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

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Reference

Lockstone, D. R. (1976) Night calls in a group practice. *Journal of the Royal College of General Practitioners*, **26**, 68-71.

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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Reference

WHO *Weekly Epidemiological Record* (1979). **54**, 191.

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