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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Communication from "centres of excellence"

SIR,—I work in an academic surgical unit attached to a "centre of excellence" with two hospitals, one of which may have been the hospital at which Dr C Barber's young patient was treated (16 November, p 1427). I sympathise with Dr Barber. Perhaps my predicament applies to many clinicians in "centres of excellence."

At the larger of the two hospitals I have neither an office nor a secretary, but I am fortunate because nearby I have an academic secretary who has "volunteered" to do unpaid NHS work to ease the running of the surgical department. She types most of my NHS letters and tries to help parents who telephone the department because there is nobody to turn to in the hospital. However, she is leaving at the end of the year and then I may join several of my colleagues who have no secretarial support.

At the smaller hospital vacancies for secretaries are common, and again I do not have an office. Although in an "inner city area," this hospital is difficult to reach by public transport and few unmarried secretaries can afford a car. Last time we advertised for a surgical secretary we had one applicant, almost certainly because the starting salary offered was only marginally above a single person's unemployment benefit. The applicant was appointed, but unfortunately suffers from a chronic illness and has been absent for three months this year. Combined with other unfilled vacancies, this means that my registrar and I have a backlog of letters of two to three months.

Within a week of a patient leaving hospital my registrar will dictate a summary into a tape recorder, and this may or may not get typed depending on whether or not a secretary is avail-

able. If the letter has not been typed within a week or two, as is likely, the notes will be removed for the outpatient clinic. Within the following week a letter will be dictated to the GP, and the tape recording put among those waiting to be typed. During the next few weeks the secretary will come to type the discharge summary but will not do so because by this time the case sheet has been removed for the second outpatient visit. At this stage in the vicious circle our stock of recording tapes will have been depleted, so all untyped material unaccompanied by case notes will be wiped out so that a new batch of discharge summaries may be dictated. So the cycle continues, and my registrar may have to dictate the summary three times during the six months he will spend with me. Even then it may not be typed, and his successor, who may never see the patient, will go through the same process.

I inherited this problem some years ago and foolishly thought that I would be able to improve matters, but a gradual deterioration has occurred as our centre of excellence has had to do an increasing amount of routine work as surrounding hospitals have closed. The DHSS has asked that we should do more day case surgery, but no extra finance has been provided, and a day case patient generates almost as much paperwork as a long stay patient.

To get out of the vicious cycle, we need more secretaries working more efficiently at increased rates of pay. Unlike industry, NHS hospital service does not allow productivity payments, so that we have come to rely on a workforce of underpaid, unprivileged, inefficient women who are now tired and demoralised by their ever

increasing workload. Bright young healthy women will not accept posts in centres of excellence because the conditions of service are poor and they can earn two to three times more for similar work in legal or city offices, which also give luncheon vouchers.

Does Dr Barber have a solution to my problem so that I may solve his; and that of the school doctor, the community physician, the community paediatrician, the health visitor, the child guidance clinic, the Rowntree Trust, the local authority housing manager, etc, all of whom inundate me with requests for information?

I wrote this letter on my home computer during my weekend "off duty," shortly before visiting a patient; and I have given up trying to telephone GPs because there is no reply, the receptionist refuses to allow me to talk to the doctor because he is busy, or I get a recorded message which tells me to phone elsewhere—usually a place where the staff have never heard of the patient.

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Prevalence of known diabetes in Asians and Europeans

SIR,—We read with great interest the results of the Southall diabetes survey (19 October, p 1081), and would like to discuss the overall prevalence of diabetes and the prevalence of classical insulin dependent diabetes in Asians.

Dr Hugh M Mather and Professor Harry Keen

report an overall high prevalence of diabetes mellitus in Asians in Southall, London, and state, "In India the prevalence of diabetes is not unusually high." In support they quote the figures published by Ahuja.¹ However, in that six centre study conducted in India the prevalence rates varied greatly from 4.8% in men in Ahmedabad (Gujarat, West India) to 0.8% in women in Delhi (North India) and women in Cuttack (South India). In the excellent study by Gupta *et al*, regrettably not quoted, age adjusted prevalence rates in urban Ahmedabad were 10.33% for those aged 51-60 years and 16.47% for those aged over 60.² The increasing prevalence of diabetes mellitus in Asians after middle age has been recognised and documented.

What has not been well documented in Asians is the prevalence of classical insulin dependent diabetes mellitus, which is known to occur in childhood. Paucity of data from the Indian sub-continent is probably due to widely differing hospital referral patterns and the high mortality associated with insulin dependent diabetes.³ In the analysis of 15 800 children below the age of 15 years the Southall survey fails to address this question.

In 1985 we surveyed 64 535 children below the age of 15 years living within Leicester city. The exact number of children with insulin dependent diabetes was determined from a central register maintained since the changeover to U 100 insulin in 1982. This was further counterchecked with independent registers maintained by the three diabetologists caring for the population of Leicester city and county, a register maintained by the diabetic health visitors, who for the past thirty years have been specifically dealing with problems encountered in the community by juvenile diabetics,⁴ and an analysis of hospital admissions for children with diabetic problems. Subsequently case notes were examined and true insulin dependence was taken as the classical rapidly progressive diabetic syndrome with florid symptoms, ketosis, and positive islet cell antibodies. The total population was determined from a recent survey (Survey of Leicester 1983, Leicester City and Leicestershire County Councils). Adjusted prevalence rates per 1000 were 0.99 for Europeans and 0.54 for Asians (ratio of prevalence 1.83; 95% confidence interval 3.6 to 0.9). This is statistically not significant.

Dr Mather and Professor Keen imply that insulin dependence in Asians may be low on the grounds that "relatively fewer Asians were receiving insulin than Europeans, and in the age group 15-29 the prevalence in Asians was less than that in Europeans." Our results show that, in Leicester, there is no substantial difference in the prevalence among Asians of classical insulin dependent diabetes starting in childhood. This is in fact supported by the Southall survey, where the prevalence of diabetes in children below the age of 15 years was not comparatively decreased in Asians. Perhaps further studies using standardised data pooled from several centres would serve to advance understanding of this subject.

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1 Ahuja MMS. Epidemiological studies on diabetes mellitus in India. In: Ahuja MMS, ed. *Epidemiology of diabetes in developing countries*. New Delhi: Interprint, 1979:29-38.

- 2 Gupta OP, Joshi MH, Dave SK. Prevalence of diabetes in India. In: Miller M, Bennett PH, eds. *Advances in metabolic disorders*. Vol 9. New York: Academic Press, 1978:147-65.
3 Bennett PH. Diabetes in developing countries and unusual populations. In: Mann JJ, Pyorala K, Teuscher A, eds. *Diabetes in epidemiological perspective*. London: Churchill Livingstone, 1983:43-57.
4 Walker JB. Field work of a diabetic clinic. *Lancet* 1953;ii:445-7.

SIR,—The Southall diabetes survey by Dr Hugh M Mather and Professor Harry Keen has revealed a much higher prevalence of diabetes in Asian migrants than in Europeans and raises the possibility of strains on future health resources if the needs of this group are ignored. We should like to raise two points arising out of the survey, which may have a bearing on any future studies of this kind.

Firstly, population studies of this nature require accurate information from the Office of Population Censuses and Surveys (OPCS), especially on subjects' ethnic origins. Unfortunately, the OPCS information on this is confined to place of birth and will become more confusing as the children of migrants to the UK raise their own children in Britain. "Place of birth of head of household" will become redundant as a substantial proportion of Asian and Afro-Caribbean people born in the UK will be mistakenly classified as white in epidemiological studies. Ethnicity is a sensitive issue, but accurate information is needed if the correct conclusions are to be drawn about the clinical course of common disorders such as diabetes in various populations. An acceptable way of collecting such information is needed, otherwise the Southall survey could well be the last successful one of its kind conducted in the UK.

Secondly, the issue of obesity and diabetes cannot be adequately unravelled in the absence of appropriate ranges of body weight for Asians. The major dietary factor linked to the prevalence of diabetes in various countries is total daily energy intake,¹ which influences the incidence of obesity. A real excess of obesity in Southall Asians might be obscured by differences in body frame size from Europeans, about which there is no available information. We have no justification for assuming that normal ranges of body mass index are similar for Asians and Europeans, although we shall have to make this assumption until more subtle measures of obesity are devised, which can then be used in large scale studies.

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1 Mann JJ. In: Mann JJ, Pyorala K, Teuscher A, eds. *Diabetes in epidemiological perspective*. London: Churchill Livingstone, 1983:122-39.

SIR,—Dr Hugh Mather and Professor Harry Keen (19 October, p 1081) reported that the prevalence of diabetes mellitus, usually type II (non-insulin dependent), was at least five times higher in Asians than in Europeans aged 40-64 years living in Southall, London. Only 7% of the Asians were Pakistanis; the rest were Indians. The high prevalence of diabetes in Indians has been reported, but no acceptable explanation has been offered.

Mann has stated, "There is more evidence for, and less against, the hypothesis that dietary fibre and the starchy foods are important nutritional factors in the aetiology and treatment of diabetes than for the sugar hypothesis."¹ I proposed the former hypothesis in 1960.²

The Indian diet nowadays is based on boiled white rice, containing dietary fibre 0.8 g/100 g; the

*Dietary fibre and starch in the common rice and wheat foods as eaten*³

	Dietary fibre (g/100 g)	Starch (g/100 g)	Dietary fibre (g/100 g starch)
Rice, polished, white, cooked	0.8	30	2.7
Bread, white	3.0	48	6.3
Bread, wholemeal	8.5	40	21.2

Pakistani diet is based on chapatis made from wheat wholemeal containing dietary fibre 9.6 g/100 g³ (British white bread contains dietary fibre 2.7 g/100 g and wholemeal bread 8.5 g/100 g³).

The digestion of digestible starch mixed with indigestible fibre can be recorded as the amount of dietary fibre (in grams) present in 100 g of its own starch (table). The high prevalence of diabetes in rice eating Asians may be explained largely by the small amount of dietary fibre surrounding the starch in their staple food.

It is doubtful whether diabetes mellitus was ever described in the ancient world of Egypt, Greece, and Rome: Galen's cases in Rome were accompanied by unquenchable thirst and were probably diabetes insipidus.⁴ On the other hand, a sweet urine attracting ants was certainly described in the warm rice eating countries of India and China even before the time of Christ.⁴ No mediaeval physician described a stream of ants coming to drink the sweet urine; but this is still seen in certain warm tropical hospitals.⁵

In Europe in 1673 Willis noticed the sweet taste of urine, while in 1776 Dobson showed that a patient's urine contained a sugar like substance.⁴ In the eighteenth century the previous low grinding system of milling flour was increasingly replaced by the new high grinding system⁶; doubtless more bran was removed to produce a whiter flour.

A strong genetic factor is present in type II diabetes, which is often associated with obesity. High fat intakes must therefore constitute a risk factor in susceptible persons. This variety of diabetes occurs frequently in middle aged people, who will already have produced their children, so that the community gene pool is not much reduced and the incidence of the disease may not fall; it may even rise if risk factors increase. This has occurred recently in several countries. A milder form of type II diabetes is sometimes reported in elderly patients in India. Diabetes in rice eaters may be found to differ from that in wheat eaters, and much of the alleged difference may depend on other associated factors such as the level of fat intake.

Type I diabetes is different. The influence of harmful genes is far less; and it is regarded as an autoimmune disease coupled with possible environmental risk factors, such as diet and the lack of physical exercise. Type I diabetes was less common in Asians in Southall than in the Europeans.

Sooner or later those who are conducting fundamental research into the causes of autoimmune diseases will begin to investigate why apparently all the more common autoimmune diseases are extremely rare in sub-Saharan African blacks.⁷ After my first 20 years as a paediatrician in Kenya and Uganda (1932-52) I began to see an occasional case of type I diabetes in children.⁸ No well documented case of multiple sclerosis has been reported in the 200 million sub-Saharan Africans. Unidentified protective factors, probably dietary, must occur, since this disease occurs frequently in South African whites. Pernicious anaemia and hyperthyroidism are also very rare in African blacks.⁷

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