The raised antibody levels in those histologically normal patients may indicate a previous C. *pyloridis* infection, a non-etiologic relationship between organism and disease or a lack of specificity in the ELISA assay due to antigenic cross-reactivity with other enteric pathogens. These alternatives are under investigation.

INCREASED PREVALENCE OF OSTEOPOROSIS IN CHRONIC LIVER DISEASE

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Accurate measurements of bone mineral content in a large series of patients with chronic liver disease have not been reported. We measured bone mineral content in lumbar spine trabecular bone by quantitative computerised tomography and in radial cortical bone using single photon absorptiometry in 64 unselected patients with chronic liver disease (20 CAH, 21 alcoholic, 17 PBC and 6 others). Serum 25 hydroxyvitamin D (25 OH D) was measured by radioimmunoassay and serum parathormone (iPTH) by immunoassay. Fourteen patients (22%) had osteoporosis (a bone mineral <2 SD below the mean age-sex-matched control value). Of these, 6 had spinal osteoporosis, 10 peripheral cortical osteoporosis and 2 both. Four patients had vertebral fractures. A similar proportion of patients had osteoporosis in each group but spinal osteoporosis occurred mainly in steroid-treated CAH, whereas peripheral osteoporosis was commoner in PBC and alcoholic patients. Either elevated serum iPTH or decreased 25 OHD were found in 48% of whom one third had osteoporosis. We conclude that the prevalence of osteoporosis is increased in chronic liver disease, patients with steroid-treated CAH being particularly at risk from spinal trabecular osteoporosis. These findings suggest that risk of fracture may be increased in later years in these patients.

Letters to the Editor

Pollution and Allergy.

Sir,
Dr. David's compulsion to defend our profession's shortcomings in the field of allergy is perhaps preventing his attention from focusing on a major problem now facing the whole of medical practice.

We are leaving an era in which germs dominated the medical scene and have entered an age of pollution. Pollution can damage the immune system and impair the body's defence against pollution. Once the immune system is damaged the person starts to develop allergies.

Allergy as an aetiological factor in the mechanism of illness is now so widespread as to justify the screening of all patients for allergy as an initial step in modern diagnosis.

Dr. David refers to pollution as the cause of today's runaway epidemic of allergic disorders. He might be correct. We cannot ignore the increase in environmental pollution and it may be no coincidence that allergic illness increases in step with pollution.

A possible explanation for the medical profession dragging its feet in the task of assessing the importance of pollution in the current medical scene is the fact that the highest levels of pollution entering the human body are administered by doctors. In terms of tonnage the greatest quantity of pollutants entering our bodies comes across the chemist counter on or off prescription.

Two wrongs do not make a right and we are very misguided in imagining we can undo the harm we do with drugs by using more drugs to treat illness caused by drugs. With rising 20% of hospital admissions diagnosed as iatrogenic illness it is time for a reappraisal of where we are going as a profession.

Dr. David does not give a direct answer to the question as to why doctors refuse to listen to what patients tell them about allergic illness, but when he reveals that he regards the psychiatrist as his guru when it comes to the field of allergy, I think he gives us his answer.

Patients today have come to hate and fear the psychiatrist. Psychiatry is unscientific, a hang over from the dark ages and the modern well read patient knows this only too well.

It was Dr. Richard Mackarness, himself a psychiatrist, who first discovered that our mental hospitals could be filled with undiagnosed cases of masked allergy.

The implications of what Mackarness wrote in his books is such bad news for psychiatry that he is now out in the cold.

Sooner or later Dr. David and the whole medical profession will be called upon to face up to these issues. Let us do it in our own time at our own instigation instead of waiting until events overtake us.

Yours sincerely,
Edward C. Hamlyn, MB ChB.
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Sir,
Mobility Allowance

As consultant members of Medical Appeal Tribunals we are with increasing frequency required to agree or reject claims for mobility allowance. A proportion of these claims are difficult to decide, but in many cases the claimant or his medical advisors are unclear as to the regulations, which must be satisfied before mobility allowance can be granted. Rejection of the claim leads to disappointment or grievous dissatisfaction, particularly when the claimant has been told by "an expert" that he or she ought to have the mobility allowance.

Basically one of two requirements must be satisfied. The first is inability to walk (even with aids) or virtual inability to walk. Those quite unable to walk rarely need to bring their case to appeal. The commonest reason for dispute is when the claimant can walk short distances, but with greater or lesser difficulty or discomfort. The regulations state that "Any walking that can be achieved only with great pain or discomfort shall be discounted". Clearly the assessment of the degree of pain or discomfort is a subjective judgement and may be contentious but the law implies that the discomfort must be so severe as to amount to inability to walk at all.

Those who are able to walk can qualify for the allowance if the exertion required to walk "constitutes a danger to the patient's life or would be liable to lead to a serious deterioriation in health". In our experience this situation is uncommon as the medical advice in conditions such as severe arthritis or advanced heart disease is usually to keep mobile rather than making no effort to move.

Personal hardship in terms of finance or inaccessability of the place of residence must be disregarded.

Our purpose in writing this letter is not to discourage our colleagues from helping those who are likely to satisfy the regulations, but to restate the restrictive terms of the law. Sometimes doctors, who, are expert in their speciality write supportive letters for their patients to submit in pursuit of their claim. However sympathetic we are with the claimant's hardship only facts which relate to the degree of discomfort or difficulty in walking or the likelihood that the effort of walking may endanger health are relevant.

We see many sad and even distressing appeals for mobility allowance, but there are no discretionary powers beyond the regulations which are legally binding.

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