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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.

Doctors and the Official Secrets Act

SIR,—Many doctors are members of DHSS or other governmental advisory committees, where our first duty is surely to promote and protect the public health. In furtherance of this duty we would expect to follow normal professional procedures, including on occasion seeking advice or further information from colleagues and not being party to concealing matters which affect the public health. Such actions, however, could bring us into conflict with the Official Secrets Act.

From a written answer by Mr Barney Hayhoe to a parliamentary question¹ it now appears that the application of the Official Secrets Act is far wider than most of us ever realised. It includes *all* the main DHSS standing expert advisory committees and seemingly all the others too: the supplementary list includes, for example, the Advisory Committee on Gene Modification Therapy, the Committee on Medical Aspects of Radiation and the Environment, the Community Medicine Inquiry, the Overseas Doctors Study Group, the Leprosy Opinion Panel, the Working Group on the Safety of Nuclear Magnetic Resonance Imaging, the Small Grants Committee—and 36 others.

The minister went on to say that "the Official Secrets Act applies to all official information whether or not a declaration has been signed. The Department does not normally call for a declaration to be made by members of advisory committees."

The decision on what constitutes "official" information is at the government's discretion. Gone are the days when it applied only to information constituting a direct and unambiguous threat

to national security: the Official Secrets Act has been used to cover a widening range of politically sensitive matters, and no one can know in advance what may be classified—perhaps retrospectively—as "official."

All doctors who are members of any governmental advisory body are thus liable for prosecution and potential imprisonment if they divulge information which the government—at the time or later—decrees to be "official." If they discuss a problem with a colleague "in confidence" and that colleague makes it public they are again liable for prosecution. It would be no defence that medical duty required openness.

When a minister announces in parliament that the Official Secrets Act applies to the Leprosy Opinion Panel, something has gone wrong. The

position is clearly crazy and out of control. The British Medical Association should organise pressure on government to exclude from its list all those advisory bodies whose business is not related to national security (which in the case of health means almost all of them). Meanwhile doctors who are members of governmental committees ought to inform their chairmen that discretion, not the Official Secrets Act, will be their guide; and that they will not accept secrecy if concern for the public health requires otherwise.

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¹ Hayhoe B. Written answer. *House of Commons Official Report (Hansard)*; 1986 May 16;97:col 587-8. (No 115.)

Pseudo-obstruction

SIR,—The review on colonic pseudo-obstruction by Professor H A F Dudley and Dr S Paterson-Brown (3 May, p 1157) is both timely and welcome. We would agree entirely that, armed with a high index of suspicion, this is a diagnosis that should be made before ill advised surgery and that treatment should be by conservative means whenever possible.

The use of a water soluble contrast enema acutely in suspected cases of mechanical large bowel obstruction is gaining popularity. Our experience¹ is very similar to that later reported by Koruth *et al.*² In a series of 117 cases not only did it exclude obstruction in 35 out of 99 patients where

the plain film diagnosis was that of obstruction, but in 18 cases where the clinical picture was of colonic pseudo-obstruction the diagnosis was confirmed in 16, an unsuspected mechanical obstruction being noted in the remaining two. Furthermore, we noted that the use of a water soluble enema in cases of pseudo-obstruction was frequently therapeutic in that the osmotic effect of the enema induced diarrhoea, thereby decompressing the colon. Indeed, only one patient in this series came to surgery for impending caecal rupture.

Having diagnosed pseudo-obstruction colonoscopic decompression seems appropriate whenever possible. However, there are cases when it

fails or is not available or when the clinical condition progresses. Faced with the necessity for a laparotomy, principally to prevent colonic perforation, what should be the procedure of choice? We agree that in the presence of frank caecal perforation or gangrene caecal exteriorisation would be appropriate. However, we have recently seen two cases (one patient with uraemia and one with subclinical hypothyroidism) where laparotomy was prompted by failed conservative measures (including colonoscopy), caecal tenderness on examination, and caecal diameters of 13 and 15 cm. At laparotomy the condition was confirmed and a transverse loop colostomy was performed, after which full colonoscopic decompression was achieved by the operating surgeon using a 60 cm flexible sigmoidoscope. In one patient this decompression was repeated in the postoperative period and in both cases the patients made full recoveries.

This recent experience serves to emphasise that, although there is no obvious mechanical obstruction in these cases, a grossly distended transverse colon may well lead to temporary obstruction at both flexures. It is therefore unlikely that a single stoma will achieve full decompression unless this is associated with some form of endoscopic decompression at the time of surgery or immediately afterwards. We would suggest that this can be achieved through a transverse loop colostomy and the use of a 60 cm flexible sigmoidoscope.

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- 1 Stewart J, Finan PJ, Courtney DF, Brennan TG. Does a water soluble contrast enema assist in the management of acute large bowel obstruction: a prospective study of 117 cases. *Br J Surg* 1984;71:799-801.
- 2 Koruth NM, Koruth A, Matheson NA. The place of contrast enema in the management of large bowel obstruction. *J R Coll Surg Edinb* 1985;30:258-60.

Acute adrenal crisis precipitated by thyroxine

SIR,—We were interested to read the report by Dr V Fonseca and others of acute adrenal crisis precipitated by thyroxine (3 May, p 1185). However, it is not clear that both of the patients described had permanent hypothyroidism. Although both patients had high serum concentrations of thyroid stimulating hormone (TSH), the first in fact had a free thyroxine concentration within the normal range.

Adrenal insufficiency is often associated with raised serum TSH and normal or low thyroxine concentrations, abnormalities which may be completely reversible with corticosteroid treatment alone, even in the presence of thyroid autoantibodies.^{1,3} Corticosteroid deficiency may impair thyroid function, leading to a rise in serum TSH, but it may also promote pituitary TSH secretion directly.⁴ Therefore a raised TSH level alone may not necessarily imply hypothyroidism in patients with adrenal insufficiency; even true biochemical and clinical hypothyroidism may not be permanent.⁵ Treatment with thyroxine as well as corticosteroids may be indicated in some patients, but perhaps only temporarily.

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- 1 Topliss DJ, White EL, Stockigt JR. Significance of thyrotropin excess in untreated primary adrenal insufficiency. *J Clin Endocrinol Metab* 1980;50:52-6.

- 2 Barnett AH, Donald RA, Espiner EA. High concentrations of thyroid-stimulating hormone in untreated glucocorticoid deficiency: indication of primary hypothyroidism? *Br Med J* 1982;285:172-3.
- 3 Jeffcoate WJ, Davis JRE. Reversible hypothyroidism in adrenal insufficiency. *Br Med J* 1982;285:651-2.
- 4 Morley JE. Neuroendocrine control of thyrotropin secretion. *Endocr Rev* 1981;2:396-436.
- 5 Gharib H, Hodgson SF, Gastineau CF, Scholz DA, Smith LA. Reversible hypothyroidism in Addison's disease. *Lancet* 1972;ii:734-6.

Deficient urinary fibrinolysis in renal stone disease

SIR,—The study by Mr Clive A Charlton and Dr Clive Osmond (10 May, p 1239) shows a lower urinary fibrinolytic activity in some stone formers than in matched controls when estimated by a fibrin plate method. This technique measures the overall fibrinolytic activity of the urine under test, which is a composite of activators and inhibitors. There are two fibrinolytic enzymes responsible for plasminogen activation and specific fibrin degradation—namely, tissue (vascular) plasminogen activator and urokinase¹—and both are present in human kidney.²

This paper does not differentiate between the two fibrinolytic enzymes and therefore the results do not reflect the urinary urokinase content, as suggested, but the composite urinary fibrinolytic activity. Before attempts are made to raise levels of urinary fibrinolytic activity to prevent stone formation, both tissue plasminogen activator and urokinase values should be independently estimated in stone formers and controls.

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- 1 Cederholm-Williams SA. Molecular biology of plasminogen activators and recombinant DNA progress. *Bioessays* 1984;1:168-73.
- 2 Angles-Cano E, Rondeau E, Balaton A, Delarue F, Sultan Y, Sraer JD. Plasminogen activators of isolated human glomeruli. In: Davidson JF, Donati MB, Coccheri S, eds. *Progress in fibrinolysis VII*. Edinburgh: Churchill Livingstone, 1985.

Bed blocking in Bromley and Belfast

SIR,—Dr Pamela A Maguire and colleagues (10 May, p 1251) claim that prolonged stay in hospital of elderly patients is related to medical rather than social factors. Their paper supports neither this conclusion nor the suggestion that "improvements in community social services would at best have a marginal effect on the turnover of elderly patients in general medical wards."

Firstly, they admit that support provided by only a neighbour was associated with a reduction in the proportion discharged at 28 days. Secondly, they found that the "main reason" for admission was medical apart from the seven (2%) they categorised as social problems. If they had also examined the underlying social reasons for admission, tried to assess the interplay between medical and social reasons, and compared the final outcome in their group with that in a group who were not admitted but in whom the age distribution and range of medical problems were similar, they might have reached a different conclusion. Discharge is not in itself an outcome measure. The number and length of all admissions in the previous year would have provided better evidence for or against their hypothesis. The role of community services in preventing admission is not addressed. What, for example, were the social circumstances of those 59 patients who died within 14 days, and who were excluded from the analysis?

Is time of discharge a more meaningful outcome than death?

Thirdly, they present results to show the effect of age on time of discharge but then claim that "age alone does not make a major contribution to prolonged hospital discharge." No analysis is offered of the relative contribution age represents compared with, for example, social support or continence, despite the availability of well developed techniques to do just this,¹ thereby enabling the reader to see how major or not such an effect might be.

Fourthly, it is a sleight of hand to assert that "contact with members of a geriatric medical unit . . . results in shorter lengths of hospital stay" when no data from within this study have been presented to support such an assertion. It is rendered less defensible when followed by reference to the lower mortality, fewer admissions to nursing homes, and improvement in functional state after discharge from hospital found in a North American trial,² which has both intrinsic methodological problems of its own and little relevance in this context to the acute hospital care of elderly people in Britain.

Finally, to claim that "improvements in community social services would have at best a marginal effect on the turnover of elderly patients in general medical wards," even if this paper suggested that, is to betray an ignorance of the fact that it is precisely changes at the margin which may make a real difference to the optimal allocation of resources.

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- 1 Mitchell JB. Patient outcomes in alternative long-term care settings. *Medical Care* 1978;16:439-52.
- 2 Rubenstein LZ, Josephson KR, Wieland GD, et al. Effectiveness of a geriatric evaluation unit. A randomised controlled trial. *N Engl J Med* 1984;311:1664-70.

AUTHORS' REPLY—As both the title and the text indicate, our paper was concerned with length of stay of elderly patients in acute medical wards. The study was performed without any preconceived ideas of the likely results, and the conclusions are based on the analysis of the data, which were collected as objectively as possible. Measures to prevent admission are of great importance but were not the subject of this study.

It is therefore difficult to understand Dr Gill's suggestion that examining patients who were not admitted to hospital could have been used in a study predicting length of stay in hospital. The fact that the reason for admission was stated to be medical in most cases indicates not that social factors were ignored but that admission to a busy general hospital is primarily for medical reasons. It is reasonable to presume that patients admitted primarily for social reasons would have been identified as having social reasons for delay in discharge.

Dr Gill states that "discharge is not in itself an outcome measure." However, it is difficult to see how any other event than discharge could be used to measure length of stay in hospital. With respect to the optimal use of hospital beds discharge is a major outcome measure as, unless patients are discharged, other patients cannot be admitted. Death also frees a bed, as Dr Gill indicates. However, the factors involved in death are likely to be different from those related to discharge.

Dr Gill quotes our statement that "age alone does not make a major contribution to prolonged hospital discharge" out of context. This statement is used in the context of the fact that over half of those aged 80 and over were discharged from hospital within 14 days of admission. We go on to say that "very old patients remaining in hospital