

authorities advocate using haematin to reduce the activity of the rate limiting enzyme aminolaevulinic acid synthetase.

This case shows that acute intermittent porphyria may present as seizures and that failure to recognise this may lead to devastating neuropathy. To screen for porphyria everyone presenting with fits is not justified or necessary, but certain clinical pointers should be looked for. A history of episodes of abdominal pain or vomiting should be sought carefully. During the examination persistent tachycardia or hypertension should raise suspicion of the disease. Motor neuropathy and absent tendon reflexes are found in over half of cases. Patients with the disease will have increased porphobilinogen and free porphyrins in the urine.

Finally, after the diagnosis has been proved the relatives must be studied as the condition is autosomal dominant and affected family members are at risk throughout their lifetime of having an attack precipitated by many of the commonly used drugs.¹

Testing for porphyrins and their precursors in the urine will identify only some relatives with latent disease. Direct analysis of red cell enzymes for uroporphyrinogen-I-synthetase is helpful. In those with latent disease activity is reduced to 50% of normal, although one kindred with normal activity has been reported.⁹ Further discrimination of those with latent disease was attained when erythrocyte uroporphyrinogen-I-synthetase activity was combined with estimations of leucocyte δ -aminolaevulinic acid synthetase activity, which is increased.¹⁰

We have established that our patient's father has latent acute intermittent porphyria; further study is in progress.

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Letter from . . . Chicago

Seagulls or exports

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A man minding his business in the streets of Seattle was suddenly hit on the head by a falling rock. While surgeons stitched up his scalp eyewitnesses described how a seagull had come out of an open window carrying a paperweight; it then shot up into the air before letting it drop. Bird experts explained that its motives were culinary rather than criminal, this being how seagulls crack open the shells of long neck clams before having their soft inner contents for dinner. Some people predicted that the injured man would sue the owner of the rock, the seagull, or the branch of government that was allowing these dangerous birds to roam free. Others, seeing an opportunity to cut down on the surplus of malpractice lawyers, wanted to train seagulls to project their missiles selectively at prearranged targets.

At this brutal suggestion the health maintenance organisations were appalled. Heavily committed to marketing, promoting, and advertising, they could hardly afford to pay for fixing thousands of cracked skulls. Not that they would have otherwise objected, now that they too are being sued. Thus there had been a recent case in litigation of a doctor who refused to authorise a child to be examined in an emergency room, insisting instead that the mother bring him to his office in the morning. That would avoid the health maintenance organisation having to pay the hospital for services

rendered. Otherwise, how is market profitability to be maintained and the shareholders kept satisfied? For competition is fierce out there, with everybody fighting for a piece of the action, and the insurance companies are now coming up with new plans that do not tie down the patients to any particular doctor or hospital. Some people indeed do resent the lack of choice offered by health maintenance organisations—and sometimes the lack of service too. "It's like socialised medicine," said one patient recently. "It's good for people who are not ill," explained a district nurse; and now the employers are discovering that health maintenance organisations do not necessarily save them money. Even in that Mecca of the health maintenance organisation, Minneapolis, "where it all began," enrolment has been declining for the first time in years. Although some 20 million people throughout the United States are enrolled in health maintenance organisations, the heightened competition has given rise to much talk of marketing blitzes, mergers, consolidations, and even bankruptcies.

Similar problems beset some of the large "for profit" hospital chains. Four large companies (Humana, Hospital Corporation of America, American Medical International, and National Medical Enterprises) own or manage 12% of all United States hospitals and hope to expand further through a network of clinics and doctors treating the patients enrolled in their plans. Various health gurus, looking into their crystal balls, see a rosy corporate future, predicting that eventually a few chains will control American medicine, providing cost efficient and readily available though somewhat regimented care. So far investors have been rewarded with annual earnings as high as 20%—until that black day when

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news of declining earnings or unexpected losses sent the shares of these corporations plunging. Analysts blamed increased competition, more government controls, and less reimbursement, and the continuing phenomenon of empty hospital beds. Now the companies are changing their strategies, reducing staff, cutting costs, reorganising or restructuring, shifting emphasis to outpatient care, and not acquiring new hospitals.

“Perils” of cheap generic drugs

Still maintaining profitability, meanwhile, are the drug companies. Sales are up, so are their prices. Indeed, at a recent congressional hearing, the drug manufacturers were accused of “greed on a massive scale” for hiking their prices out of proportion to the current inflation rate. While some patients testified how they spent more than a quarter of their incomes on medicine, the manufacturers complained of the high cost of developing drugs and of obtaining marketing approval, as well as of competition from generic drugs. Already some people predict that generic manufacturers will eventually control 25-50% of the market. Recently the Federal Drug Commission estimated that in 1984 the public saved between \$130 and \$236 million by using generic drugs. Within four weeks of the Food and Drug Administration’s approval of generic diazepam the makers of Valium lost one fifth of their \$300 million market share. As patients switch away from the more expensive brand names the drug manufacturers issue dire warnings on the perils of generic drugs and pray for a flock of seagulls that would pick them all up and dump them in the ocean.

The same kind of treatment, according to politicians already worried by present health costs, might well be meted out to transplant surgeons now proposing to spend \$3 billion a year on heart transplants. Amid fears that costs could quickly get out of hand, the debate has centred largely on who would pay and for what. Both government and private insurers are considering setting up stringent criteria, limiting the procedure to people under 55 with no other medical problems, and centralising transplants to a few approved centres. A similar debate is going on about artificial hearts such as the Jarvik-7, which surgeons would like to implant at a rate of 80 000 a year. So far they have treated in the United States some six patients, of whom two died, two suffered strokes, and others linger on in a precarious condition.

Meanwhile the seagulls could also help by taking away the problem of the acquired immune deficiency syndrome (AIDS). There have now been 16 000 cases in the United States—73% in homosexuals, 17% in drug abusers, and 2% from transfusions. The average medical bill for one case is estimated at \$140 000, and as the affected population is expected to double yearly the ultimate costs to society will be high—at least \$240 million in 1986. In addition, fear of AIDS is spreading like wildfire, causing marked changes in the public’s attitude and quite a backlash against homosexuals, so that we may well have seen the last of the once well attended gay parades. As many people doubt the official line that AIDS cannot be transmitted by casual contact they are beginning to take all kinds of precautions. Churches have stopped using common communion cups; restaurants have introduced disposable cups and eating utensils; patrons avoid establishments staffed by gay waiters or barbers; patients refuse blood transfusion or giving blood; and dentists have been asked by their patients to wear masks and gloves. Undertakers have refused to embalm bodies of AIDS victims; affected children have been banned from attending school; and workers have been dismissed from their jobs. In New York the prison guards wear special clothing to avoid contamination, and in San Francisco the firemen carry special mouthpieces to avoid direct contact during mouth to mouth resuscitation.

Looking for other candidates for gull treatment, we find the politicians who for the second year have frozen Medicare payments to doctors. Others would direct their displeasure at the authors of the Gramm-Rudman law, which triggers automatic across the board budget cuts unless the federal deficit is reduced by a predetermined amount each year. Others would nominate the antiabortionists who last year committed almost 200 acts of violence against clinics

performing abortions—including bombings, vandalism, arson, invasions, threats, demonstrating with bloody dolls, and showing films of babies being hacked to pieces. Scientists might nominate government officials constantly cutting back on research funds or animal rights activists wanting to ban experiments on animals. Practitioners are getting increasingly piqued by swarms of reviewers constantly finding fault, fussing about appropriateness of care and disallowing payments, and always setting up new criteria, standards, goals, and objectives, but probably achieving very little.

Going into suspended animation

Yet what we cannot dump into the ocean we may turn into ice. One approach is to use phenothiazines, which this winter contributed to the accidental development of hypothermia in several old people by affecting the mechanisms regulating body temperature. A more premeditated kind of suspended animation is being advocated by a company whose motto is “never say die.” It arranges for people to be frozen but to wake up centuries later, a possibility already fully exploited by novelists and dubbed the Ponce de León syndrome. After preliminary anticoagulation at the point of death the initial freezing is achieved by means of an antifreeze solution. When the temperature reaches freezing point the tissues are infiltrated with glycerol to prevent cell damage. At minus 79°C the body is immersed in liquid alcohol; at minus 196°C it is stored in liquid nitrogen. The process is expensive, \$80 000 for freezing a whole body, but only \$30 000 for the head with an understanding that a new body will be provided free of charge on awakening. Another approach to at least a limited form of immortality is offered by a company that would pulverise people after death and store them in small capsules. When enough capsules have been gathered to make it pay they would be sent off by satellite into a remote orbit, there to revolve for ever or until somebody can come up with a better plan.

Looking for a less violent solution to the liability crisis, some economists want to redress the trade deficit by exporting our surplus of lawyers. Sent out in bulk and subsidised by American start up funds, they could teach our competitors about antitrust laws, personal injury cases, unfair trade and labour practices, tax shelters, environmental violations, and corporate takeovers. They could induce overseas managers to lower productivity and increase corporate debt. They could teach burglars to sue their clients for having unsafe lodgings, drunken drivers to sue telephone companies for putting obstructing booths in their way, and parents to sue peanut butter manufacturers when boys choke while trying to swallow half a sandwich in one gulp. Sports programmes and ambulance services could be eliminated as soon as townships become unable to obtain liability insurance. Doctors could be made to retire early or at least give up risky procedures such as delivering babies. They could be taught to order “defensive” tests, raise their fees to pay malpractice premiums of \$100 000 a year, and refuse to see patients who have a litigious look about them.

If exporting lawyers does not help the balance of trade we could also send surplus doctors or even house officers who are now assiduously training for non-existent jobs. Specialists, in particular, could be profitably shipped abroad because they perform too many procedures, put the academic centres out of business by not referring cases, and so dilute the clinical material that many of them will remain relatively inexperienced in diagnosing and treating rare cases. In the event of doctors being unwilling to be exported, we could send abroad medical licences—rather like the bureaucrats transferring a position but not the body that goes with it. Already in New York a judge has ruled that medical degrees acquired during a marriage are common property, and that wives working to put their husbands through medical school deserve ample compensation if their husbands should abandon them on graduating in quest of greener and often younger fields. Then we could also export empty hospital beds, perhaps entire hospitals, hospital chains, health maintenance organisations, antiabortionists, antivivisectionists, generic drugs, cardiac surgeons, frozen politicians, pulverised chart reviewers, and anything else that cannot be sent into orbit or safely entrusted to a flock of trained seagulls.