to mast cells, an allergic reaction may be referred to as a 'cell-mediated' immune response. While not accepted under current immunological dogma, such a statement is semantically correct. If Dr Fields wishes to criticize the essay, would he not be better to refer to the statement on p. 266 "that these cells (T-cells) are responsible for the production of IgE immunity" which

although not incorrect, gives the misleading impression that T-cells differentiate into antibody-forming cells.

2. I wonder how many general practitioners would be willing to undertake the long and tedious process of skin testing and desensitization described in the essay? Dr Harland discusses these points quite adequately. Further, he stresses that he depended on a specially trained nurse to carry out appropriate skin tests. Without such help, which is freely acknowledged, it is unlikely that this essay would ever have been written.

3. I am somewhat worried by Dr Fields' reference to "delayed hyposensitivity"; I can only assume that this was a misprint since such a condition is unknown to practising immunologists. His use of the term "blocking antibodies" betrays a lack of understanding of serological terminology; in any case, such antibodies are not of the IgE class.

4. I am distressed that you should have allowed publication of the last paragraph of Dr Fields' letter which is little more than a poorly veiled attack on the integrity of the prize-winning essayist and a reflection upon those who judged the essay. Dr Harland states (p. 280): "as I continue to research the literature"—where would any medical research worker start but with the *Index Medicus*? Are we to think that Dr Fields believes that the author wrote his essay on the foundation of *titles* derived from the *Index Medicus* rather than assiduous reading of literature derived from them, and extensive clinical observation?

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## EPIDEMIC POLYARTHRITIS

Sir,

Puzzling polyarthritis in patients who have visited Fiji this year may well be due to epidemic polyarthritis. This is a mosquito-borne group A arbovirus disease caused by the Ross River virus, well known in Australia, recorded from New Guinea, and reported as a massive outbreak in Fiji for the first time in the *WHO Weekly Epidemiological Record* (1979).

The risk to visitors, at least during the month of April, is demonstrated by the evidence of a party of 21 people from Wanganui who were in Fiji from 11 to 24 April 1979. Ten had typical symptoms; nine out of 16 who submitted blood samples had antibodies to the virus, although two of these remained

symptom free. Other viruses may also be about, as one patient with typical symptoms had three negative tests both for Ross River virus and dengue antibodies.

Clinically, the patient is likely to present with joint swelling, which may soon resolve, whereas moderate pain and stiffness may persist or recur, especially if salicylates are stopped. Generalized macular or maculopapular rash is common around the onset (which is usually accompanied by only mild, if any, pyrexia), but disappears in about a week. In a Wanganui case, a localized papular rash near an affected joint developed months after onset. Typically involved have been the ankle, knee, and interphalangeal or metatarso-phalangeal joints. Major disability has not been reported to me—anxiety about rheumatoid disease seems more important. However, a colleague with experience of the condition in Australia stated that nurses with the disease could be intermittently unfit for duty up to a year from onset.

"Have you been to Fiji or Australia this year?" is now, I suggest, a pertinent question for polyarthritis victims in many parts of the world. Serological identification was carried out by Professor J. A. R. Miles and his colleagues of the Virus Research Institute, University of Otago, Dunedin, to whom I am most grateful.

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## NEGATIVE EVIDENCE IN MEDICAL PRACTICE

Sir,

Influenza is one of the most common diagnoses made in general practice, yet how is it made? Largely on the history and the absence of physical signs of any other disease. Virology is rarely carried out on the grounds of time, expense, and the seriousness of the patient's condition. In scientific terms the diagnosis of influenza is not worth much. I once went to a lecture on conjunctivitis given by an ophthalmic surgeon who stated that the majority of cases were bilateral. Most general practitioners will agree that bilateral conjunctivitis is very uncommon and conjunctivitis is rarely referred to a consultant. Perhaps by the