CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

The GP and the specialist: obstetrics

SIR,—Obstetricians are frequently enjoining general practitioners (11 December, p 1711) to refer (often completely normal) obstetric patients to them "early." Why should this be, and how soon is "early"? The optimum time for the first consultation at the hospital is at 16 weeks. By this time the fundus should be palpable abdominally, and further vaginal examination will be unnecessary. If gestational dating is in question an ultrasound scan will be at its most reliable, and the usual battery of blood tests can include the α-fetoprotein screen, thereby avoiding yet another venepuncture. Only in exceptional cases—for example, recurrent abortion—is a specialist opinion advantageous before 16 weeks, and patients could be saved considerable inconvenience if most booking appointments were scheduled for this time.

Secondly, should routine (blood) screening tests always be left until the hospital appointment? There is some advantage (in primigravidas at least) in determining rubella and rhesus states as early as possible. Ideally, of course, this should have been done before pregnancy but if a woman suffers some febrile illness or rash in the first trimester it will at least be reassuring to know that she is immune to rubella or, if she aborts, whether anti-D globulin need be administered.

Thirdly, should cervical cytology be undertaken in early pregnancy in women not previously screened? Subsequent miscarriage might easily be misinterpreted by the patient. Surely the best time for routine cytology is at the postnatal examination or the family planning clinic.

Fourthly, how often should "shared care" patients return to the specialist clinic? Unless there is a problem is it really necessary for women to go back more than once (for example, at 34-36 weeks) so the consultant can confirm the presentation and reassure himself that there is no occult pre-eclampsia or growth retardation? Trust and flexibility are of the essence where maternity care is shared between general practitioners and specialists and general practitioners are as well able as junior hospital medical staff to accept a tight regimen for antenatal care. If a specialist is not satisfied with their performance in his locality he should take steps, through postgraduate medical educational programmes, to update them.

Finally, interchange of information between general practitioners and specialists undertaking shared care is of paramount importance. Formal dictated letters are time wasting and subject to delay. The national cooperation card is satisfactory if properly completed, but important investigative results (for example, blood group, haemoglobin, rubella state, scan reports, etc) are often omitted. But why not let women carry their own hospital obstetric record folders? This would give medical attendants in either routine or emergency situations instant access to the most complete and up to date information available. Furthermore, obstetric records can be designed in such a way as to present a check list of necessary procedures through the whole time scale of the pregnancy, and the risk of omission would thereby be much diminished. In areas where such schemes have been tried there seems to be no great disadvantage and much benefit.

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An absence of alcohol policy

SIR,—As consultants working in alcohol abuse we welcome your excellent leading article (11 December, p 1680). You correctly identified some of the major factors in preventing the

development of such a policy. You supported the establishment (in place of the present four national groups) of a new "broadly based single organisation . . . to coordinate the efforts of all concerned and to formulate tough effective policies." Unfortunately it seems that the development of such a new national organisation could be sabotaged or delayed by the medical profession itself.

The leading article indicated that one of the four present national groups, the Medical Council on Alcoholism, might be determined to continue alone. Recently all members of the Medical Council on Alcoholism have received a letter which states: "The executive committee agree that the Medical Council on Alcoholism did not intend to be absorbed into the new national organisation." Even delaying the establishment of the new organisation could be harmful. The other three national bodies, unlike the Medical Council on Alcoholism, are heavily dependent on funding from the Department of Health and Social Security and could quickly collapse. Employees with useful expertise and other resources will soon be lost to the field of alcohol abuse.

In the past the Medical Council on Alcoholism has failed to attract the support even of the medical profession itself. While admiring some of its work many professionals active in the field condemn its inability to move with the times, in particular with regard to new understandings of the nature of alcohol abuse and of the consequent need for multidisciplinary work. When the new national organisation eventually comes into existence it must have a part in medical education and the younger doctors will wish to contribute their expertise to it. It is difficult to see what roles the Medical Council on Alcoholism will have left for it; it is surely better for its healthy parts to be absorbed into the new national organisation as soon as possible.

We hope that the executive committee of the Medical Council on Alcoholism will reconsider its decision to "go it alone" in the light of your leading article, which we believe accurately reflects informed medical opinion in this country.

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SIR,—Your recent leading article (11 December, p 1680) strongly criticises the work of the Medical Council on Alcoholism and welcomes its demise. The article contained inaccuracies, however, about the work of the council and also shows, as your articles often do, a considerable naivety in the field of alcoholism.

It is important that your readers have the opportunity to be aware of the work which over the last decade has been carried out by the Medical Council on Alcoholism. This includes: (1) Distribution of research funds in the field of alcoholism through the research committee, and it should be noted that it is the only organisation which *exclusively* funds research into alcoholism. Other bodies which fund research into alcoholism do so in the context of alcoholism being a competing priority. (2) Education of undergraduate students by regular seminars in various cities throughout the UK, which are well attended by medical students, and the publication of a handbook for medical students. Your readers will be aware of the almost total lack of teaching on alcoholism at many undergraduate medical schools. (3) The sponsoring and assisting of a wide range of medical organisations to develop meetings on alcoholism specifically for medical audiences. These range from postgraduate meetings to major conferences, although the emphasis has been mainly on "the low cost, bread and butter type meetings." I spoke at a provincial town this week where there are no alcoholism services, and thanks were expressed to the Medical Council on Alcoholism for the stimulation and helping of local people to organise such a medical meeting. (4) The production of a journal trying to give information at a fairly basic level to general practitioners and others.

It is also important to refute a statement made in your leading article, which again was notably unsigned, that the Medical Council on Alcoholism does not accept the role of other professions in the field of alcoholism. That has never been the case, and at any rate the council is not primarily involved in services for alcoholics. The Medical Council on Alcoholism has, however, emphasised the important contribution doctors make in alcoholism and also in medical education and that the teachers should be predominantly medical.

The naivety of the point of view which you expressed is the pious hope that if the Medical Council on Alcoholism is abolished another medical organisation or organisations will take on this work. There is no evidence that any medical body is prepared to do this. The demise of the Medical Council on Alcoholism, which you recommend together with the withdrawal of public funds from the alcoholism bodies, is likely to lead only to internecine warfare among those minority members of the helping professions who show any interest at all in this subject.

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SIR,—Your unsigned leading article (11 December, p 1680) is, in respect of the Medical Council on Alcoholism, misleading. The singling out of Sir Reginald Murley was, in the particular context of the leading article, discourteous; he is a punctilious chairman. He represents the unanimous view of the executive committee of the Medical Council on Alcoholism in rejecting the report of the working party of the Department of Health and Social Security. That executive committee represents at least as much commitment to and expertise in the field of alcoholism as the DHSS working party, the British Medical Association Board of Science, and the *BMJ*. My main criticism, however, is that you accepted the working party's lay findings at face value. Its report contains assertions but no evidence. The working party seems to me to be a classic bureaucratic device to push through a predetermined policy. As the Red Queen said: "Sentence first, verdict afterwards," and, I would add, evidence nowhere. We are a strange profession: just imagine the outcry that would have greeted a similarly flawed report by a working party composed only of doctors reporting, for example, on the British Association of Social Workers.

The working party's assertion that the Medical Council on Alcoholism rejects the idea of multidisciplinary working is quite unfounded. As 22 of the 29 consultants in charge of alcoholism treatment units are members of the Medical Council on Alcoholism and five are on the executive committee I cannot see how the working party could credibly reach such a conclusion; nor the *BMJ* by implication. In paragraph 35[1] the working party would have us believe that the Medical Council on Alcoholism rejects the idea that alcohol abuse is a social disorder with medical complications. (I would add a caveat that alcohol abuse as a term lacks scientific precision and utility.) The Medical Council on Alcoholism accepts that alcohol abuse is a social problem just as traumatic surgeons accept that bad driving is a social problem (driving abuse?). But both traumatic surgeons and the Medical Council on Alcoholism accept that the casualties of bad driving and alcohol abuse respectively are the very proper responsibility of the medical profession. Hence the title Medical Council on Alcoholism. It may be that the working party falls into the fallacy that social problems concern only social workers or those trained in the social sciences or indeed any lay people but never a medical practitioner. Sadly the author of the leading article is guilty of loose thinking when he speaks of the Medical Council on Alcoholism as an antialcohol group. The Medical Council on Alcoholism is concerned with the hazards of alcohol use and their prevention, but not with alcohol use as such.

Surely the BMA and *BMJ* should have independently examined the Medical Council on Alcoholism before swallowing hook, line, and sinker the DHSS report. At the very least they should have seen the respective committees of the Medical Council on Alcoholism as well as our chairman and executive director.

If the *BMJ* has a predetermined view of the Medical Council on Alcoholism or believes it is privy to other evidence this should be revealed to allow open discussion. I am disappointed in the lack of rigorous analysis and objectivity in your leading article in respect of the Medical Council on Alcoholism. It undermines the credibility of the *BMJ*, and I would hate to see that compromised.

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[1] Department of Health and Social Security. *National voluntary organisations and alcohol misuse*. London: DHSS, 1982.

Microscopic colitis associated with gall stones

SIR,—We were interested to read the report of microscopic colitis by Dr J G C Kingham and others (4 December, p 1601) since we have also seen several cases of this condition and in one case we believe it to have been due to gall stones.

A 53 year old woman presented with a three year history of diarrhoea; she denied abdominal pain. Clinical and sigmoidoscopic examination were normal, but a rectal biopsy specimen showed a microscopic colitis. There were no clinical, haematological, or biochemical features of malabsorption. Barium enema and small bowel meal, jejunal biopsy, pancreatic function tests, sugar tests, gastrointestinal hormone screen, and faecal fat were all normal. Colonoscopy was normal, but diffuse microscopic colitis was confirmed on all colonic biopsy specimens. ^{14}C-glycocholate breath test was weakly positive, and a jejunal aspirate yielded moderate numbers of intestinal organisms on culture. Endoscopic retrograde cholangiopancreatography showed a normal pancreatogram, but the gall bladder contained numerous large stones. We considered that her diarrhoea might be the result of chronic low grade infection within the gall bladder either by "seeding" of the small intestine with organisms or through deconjugation of bile acids within the gall bladder;