In a cross-section taken at an earlier age, one would expect more non-noise-induced cases. Also, compensation cases are preselected by the worker's belief that he has a noise-induced loss.

The data clearly show the value of otologic referral for asymmetrical hearing losses. Dr. LaDou is correct in stating that CT scanning and myelography are not routinely indicated, but should be used in selected cases based on the results of otologic and specialized audiologic testing. Indeed, the single instance of acoustic neurinoma found in the series of Alberti and coworkers[2] was in a patient who did not have significantly asymmetrical pure-tone thresholds, but was found to have reduced discrimination and vestibular response unilaterally.

It is at present impossible to specify the *right* criterion for referral in cases of threshold asymmetry. The 15 dB four-frequency average used by Alberti and colleagues[2] is probably too lax, unless nearly all the *specific* cases had asymmetries much larger than 15 dB; this information is not available. In another study,[3] a 45 dB average asymmetry at any two frequencies was required for otologic referral: in 50 percent of the patients there were specific diagnoses. The American Council of Otolaryngology[4] has tentatively suggested that a 15 dB mean asymmetry at 0.5, 1 and 2 kHz *or* a 30 dB mean asymmetry at 3, 4 and 6 kHz should lead to referral. Studies now in progress should clarify this point.

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Medi-Cal: A Debacle?

To the Editor: The correspondence (West J Med 133:258-259, Sep 1980; 133:349, Oct 1980) relating to the article by Beverlee A. Myers, "Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt" (West J Med 132:550-561, Jun 1980), prompts me to make the following observations.

The entire Medicaid mess can be blamed on the total lack of foresight by some planners in this country. The high ideals of the late 1960's were translated into the Medicaid program which was going to provide mainstream care for all Americans. After a trial period of some 15 or so years the experiment has proved a dismal failure. The two-class system of care is now more entrenched than it ever was and the costs have been staggering. At the time Medicaid was introduced, there were a number of county hospitals in the state of California providing very good care for those less fortunate or more unwilling citizens (less fortunate because of their illness or because of financial impecunity; more unwilling because a small segment of the population could never be motivated to work). The rolls for California's Medicaid program (Medi-Cal) have skyrocketed to the point that more than 16 percent of California's population is covered by that program. The financing has been inadequate and the restrictions have been burdensome for the physicians taking care of these patients. It is no surprise therefore that most of the physicians of the state are reluctant to see new Medi-Cal patients.

Perhaps more devastating has been the impact of the Medi-Cal program on those hospitals that formerly took care of indigent patients. Several of them have disappeared into the night. Many of them have lost their affiliations with the universities, which provided excellent ongoing care by young physicians and specialists in training, well supervised by the established practitioners in the community. The latter group gave gladly of their time unstintingly and gratis. The architects of the highly idealistic Medicare and Medicaid programs have put an end for all time to doctors giving time on a voluntary basis. I cannot see physicians going back to the old charity system as it existed in this country, even if the powers that be were in favor of reverting to that system.

Even the surviving and larger county hospitals in the state are having tremendous difficulties in maintaining staff and morale. Furthermore, as was pointed out in the correspondence by Dr. Rodnick in September, the costs of providing this care in county facilities is sometimes four times as high as it would be in the private sector. What is worse to my mind is the disjointed service that is being provided now in county hospitals. Many of them are staffed almost exclusively by nurses from registries, and a patient may not see the same nurse twice in

a full ten-day stay. The physicians, too, are changing, and moonlighting physicians are commonplace in county hospital facilities.

It is my belief that having embarked on the road of destroying the county hospitals the government should complete the job. With the savings that would be gained, the local administrations and the state could provide realistic remuneration for the hospitals and the physicians in the private sector to take care of these patients.

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Psoriasis and Diet

TO THE EDITOR: I enjoyed very much the excellent discussion in September's Medical Staff Conference, "Psoriasis." The conclusion of the discussion that we now have no ideal treatment for psoriasis is clearly valid. Still, I would like to mention a personal experience that has left me wondering just what causes psoriasis and if proceeding with a different kind of research would be useful.

In 1968 my wife, a registered nurse, developed a rash that gradually progressed to a moderately severe psoriasis. Although we sought the finest dermatological treatment, the rash persisted: she held it in check with topical steroids. After seven years of this she discovered by using an elimination diet that the rash resolved when she stopped eating fruits (especially citrus fruits), nuts, corn and milk.

Although this is only one case, it was carefully studied, so I felt reasonably comfortable in trying a similar program on five of my patients. All improved. I also asked them to stop using such acidic foods as coffee, tomatoes, sodas and pineapples because empirically I had found this helped. In fact, elimination of acids has helped a number of patients with various rashes during the five years I have used it. This method is without side effects, simple, easily administered and reasonably effective. Although not ideal, it may be worth considering for certain cases.

Theoretically, this approach makes some sense because our gut bacteria, fungi and viruses make substances that we sometimes absorb (B_{12} for one),[1] and these flora must eat what we put in our intestines. Their excretions are probably directly related to the substances they ingest. Perhaps some gut-flora excretions cause drug-type eruptions because gut-microorganisms synthesize drug-like substances when we ingest certain items.

We might benefit by addressing more research to the chemical reactions (gut secretions plus ingested substances) and gut-flora eliminations that take place when people eat certain cooked[2] and uncooked[3-5] foods and combinations of them.

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Repository, Not Respiratory

AN ERROR has been noted in a letter, "Triamcinolone and Keloids," by Ernst Epstein, MD, in the September issue, page 257. In typsetting, the word *respiratory* was twice substituted for *repository*. The section affected should have read as follows: "However, there are three, not two, commercially available *repository* triamcinolone injection materials. Triamcinolone hexacetonide was not mentioned. This salt is the least soluble, and therefore the longest acting of the *repository* triamcinolone preparations on the market" [italics added].

—ED.