

with late syphilis to exclude asymptomatic neurological involvement [2]. This has implications in deciding whether to use standard or high dose penicillin treatment. If patients decline to have lumbar puncture and asymptomatic neurosyphilis cannot be excluded, then logically such patients should also be treated with high dose penicillin as for neurosyphilis. For patients who are allergic to penicillin, doxycycline 300 mg daily for 21 days is a second-line alternative [3].

Second, in the era of AIDS benzathine penicillin should not be used as first-line treatment for any stages of syphilis. Reports of patients with AIDS who progressed to neurosyphilis despite so-called 'adequate' treatment generally emanated from the USA where benzathine penicillin is commonly used. This is not a problem in the UK where a course of procaine penicillin is the first-line treatment for syphilis.

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Sir—We read with interest the account of new cases of neurosyphilis seen by Dr Niemen [1] in the Paddington and North Kensington Health Authority, a district in West London with large centre for sexually transmitted diseases (STDs), and noted his high proportion of patients with meningovascular syphilis. He quoted a recent reference to neurosyphilis [2] in which it was stated that 3-15% of cases were meningovascular and inculpated us with 'a similar error of emphasis' when we outlined features of neurosyphilis for a publication intended for international circular [3]. We wish to make three points.

First, our account was purely descriptive and carefully made *no* reference to the relative frequencies of the different types of neurosyphilis. Second, Niemen does not tell us whether his cases were early or late. Early neurosyphilis is either asymptomatic (unlikely to present to a neurologist) or meningovascular. The figures he quoted from Reik [2] refer to late neurosyphilis—if Niemen's cases were early, one would *expect* them to be meningovascular. The famous series of untreated cases followed in Oslo from 1890 to the last report in 1955 showed approximately equal proportions of meningovascular disease, general paresis and tabes dorsalis [4]. This study is open to criticism but is widely quoted. The most recent comprehensive text on STDs [4] indicates that all the classical forms of late neurosyphilis, as well as as non-classical cases, still present intermit-

tently at large tertiary referral hospitals in the USA and Europe. If Nieman's cases were late, it would be interesting to know whether other readers of the *Journal* have experienced a similar change towards meningovascular disease.

Finally, we were amused to see one of our names mis-spelled immediately above your notes to contributors making authors responsible for the accuracy of their references!

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Quality of care with fewer junior doctors

Sir—The reduction in junior staff numbers proposed in the 'Achieving a balance' agreement is to be more than compensated for by the increase in the number of consultant posts, in that every registrar post lost should be replaced by a consultant post and in addition, there will be continuing consultant expansion. Consequently, a survey (*Journal*, January 92, p36) that asks consultants' opinions on the potentially negative aspect of the whole agreement without asking them their opinion of the positive benefits that are to be gained from the agreement, is, at best, misleading, as it does not anywhere acknowledge the benefits that will be obtained from correcting the severe imbalances that currently exist in hospital medical staffing.

It would have been more appropriate to publish it alongside surveys of junior doctors' views of correcting the medical manpower blockages that currently exist, as well as their views on increasing the number of consultants in hospitals, as well as the views of patients, managers and politicians of having more of the work performed by fully trained consultants rather than untrained junior staff.

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Teaching rheumatology

Sir—Your article on the teaching of rheumatology (*Journal*, January 92, p41) suggests that there is some confusion in the implicit dispute between those subspecialists who feel that students ought to know more

about their subject and generalists who believe that the clinical curriculum is already overloaded. There is indeed little point in students trying to acquire detailed knowledge or the diagnostic categories and related therapies in every branch of medicine, most of which will be out of date within a year or two and irrelevant for a large fraction of practising doctors, but there can be little doubt that skills in history taking and particularly physical examination are best taught by those who use them most and understand them best, ie otoscopy is best taught by ENT surgeons, ophthalmoscopy by eye surgeons, auscultation by cardiologists, infant assessment by community paediatricians and mobility at joints by rheumatologists or orthopaedic surgeons. Perhaps clinical teaching in hospital should concentrate on such skills; leaving GPs to instruct students on how to recognise whether an illness is significant and how to assign patients to the appropriate specialists or consultants.

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Postcricoid web dysphagia

Sir—The article by Dr Slater (*Journal*, July 91, p257) and the letter of Dr Baron (*Journal*, October 91, p361) are most interesting. Let us call the syndrome, for the present, postcricoid web dysphagia.

I cannot think that the work of Elwood [1] and his associates is evidence one way or another about the relation of iron deficiency to the formation of the web. It is no use studying the iron state of the patient when she is no longer losing blood or has been treated with iron. The only data that matter would be those meas-

ured over the time when the web was forming. Once the web has formed, no repletion with iron will make it go away. It needs to be dilated, and the dilating repeated as often as necessary.

One should seldom, if ever, claim any description as the first. Postcricoid web dysphagia was described by Baillie 1793 [2], Home 1795 and 1803 [3], Munro 1811 [4] and Syme 1837 [5]. The more recent identification of the associated iron deficiency was of the first importance. It is not clear that that can be credited to any one observer. The work of all of them has not been in vain. It will do no one any injustice to abandon the eponyms.

My own opinion is that the web, or cuff, is a consequence of iron deficiency [6] and if iron deficiency in women is abolished by the efforts of our profession, it will be clear, as time goes by, whether the incidence of postcricoid stricture has also diminished.

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