respectability may not be prejudiced by what you call the "unrealistic breadth" of its teaching. Such comments are characteristic of the intellectual resistance you refer to and symptomatic of the unrealistic narrowness of other specialist academic disciplines jealous of surrendering any of their share of the cake.

If the implications were to be accepted academic general practice would lose most of its credibility and support, even among its loyalists. There are many who fear that there is already too much separation between the teaching and the doing. Worse still, by adding the idea of a refined and extracted variety of general practice taught by lapsed general practitioners to the existing academic repertoire you threaten to exacerbate the tragic divorce of medical science from any philosophy of healing. This is already the consequence of the "hidden curriculum"[1] of traditional medical education, whose narrow academic attitudes permeate medical practice.

Illness is a process which handicaps an individual in the fulfilment of his life. Healing seeks to restore the individual to a degree of wholeness that permits a greater degree of fulfilment. That broad concept may not gain much academic respect but is in fact where good general practice and surely all good medicine begin and end, whatever clinical orderliness we may attempt to impose on such a mysterious phenomenon. We will never make sense of illness if we retreat from the realistically broad front that general practice presents. We will only accumulate an increasing fund of ingenious answers to the wrong questions. If teachers of general practice submit to your proposals they will have to find themselves another title. "Departments of medical fieldwork" perhaps.

Why, on the other hand, should not the traditional academic establishment learn to tolerate and even welcome a more realistic breadth of perception which does come to the perceptive by encountering illness straight off the streets and in the home? Such a change in perspective might not be merely refreshing, it might teach us to ask more of the right questions; to make more sense of the phenomenon of illness on which esoteric medicine feeds but which it does little to illuminate. It might also help us to understand better the relationship between medicine and healing and to make sure that the medicine we practise serves the healing we profess.

JEREMY SWAYNE

Coleford, Glos

[1] Marinker, M L, *Journal of the Royal College of General Practitioners*, 1974, **24**, 445.

## Early detection of asymptomatic bacteriuria in pregnancy

SIR,—The importance of screening pregnant women for asymptomatic bacteriuria was emphasised by Professor A W Asscher (21 May, p 1332), who claimed that "some 30% of pregnant women with covert bacteriuria develop acute pyelonephritis and eradication of the bacteriuria in early pregnancy can prevent this."

A frequent difficulty in such screening is in obtaining samples of urine for bacteriology during the first few months of pregnancy. However, it would seem that urine samples are now sent by general practitioners for early diagnosis of pregnancy from the majority of pregnant women. Thus we thought it would be worth while screening these samples for bacteriuria, especially since Boricon containers (the boric acid preventing overgrowth of organisms in the urine before culture) are used for the collection of urine specimens in this area.

During the nine-month period February-October 1977 a total of 1348 urine specimens submitted by general practitioners gave positive pregnancy results. Of these, 124 (9%) showed significant bacteriuria (≥ 100 000 organisms/ml). Repeat midstream urine (MSU) specimens were then requested from these 124 women, but from only 43 (35%) were further specimens received; of these 43 MSU specimens, 63% proved to have significant bacteriuria.

This preliminary study would indicate that routine screening for bacteriuria of all positive pregnancy test urines collected in Boricon containers will detect a considerable number of women with asymptomatic bacteriuria in the early stages of pregnancy.

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## Schistosomal myelopathy

SIR,—We are grateful to Dr F Hassib (16 July, p 189) and Dr J A Siddorn (13 August, p 458) for their interest in our short report. Taking the points in turn:

(1) Dr Hassib questions our use of the term "necrotising" to describe our patient's myelopathy. He is right in the sense that no spinal cord biopsy (a hazardous and, in this case, unwarranted procedure) was performed and that histological verification is therefore lacking. The very rapid rate of onset and the clinical similarity to some of the verified cases of necrotising schistosomal myelopathy reported by Maciel *et al*[1] and more recently by Lechtenberg and Vaida[2] leaves little doubt that our patient was *not* suffering from an intraspinal schistosomal granuloma. The total failure of response to antischistosomal therapy is also in keeping with this view.

(2) Although not mentioned in our report, a second myelogram was in fact performed. Both were negative. Neither of them showed the "specific" myelographic appearance ("abrupt intramedullary block, strictly located opposite T12 and L1, with irregular often trifid edges") reported by El-Banhawy *et al*[3] in cases of schistosomal granuloma.

(3) Antibodies to *Schistosoma mansoni* ova and worms were measured by the method described by Phillips and Draper,[4] as stated in our paper. It is reasonable to assume that the raised serum IgM and cerebrospinal fluid (CSF) IgG concentrations could have been due in part to these raised antibodies.

(4) Dr Hassib disagrees with the relevance of our citations of the literature. (*a*) The article by Phillips and Draper[4] does not "only" deal with immune complexes but clearly also describes the presence of antibodies in various groups. (*b*) Wakefield *et al*[5] emphasised the importance of eosinophilia in the spinal fluid in these cases but they also wrote that "the cellular response in the CSF appears to vary" and indeed in the *specific* cases cited in their report there was a predominance of lymphocytes in the CSF (97%, later falling to 90%, in the first case; 60% in the second case). Moreover, in each of the six cases cited by Bird[6] there was an overwhelmingly lymphocytic pleocytosis in the CSF, a small number of eosinophils being seen in only one case. Schistosomiasis would *not* appear to be a common cause of the eosinophilic meningitis syndromes reviewed by Lafon *et al*.[7] (*c*) Dr Hassib disagrees with our interpretation of the article by Bird.[6] Bird wrote that "when subjects with no immunity are exposed to schistosomiasis as occurs when city dwellers visit affected rural areas, the condition can take on most serious and sometimes fatal forms . . . . These states, rare in the relatively immune indigenous population, are not so uncommon among susceptible subjects with no immunity." Hence we wrote, "The importance of the individual allergic response to acute infestation with *S mansoni* has long been recognised."

(5) Dr Hassib objects to our comment that "antibodies to *S mansoni*-specific ova and worms were shown and this was reflected in the raised serum IgM and CSF IgG concentrations—an observation not previously made." In the reference quoted by Dr Hassib as an earlier description of this finding Hillyer[8] had not made *any* measurements on the CSF and the sera used were those of 10 patients with *S japonicum* infection. He demonstrated only the presence of anti-DNA antibodies and he did not make any specific measurements of immunoglobulins. We conclude that our observation has not been previously made.

(6) We are uncertain why Dr Hassib suggests that electrophysiological studies "must be most relevant" in our case, as in a short communication only the most relevant investigations are included. We fail in particular to see what an electroencephalogram would have added to the diagnosis of a cord lesion or an electromyogram to the diagnosis of a patient with obvious lower motor neurone lesions (as evidenced by residual flaccid paraplegia).

(7) Professor A W Woodruff advised treatment in our patient and he has made the following comments: "Niridazole 25 mg/kg twice daily for 14 days is the standard dosage regimen. Hycanthone treatment is a single-dose regimen still under trial. It is reported to have a 60% success rate but is hepatotoxic and possibly carcinogenic." The use and dosage of prednisolone employed were, in this condition, empirical.

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[6] Bird, A V, *Neurology*, 1964, **14**, 647.
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## Growing old gracefully

SIR,—Your reviewer Dr P J R Nichols (29 October, p 1135) quotes Dr Alex Comfort as writing, "Your memory, sexuality, [and] activity . . . should normally last as long as you do."

From the late eighties I wonder what "should normally" means. When Dr Comfort reaches his eighties I feel sure he'll be all right for "laughter and the love of friends"—those that survive—"books and his food and summer rain" and all that, but it would surprise me if memory will tell him—unbidden—where he put down his pen or his reading glasses two minutes ago or if his activity is unimpaired, and these will be matters for regret. Sexuality is different. He will find it a mere wisp of what that splendid committee of Quakers called