

Letters to the Editor

RECURRENT ROTAVIRUS GASTROENTERITIS

SIR,—To assess the relative importance of various enteropathogens isolated or detected in a routine laboratory we studied outbreaks of gastroenteritis in a closed community—namely, a Brussels crèche where children were followed up clinically for 14 months (November, 1975, to January, 1977). Twice a month stools from all the children were investigated blind for bacteria, viruses, and parasites. The children varied in age from 2 months to 3 years, but this analysis is confined to those under 2 years of age.

ROTAVIRUS GASTROENTERITIS IN CHILDREN < 2 YEARS OF AGE DURING TWO EPIDEMICS IN A NURSERY

	1975	1976	Total
No. of stools tested	19	14	33
No. of rotavirus-positive stools	12	11	23
No. of children with diarrhoea	11	11	22

There were two epidemics of rotavirus gastroenteritis confirmed by electronmicroscopy,¹ one in November, 1975, and the other in November, 1976. Each outbreak lasted about a week and two-thirds of the children were infected (see table). 5 children had rotavirus-associated diarrhoea both in 1975 (age 3-10 months, mean 6 months) and in 1976.

The severity of the symptoms in the two attacks showed a complementary relationship. The 3-month-old baby had mild symptoms in 1975, but had acute diarrhoea, high fever, and vomiting a year later. The opposite pattern of clinical severity was observed with the oldest child.

We think this is the first description of repeat infection with rotavirus. Rotavirus shedding after the first outbreak did not persist; the virus could not be detected in the stools of the infected children for more than 10 days, and its presence in large numbers was associated with clear-cut symptoms. Regular monthly examination of the stools did not reveal rotavirus particles between the two epidemics.

We have reported the existence of two types of human rotaviruses.² When we typed the rotavirus-positive stools we found that the 1975 epidemic was associated with type 1 while in 1976 all stool samples contained rotavirus type 2. This finding is very important, especially with regard to the production of a vaccine.

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DECLINE OF THE FIRST M.B.

SIR,—Several contributors to your series If I were a Dean stressed the importance of certain groups becoming medical students, notably those with experience in industry, the health services, or those with degrees in other, non-scientific, or non-biological subjects; with this we are in fundamental agreement. For many such individuals the only route of entry to medical school is via a 1st M.B. course, for otherwise they do not have an adequate scientific background. It is therefore disconcerting to find, at least in the University of Birmingham, a sudden and rapid decline in the number of students accepted for such courses.

Year	No. admitted to 1st M.B. course
1970	12
1971	20
1972	18
1973	21
1974	8
1975	7
1976	5
1977	5

The sudden decrease, between 1973 and 1974, is coincident with a change in admissions tutor. The present admissions tutor has publicly stated that he feels the 1st M.B. course to be "applying science with a spray gun" and that it is "a soft way into medical school": we know of no evidence to support these statements.

In its submission to a General Medical Council survey on medical schools,¹ Birmingham stated that there would be twenty 1st M.B. places each year, a figure which is projected to the year 1979. It was also stated that 10% of 2nd M.B. places would be for mature students (i.e., about 16 per year), a figure which contrasts strongly with the present number of about 6 per year.

To argue that the 1st M.B. course should be scrapped in favour of A-level courses at other institutions, such as technical colleges, may be educationally sound, but suffers from a major defect: students studying A-levels at technical college are not entitled to grants, whilst 1st M.B. students are. The sometimes near-disastrous consequences of this financial disadvantage have been eloquently described by Mr Dodds (March 18, p. 610). Furthermore it means that mature students are being expected to embark upon a 2 year A-level course without the assurance of a place at medical school at the end of the course.

In the interests of broadening the experience, commitment, and maturity of medical students, and hence doctors, the 1st M.B. course should not be allowed to slip quietly into oblivion without any public discussion.

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BICYCLE SADDLES AND TORSION OF THE TESTIS

SIR,—Little is known about the aetiology of torsion of the testis. In one series of 100 cases of torsion of the testis or the appendix testis² 6 patients had a history suggestive of trauma or strain, but no details of the injuries were given. In the past few years five teenage boys have been seen in whom torsion followed a ride on a racing bicycle with a long narrow saddle, the front of which comes forward under the perineum and scrotum. It would appear that the testis becomes twisted between the thigh and the saddle as the legs go up and down. Presumably the dropped handlebars tend to bring the legs closer up to the abdomen and increase the compression of the scrotum and its contents against the saddle.

Case 1.—A 14-year-old boy was admitted to the Queen Elizabeth Hospital, Gateshead on Dec. 27, 1977, with a torsion of the testis coming on 2 h previously. He had been given a racing bicycle as a Christmas present. At operation a typical torsion of the testis was found, and both testes were fixed in the scrotum.

1. Flewett, T. H., Bryden, A. S., Davies, H. J. *clin. Path.* 1974, 27, 603.
2. Zissis, G., Lambert, J. P. *Lancet*, 1978, i, 38.

1. General Medical Council. Basic Medical Education in the British Isles. Nuffield Provincial Hospitals Trust, London, 1977.
2. Chapman, R. H., Walton, A. J. *Br. med. J.* 1972, i, 164.