

- 3 Froelicher VF, Morgan D. Exercise testing and ancillary techniques to screen for coronary heart disease. *Prog Cardiovasc Dis* 1981;2:24:261-74.
- 4 Bruce RA, DeRouen TA, Hossack KF. Value of maximal exercise tests in risk assessment of primary coronary heart disease events in healthy men. *Am J Cardiol* 1980;46:371-8.
- 5 Gordon DJ, Lars-Goran E, Karon JM, et al. Predictive value of the exercise tolerance test for mortality in North American men: the Lipid Research Clinic's mortality follow up study. *Circulation* 1986;74:252-61.
- 6 McHenry PL, O'Donnell J, Morris SN, Jordan JJ. The abnormal exercise electrocardiogram in apparently healthy men: a predictor of angina pectoris as an initial coronary event during long term follow up. *Circulation* 1984;70:547-51.
- 7 Hollenberg M, Zolnick JM, Go M, et al. Comparison of a quantitative treadmill exercise score with standard electrocardiographic criteria in screening asymptomatic young men for coronary artery disease. *N Engl J Med* 1985;313:600-6.
- 8 Chamberlain DA. Routine and exercise electrocardiography in aircrew; technique, interpretation and recommendations. *Eur Heart J* 1984;5(suppl A):55-60.
- 9 Froelicher VF, Thompson AJ, Wolthuis R, et al. Angiographic findings in asymptomatic aircrewmembers with electrocardiographic abnormalities. *Am J Cardiol* 1977;39:31-8.
- 10 Barnard RJ, Gardner GW, Diaco NV. "Ischaemic" heart disease in firefighters with normal coronary arteries. *J Occup Med* 1976;18:181-20.
- 11 Borer JS, Brensike JF, Redwood GR, et al. Limitations of the electrocardiographic response to exercise in predicting coronary artery disease. *N Engl J Med* 1975;293:367-71.
- 12 Royal College of Physicians of London. The cardiovascular fitness of airline pilots. *Br Heart J* 1978;4:335-50.

although urgency may necessitate a retrospective study. The Nuffield Foundation was considering an investigation but seems to have dropped the idea. Perhaps it should think again, and perhaps the defence societies would like to contribute funds—while they still have some to contribute.

RICHARD SMITH

Assistant editor, *BMJ*

- 1 Mills DH. Medical insurance feasibility study. *West J Med* 1978;128:360-5.
- 2 Smith R. When things go wrong. *Br Med J* 1986;293:46-2.
- 3 Anonymous. Compensation: who cares? *Br Med J* 1982;284:1428-9.

Acute salpingitis

Acute salpingitis has become much commoner over the past decade, affecting particularly women aged 15 to 20.¹ The factors underlying this rise are sexually transmitted diseases, the use of intrauterine contraceptive devices, and infections associated with the termination of pregnancy. The infecting organisms have also changed, with chlamydia now being the commonest: it is implicated in almost two thirds of cases.²⁻⁵ Gonorrhoea is still an important cause, with the gonococcus isolated in over half the cases.² Other organisms implicated include mycoplasma,² enterobacteria, and anaerobic bacteria. A further factor in the spread of acute salpingitis is carriage of bacteria by spermatozoa to the upper genital tract.⁶

Classically acute salpingitis presents with bilateral lower abdominal pain, fever, and purulent vaginal discharge. The lower abdomen may be tender and even rigid if peritonitis is present, with absent bowel sounds. There may be a purulent, offensive vaginal discharge, which is sometimes blood stained; cervical excitation; and pain and bilateral tenderness of the fornices with enlargement of the adnexae. These findings may be unreliable: Jacobson and Westrom showed that laparoscopy failed to confirm the clinical diagnosis of acute salpingitis in almost a quarter of cases.⁷ In cases of doubt or when the condition fails to improve with antibiotic treatment laparoscopic confirmation of the diagnosis may be needed. This may show hyperaemia of the Fallopian tube, oedema, a purulent exudate, and possible evidence of previous tubal disease.

Other investigations include bacteriological culture of high vaginal swabs and cervical swabs, inserted directly into the media. The technique for taking chlamydial swabs must ensure that cells themselves are removed for culture. Estimations of antichlamydial IgG antibody may confirm the presence of chlamydial disease when the results of cultures have been negative, although a raised value does not necessarily indicate active disease.² Swabs may also be taken at laparoscopy, and an endometrial biopsy specimen for cytological studies may confirm the presence of acute salpingitis, although the appearances are not specific for a causative organism.⁸

Severely ill patients need admission to hospital with bed rest, antimicrobial therapy, and analgesia. High vaginal and cervical swabs should be taken and then antibiotic treatment given. As more than one organism is usually responsible for acute salpingitis several antimicrobials are often required, though some (such as doxycycline) should be avoided during pregnancy. A suitable regimen would be spectinomycin 4-6 g six hourly for 24 hours with doxycycline 100 mg twice daily for seven days and daily for a further 14 days, and rectal metronidazole 500 mg twice daily for 10 days. An alternative

When things go wrong—again

Wherever two or more American doctors are gathered together the word malpractice is likely to enter the conversation. Malpractice, and particularly the premiums needed to insure against it, looms large in the American medical consciousness—and no wonder. Malpractice litigation may account for a quarter of the amount spent on doctors' services in America (about \$20 billion), and it stops doctors delivering babies, "takes the fun out of medicine," and still fails to compensate most of those injured by medical care, even those injured through negligence.¹ Legislatures in most if not all states are struggling, without much success, to contain the crisis.

We are still a long way from such misery in Britain, but this year's 87% increase in defence society subscriptions has produced squeals of pain from doctors (p 666). It follows last year's 70% increase, when we published a leading article arguing not for reform of a legal system manifestly incapable of dealing with this medicosocial problem but rather for a newly minted no fault system.² We have been arguing the case for such a system for years,³ and in the past year the BMA has come out in favour of a no fault system, one that would cover medical misadventure rather than all disability.

Now the BMA wants a parliamentary select committee to investigate this problem, a recommendation to be wholeheartedly supported—and not just because doctors' pockets are suffering. Action now may avoid an American style crisis, and a select committee would consider the interests of all groups—patients, doctors, lawyers, and the defence societies. More than anything we need facts, and the select committee would have the power to require people to give evidence. The defence societies might have to release information that would give us more insight into the extent of malpractice. But that still would not tell us how many people are injured by medical care and what happens to them—because many such people make no complaint. Even after more than a decade of worrying about malpractice the Americans lack the basic data. Dr John Havard quoted last month (15 August, p 399) a statement from an American government committee that the debate on malpractice had "been based more on rhetoric, speculation and misconception, than on factual quantitative data."

We need to avoid such a fate, and a select committee inquiry would help. It would not in itself, however, be enough. We also need a large scale prospective investigation,

regimen comprises penicillin, 12-20 megaunits daily in divided doses, switching after 72 hours to a tetracycline (doxycycline 100 mg twice daily) or erythromycin 500 mg four times daily for 7-10 days; gentamicin is also given, 2-5 mg/kg body weight daily in divided doses, together with rectal metronidazole 500 mg twice daily for 10 days. Cephalosporins have a lesser role as they are not effective against chlamydia. Penicillinase producing *Neisseria gonorrhoeae* may be managed with cefoxitin in an intramuscular dose of 1-2 g six hourly.

The patient may also need her blood volume restored and the electrolyte and fluid balance corrected, thereby ensuring an adequate urine output. The development of a pelvic abscess needs prompt and adequate drainage. Treatment should be continued until the clinical signs abate, while measurements of the erythrocyte sedimentation rate may be used to monitor progress.

Milder acute salpingitis may be treated either in hospital or at home, with doxycycline 100 mg daily for 14 days and rectal metronidazole 500 mg twice daily for 7-14 days. If the patient is pregnant erythromycin should be substituted for the doxycycline at 500 mg four times a day for 7-14 days.

It is important to treat the initial episode adequately and correctly. Inadequate treatment will lead to sterility and chronic pelvic inflammatory disease. One episode of acute salpingitis may lead to infertility in 13% of cases and the proportions for a second and third episode are 31% and 35% respectively.^{1,9} Contact tracing and treatment are especially important in preventing this condition, as no fewer than half of male partners have definite gonococcal and chlamydial infection.³

STUART L STANTON

Consultant Gynaecologist, Department of Gynaecology,
St George's Hospital, London SW17 0RE

- Westrom L. Incidence, prevalence and trends of pelvic inflammatory disease and its consequences in industrialised countries. *Am J Obstet Gynecol* 1980;139:880.
- Kinghorn G, Duerden B, Hafiz S. Clinical and microbial investigation of women with acute salpingitis and their consorts. *Br J Obstet Gynaecol* 1986;93:869-80.
- Magnusson S, Oskarsson T, Gersson R, Sveinsson B, Steingrimsdottir O, Thorarinnsson H. Lower genital tract infection of *Chlamydia trachomatis* and *Neisseria gonorrhoea* in Icelandic women with salpingitis. *Am J Obstet Gynecol* 1986;155:602-7.
- Mardh P. Microbial etiology of pelvic inflammatory disease. *Sex Transm Dis* 1984;11 (suppl): 428-98.
- Monif G. Choice of antibiotics and length of therapy in the treatment of acute salpingitis. *Am J Med* 1985;78:188-93.
- Toth A, Lesser M, Labriola D. Development of infections of the genito-urinary tract in wives of infertile males and possible role of spermatozoa in development of salpingitis. *Surg Gynecol Obstet* 1984;159:565-9.
- Jacobson L, Westrom L. Objectivized diagnosis of acute pelvic inflammatory disease. *Am J Obstet Gynecol* 1969;105:1088.
- Paavonen J, Aine R, Teisala K, Heinonen P, Punnonen R. Comparison of endometrial biopsy and peritoneal fluid cytologic testing with laparoscopy in the diagnosis of acute pelvic inflammatory disease. *Am J Obstet Gynecol* 1985;151:645-50.
- Westrom L. Effect of acute pelvic inflammatory disease on fertility. *Am J Obstet Gynecol* 1975;121:707-13.

British Society of Gastroenterology: golden jubilee

The gut has just not had the same cachet as the brain or heart. Plato rated it well below the other two and so has almost everybody else since. Neurologists and cardiologists are thought to be smart. In modern folklore brain and heart surgeons are at the top of the surgical tree, their work tailor made for colour supplement celebration. The gut and all its works? Forget it.

For the public the gut still has an image problem; for doctors it has become the exciting place to be. Fifty years ago

the gut may have been "invisible, impalpable, and, except at both ends, inaccessible"—in the words of Sir Francis Avery Jones. Today, thanks to fiberoptic endoscopy, biopsy, and imaging techniques, it is almost fully charted. This process has been coordinated in Britain by the British Society of Gastroenterology.

Sir Arthur Hurst (1879-1944) was the first British doctor to take the gut seriously. His enthusiasm fired others, and in 1937 he formed the Gastroenterological Club, which in its early days resembled, perhaps appropriately, a gentlemen's dining club. Exclusivity was one of its features—even in 1952 (by which time the club had become the British Society of Gastroenterology) it agreed that "the society should be kept as small as possible and should consist only of people really interested and active in gastroenterology."¹ That year it increased its number of ordinary members to 65.

From the beginning it was not too exclusive to admit radiologists, biochemists, pathologists, and surgeons to its membership, and one of its great strengths has been cross fertilisation among different disciplines. Later the society realised that more and more people were "really interested and active in gastroenterology," and in its golden jubilee year it has 1500 members. In Britain almost 300 consultant physicians have a special interest in gastroenterology²: after endocrinology it is the most common special interest expressed by general physicians.³ The society's academic meetings now happen twice a year and attract hundreds. For next week's golden jubilee meeting 1470 have registered.

These meetings allow scientific advances to be rapidly disseminated, a process helped by the society's journal, *Gut*, which started publication in 1960 aided by the *BMJ*. In 1971 an independent charity was formed to raise funds "to promote the fuller development of gastroenterological research and education." The British Digestive Foundation's assets now just top £1m, but compared with other charities its income is miniscule given the proportion of gastroenterological disease—one in four cancers, one in 10 deaths, one in five operations, and one in five general practice consultations.⁴ The gut's poor public image has got to be changed. (In this respect President Reagan has done a great public relations job on the colon.)

Medically there is much to do. Reading through the collection of papers published by the society to commemorate its golden jubilee one learns much of diagnosis and treatment, of how the new territory was mapped out.⁵ But, as *Gut*'s golden jubilee supplement* concludes: "However much we may have achieved, we still recognise our humiliating ignorance of the pathogenesis, pathophysiology, and even the clinical chemistry of observable abnormalities of most of the common diseases in our field. We have to admit to a paucity of successful or even rational treatments for many of the diseases under our care. Much remains to be conquered."⁶

We wish them well.

TONY DELAMOTHE
Assistant editor, *BMJ*

- Sladen GE. Membership of the BSG 1937-1987. *Gut* 1987;28 (jubilee suppl):16-7.
- Department of Health and Social Security, Medical Manpower and Education Division. Medical and dental staffing prospects in the NHS in England and Wales in 1986. *Health Trends* 1987; 19:1-8.
- Houghton J, Richings J. The second specialty of general physicians. *J R Coll Physicians Lond* 1981;15:28-31.
- Sarner M. The British Digestive Foundation. *Gut* 1987;28 (jubilee suppl):46-7.
- British Society of Gastroenterology. *A selection of scientific papers*. Welwyn Garden City: Smith Kline and French Laboratories Ltd, 1987.
- Alexander-Williams J, Baron JH. British Society of Gastroenterology 1937-87: an overview. *Gut* 1987;28 (jubilee suppl):53-5.

**Gut*'s Jubilee Supplement is available from the Publishing Manager, *BMJ*, price £10. It contains a history of the British Society of Gastroenterology and biographies of its leading members.