erythrocytic cation transport. The inhibitor may act on leucocytes but not erythrocytes.[4 5]

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Gonorrhoea in children

SIR,—We were impressed by the confident way that Minerva (20 September, p 762) commented on the highly controversial and topical issue of gonorrhoea in children. Assuming that the aim of this was to attract debate and discussion, we will admit to having accepted the bait and swallowed it hook, line, and sinker.

The article quoted is a single case report of four children who showed evidence of gonococcal infection and in whom, because there was no immediate history or sign of sexual abuse, non-venereal transmission was presumed to have taken place. The presumed source of the infection, an 18 year old family friend, refused to attend for screening, and other information pointed to family circumstances that were certainly less than straightforward.

No direct evidence has ever been published that gonorrhoea can be transmitted by towels, flannels, or other inanimate objects. We believe that this has always been a convenient and comfortable way of avoiding the issue of child sexual abuse. With recent research indicating the high incidence of sexual contact between adults and children, we no longer need to propose methods of transmission that are scientifically unproved. The presumption must be that gonorrhoea is a sexually transmitted disease in every case and that protection for the child must be pursued.

We have followed that policy in Leeds, even when there was no other evidence of sexual abuse, and have been rewarded in time by confirmation, often from the child's statements, that abuse has indeed taken place.

Finally, we would like to encourage specialists in genitourinary medicine to look seriously at this problem and to join forces with colleagues in paediatrics to provide effective management for these children, as our colleagues in Leeds have done with us.

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Dietary supplementation in pregnancy

SIR,—We have just completed a trial of nutritional supplementation in pregnancy. Out of 450 patients recruited to the study, 78 white women and 78 Asian women were judged to be nutritionally at risk because of inadequate increase in triceps skinfold in the second trimester as described by Wharton.[1]

Half the women in each group were given a milk based supplement throughout the third trimester; this gave daily protein and energy supplements comparable to the protein energy supplement used in the Sorrento trial,[2 3] referred to both by Messrs A Malhotra and R S Sawers (23 August, p 465) and by Dr B A Wharton (20 September, p 759). The supplement did not increase birth weight in either group; indeed, the babies of supplemented women were lighter than those of unsupplemented women. We had more Sikhs than Moslems in our study whereas Sorrento had a majority of Pakistani (mainly Moslem) women, but the seven supplemented Moslem women's babies were smaller than the eight unsupplemented Moslem women's babies in our series. We therefore conclude that protein energy supplementation is not beneficial even to selected pregnant women in the West Midlands, whether Asian or white.

Dr Wharton's reiteration of the importance of vitamin D supplementation is much needed. Few obstetricians practise this, but in our recent study, as in our earlier ones,[4 5] we found evidence of vitamin D deficiency in Asian women. If routine supplementation of all Asian women with calcium and vitamin D is thought to be inappropriate surely all could be screened at 28 weeks for raised maternal (total minus heat stable) alkaline phosphatase values and supplemented when necessary.

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The neuropathy of the critically ill

SIR,—We have seen five patients in the past six years with the neuropathy described by Dr A C Williams and colleagues (27 September, p 790).

All had severe adult respiratory distress syndrome after trauma or sepsis and had a prolonged stay in intensive care (five to six weeks). They developed a peripheral neuropathy, usually worse in the legs, which recovered over several months, but some residual motor weakness usually remained. Two patients described the classic burning sensations often associated with thiamine deficiency. This, plus several previous articles[1 2] and letters,[3] lead me to think that this may be the underlying cause. Thiamine requirements may be exceedingly high in critically ill patients fed parenterally, while some vitamin preparations contain only 1·2 mg thiamine (Solivito, Kabivitrum Ltd). Critically ill patients probably require at least 0·3 mg thiamine/kg/day.[4] This requirement may be further increased by the administration of intravenous carbohydrates, as thiamine is consumed as a cofactor in carbohydrate metabolism. Dr Williams and his colleagues did not mention the quantities of thiamine or carbohydrate given to their patient.

All our critically ill patients fed parenterally receive thiamine 50 mg/day, though we have recently increased this to 100 mg/day for any patients staying for more than two weeks.

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A secret ballot?

SIR,—May I through your correspondence columns ask those elected members of the council of the British Medical Association why they do not want those people who elected them to know how they vote on vital issues which will shape our profession for the next 20-25 years.

Let me explain to your readers, the people who elected us. When a vote was being taken on the BMA's response to *Hospital Medical Staffing: Achieving a Balance* I asked for a roll call—that is, the recording of the way each member voted—to be taken so that the electorate might know how the people they elected voted on so vital an issue. With the honourable exceptions of Ruth Gilbert, J Wight, and S J Hawkins no one appeared willing to let the electorate know how they voted. Even the gentle nudging of the chairman of council failed to produce more support for the idea.

Are we to be a democratic organisation or do we just pay lip service to democracy? At least 35 of our elected representatives seem to think we should just pay lip service to it.

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Ceruletide for retained biliary stones

SIR,—Unlike Mr S J Walker and colleagues (6 September, p 595), we have had encouraging results with irrigation plus ceruletide in the treatment of retained biliary stones.

We administered intravenous ceruletide (2 ng/kg/min for 1 h) plus intraductal saline (0·8-3·0 litres, mean 1·5 litres, infused at a rate that kept bile pressure below 30 cm H_2O) to 10 subjects. We treated 6 single and 14 multiple choledochal stones which were distal to the T tube. Eleven stones (8 radiolucent, 3 radio-opaque) 0·5-0·9 cm in diameter (mean 0·7 cm) were eliminated without difficulty at the first attempt. The remaining six radiolucent stones (1·0-1·5 cm, mean 1·2 cm) were treated with glyceryl mono-octanoate infused continuously at a rate of 3-4 ml/h, as previously reported.[1] The mean volume instilled was 660 ml and the mean duration of treatment was eight days. Glyceryl mono-octanoate reduced the diameter of the concretions (to less than 1·0 cm), which were then eliminated by another infusion of saline plus ceruletide. The last three radio-opaque stones (1·0-1·3 cm, mean 1·2 cm), belonging to two patients, were successfully removed through the T tube by endoscopic procedures. The irrigation technique plus ceruletide was well tolerated. Cultures of bile were always negative. No changes