

dependent elderly patients," will also lay down quality standards.

Peterken says that the critics of the white paper *Working for Patients* go on about it being "an accountant's bonanza." But it is also a way of ensuring that standards of quality get written down for the first time, he says. "We all talk about how marvellous the NHS has been for 40 years, but ask what its standards of quality are, and apart from one or two things like perinatal mortality nobody's got a clue."

A closer examination of why Glasgow has decided to strike a deal with Takare rather than build and staff its own accommodation for the highly dependent elderly gives an inkling of where the "Glasgow experiment" is heading. Takare was favoured because it can build more cheaply and more quickly—a construction period of 12-15 months is "unheard of in the NHS"—and can provide a very good standard of patient care for about 15% less than the NHS. (The difference, according to Peterken, is because nurses don't get all the sick pay benefits and night shift benefits they would under the Whitley council agreements.) "The quality of care is going to be fine: in fact when we write contracts with our own long stay hospitals we shall be attempting to demand the same quality of care that we can buy out there. There's no reason in principle why the NHS shouldn't be as good—it may be that the Whitley rates would add 10-15% to the cost, we wouldn't mind that—it's the quality of care and management that we're missing. And I don't mean technical, medical care—I mean the whole environment; the way patients are treated as human beings."

Managing in Scotland

Peterken seems to see eye to eye with Michael Forsyth, recently promoted to Minister of State at the Scottish Office with responsibility for health and education, which probably makes him unique among general managers north of the border. (Roy Hattersley once quipped that Peterken had a passion for privatisa-

tion that was unusual in a public servant.) Forsyth describes Peterken as "my favourite manager." Sometimes "business" seems to have been done directly between the two, leaving the Scottish Home and Health Department and the Scottish NHS Management Executive as exasperated bystanders.

Enthusiasm for becoming self governing trusts is low in Scotland with just four units expressing an interest, and none so far submitting formal applications. None are in greater Glasgow. Implementing the strategic reviews and the patients' charter and costing medical procedures have a higher priority there.

In future, Glasgow's financial success is going to depend on accurately charging for cross boundary flows, and Glasgow should know its costs "fairly accurately" by April 1992. Peterken expects two useful results from this exercise—firstly, how the cost of a hip operation in Glasgow compares with one in Ayrshire. "And of course the other very valuable management tool is finding out how much a hip operation costs in the Western Infirmary compared with one in the Royal Infirmary or Stobhill, and if there are differences why, and why can't we all get down to a reasonable cost?"

Even Peterken's staunchest critics rate him as a superb financial manager, but then they use that against him: "All decisions are based on financial grounds" and "He won't move until he sees a pound sign." According to Peterken, the lack of costings of the recommendations that go before the board drove him mad when he first arrived in Glasgow. "There's no excuse for that in a public sector activity, which is using taxpayers' money. You wouldn't get that in local government. A lot of the changes in the NHS are still catching up with the level of efficiency that local governments have been achieving for years."

Glasgow clearly needed sorting out when Peterken arrived. Whether his tough management approach, paying scant attention to medical advice, will pay off in the long run is keenly awaited by observers on both sides of the border. Will Glasgow prove a blueprint for the rest of the NHS or a political cul de sac?

Letter from Brasilia

Mucocutaneous leishmaniasis

P D Marsden

In this letter I shall consider the last form of leishmaniasis found in Brazil, mucocutaneous leishmaniasis or espundia. This disease is virtually restricted to South America, though it occurs in Sudan. In the old days, when they were chopping down the forests in São Paulo state in the south of Brazil, some distinguished work was done on the disease by Brazilian investigators, and important contributions have also been made by Peruvian, Ecuadorian, and Bolivian researchers. Recently, however, there has been a hiatus in the research effort. When I came to Brasilia in 1973 I noted down possible clinical research projects after my ward rounds. I had been taught, "Go to the bedside and you will rapidly find things to work on in research." Clinical medicine is so imperfect, and I think I collected about a dozen projects, although I have had time to work on only one apart from control of Chagas' disease—mucocutaneous leishmaniasis.

One of our first patients was a woman in danger of losing her lower eyelids from the severe granulomatous infection in the centre of her face. Published work did not give much advice on diagnosis or the appropriate

dose of antimonial drugs. I found, to my surprise, that patients with espundia were not uncommon on the ward and that they were difficult to treat, often spending months in the hospital. We reviewed the published work in detail and could not offer a prognosis based on the information available. Now I realise that this information was deficient because nobody had studied the disease in its natural setting and hospital patients frequently defaulted on follow up.

In 1974 we began work in Três Braços, Bahia state, an area of littoral forest where there is virtual mono-transmission of *Leishmania viannia braziliensis*, the parasite mainly responsible for espundia. We are still working on the prognosis, which with such a chronic unpredictable infection will take us decades. A relatively large number of patients with espundia had accumulated in the area because the disease progresses more slowly, disfiguring but not killing the patient, and adequate chemotherapy was not available. The plight of individual patients with severe disease was pitiful, and sometimes families broke up because of it. Over the years our field clinics and supporting hospital

Núcleo de Medicina
Tropical, Universidade de
Brasilia-CP 153121, 70.010
Brasilia DF, Brazil
P D Marsden, MD, professor

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Mucocutaneous leishmaniasis affecting the cheeks, nose, and upper lip

services have successfully treated this pool of patients, although we still see many new patients, who travel long distances to consult us.

Clinical management

As in all infectious diseases the presentation varies widely. Most commonly, however, the patients are men aged over 40, and 90% of them have a scar characteristic of a previous cutaneous infection with *L. viannia braziliensis*. Only the scars of a burn or a mother yaw resemble it closely. Our data suggest that patients with extensive initial skin infections above the waist who are poorly treated with antimonial drugs have a greater tendency to develop mucosal disease later, although when it develops varies for unknown reasons. Sometimes we see an active skin lesion presenting at the same time as the mucosal infection, but normally years, even decades, pass before the mucosal metastasis is clinically apparent. Metastasis usually begins on the anterior nasal septum as a friable

granuloma which eventually perforates the septum and affects the turbinates. Further granuloma in the floor of the nose often results in granuloma appearing on the palate, which may resemble a cobbled street. Gradually it extends backwards to affect the pharynx and finally the larynx. A hoarse voice is a valuable sign, and indirect laryngoscopy shows granuloma affecting the epiglottis and larynx, resulting in poor movement of the vocal cords. In one of our published series 42% of patients with espundia outside the nose had affected larynges. This can result in suffocation due to laryngeal closure, one of the two most common causes of death in espundia. Extreme care must be taken when treating such patients as reactive oedema can close off the critical airway, and we keep a tracheostomy set by the bedside during the first week of admission. The other common cause of death is aspiration pneumonia from infected secretions.

Diagnosis by isolating the parasite is harder in espundia than in other forms of leishmaniasis owing to problems of contamination and obtaining adequate biopsy material and the poor growth of *L. viannia braziliensis*. Treatment is unpredictable and may be prolonged. We routinely give patients 20 mg pentavalent antimony/kg body weight/day for 30 days, and further treatment is determined by the clinical response. The longest course of treatment we have given at this dose is 86 days, and this patient relapsed. Amphotericin or pentamidine can be used as second line drugs, but relapse can occur even after such treatment. The great majority of our patients, however, respond to our initial antimony treatment.

The large number of patients seeking help means that we cannot admit everyone with espundia. We have therefore established field clinics where antimonial drugs provided by the ministry of health are given by experienced staff. In distant farms a health service auxiliary is trained to sterilise syringes and administer the drug. Unresponsive patients eventually end up in our hospital in Brasilia for treatment under close supervision, after travelling over 1600 km. Our dream when we started this work 15 years ago was to have a single dose oral drug that was cheap and effective, but we are still using the primitive antimonial drugs. In our area no measure to control the vector seems practical and the wild animal reservoir is unknown. If a vaccine was available we could not identify a candidate population to vaccinate as the genesis of epidemics is not understood. The blood sucking female phlebotomine vector (*Lutzomyia whitmanni*) has adapted well to cacao plantations, the chief economy of the region, and our field clinic activities continue unabated. I have not yet been able to arrange a resident doctor for the field clinics.

ANY QUESTIONS

Is there any evidence that myringotomies or grommets in preschool children with fluctuating hearing loss help the development of speech, either in children with speech problems or children in their prespeech phase?

Myringotomies and grommets relieve the conductive, often fluctuating, hearing deficit of secretory otitis media; fluctuating hearing losses in childhood are rarely found for any other reason. The nub of the question is whether slight conductive defects can hinder normal speech development. The consensus view, based on several studies, is that secretory otitis media is hazardous to the development of speech and language in children¹ and is associated with delays in the development of vocabulary and grammatical skill. Why this should be so, as conductive losses do not cause the distortion typical of sensorineural impairment, is not easy to explain. It may be that the information carrying sound contrasts of speech—

fricatives, nasals, and stops—are lost even with hearing deficits as slight as 20 decibels.² Perhaps fluctuating levels of hearing offer inconsistencies of speech contrasts that are confusing to the maturing infant at a critical stage of development.³ It has also been suggested that the sensory deprivation of slight conductive impairment could impair the normal anatomical maturation of neurological auditory pathways. Whatever the explanation, the short answer to the writer's question must be yes.—H LUDMAN, consultant in ear, nose, and throat surgery, London

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