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LEADING ARTICLES

The new psychiatry	513
Primary biliary cirrhosis	514
Haemolytic disease of the newborn due to antibodies other than rhesus anti-D	514
Teratogenic risks of antiepileptic drugs	515

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Controlled trial of speech therapy versus oxprenolol for stammering	LENA RUSTIN, A KUHR, P J COOK, I M JAMES	517
Adult respiratory distress syndrome in <i>Leptospira canicola</i> infection	M ZALTZMAN, J M KALLENBACH, G D GOSS, M LEWIS, S ZWI, J H S GEAR	519
Non-operative removal of bile duct stones by duodenoscopic sphincterotomy in the elderly	A S MEE, A G VALLON, J R CROKER, P B COTTON	521
Role of local authority homes in the care of the dependent elderly: a prospective study	G MASTERTON, E M HOLLOWAY, G C TIMBURY ...	523
Exacerbation of diazepam-induced phlebitis by oral penicillamine	ROBERT D BRANDSTETTER, VINCENT P GOTZ, DEXTER D MAR, DEANE SACHS	525
Reversible renal damage due to glue sniffing	A M WILL, E H MCLAREN	525
Reactivation of vasculitis after influenza vaccination	J CANNATA, V CUESTA, V PERAL, I MAISUECHE, J HERRERA	526
Recurrent pericarditis: a rare complication of influenza vaccination	JONATHAN J STREIFLER, SHLOMO DUX, MOSHE GARTY, JOSEPH B ROSENFELD	526
Periampullary adenoma causing pancreatitis	S H WHITE, N A NAZARIAN, A MCEWEN SMITH, T W BALFOUR	527
Pneumocystis carinii pneumonia as presenting feature of lymphoma	LAWFORD S HILL, PAUL R DEAN	527
Richter's hernia: an unrecognised complication of chronic ambulatory peritoneal dialysis	D A POWER, N EDWARD, G R D CATTO, N MUIRHEAD, A MACLEOD, J ENGESET	528
Trainees' Corner: Managing Chronic Disease: Hypertension	SIMON BARLEY, JOHN COOPE, LEONARD ROGERS	529
Unemployment in My Practice: Walworth, London	ROGER HIGGS	532

MEDICAL PRACTICE

Medicine and Computers: Microcomputers in antenatal care: a feasibility study on the booking interview	R J LILFORD, T CHARD	533
Today's Treatment: Clinical pharmacology: Possible clinical importance of genetic differences in drug metabolism	DANIEL W NEBERT	537
Lesson of the Week: Chest infection associated with the Waterhouse-Friderichsen syndrome	D N SLATER, L HARVEY	543
ABC of 1 to 7: Enuresis	H B VALMAN	544
USSR Letter: Some social influences on workers' morbidity	MICHAEL RYAN	546
Statistics in Question: Assessing methods—transforming the data	SHEILA M GORE	548
Any Questions?	536, 547
Materia Non Medica—Contributions from DAVID LEVY, GARTH HILL, DOMINIC JOYCE	542
Medicine and Books	551
Personal View	TESSA RICHARDS	554

CORRESPONDENCE—List of Contents

555 OBITUARY

565

NEWS AND NOTES

Parliament—Inequalities in Health	567
Medical News—Comments on Court of Appeal decision on baby with Down's syndrome	567

BMA Notices:	
Associate Specialists Subcommittee (CCHMS)	568
Group committee elections	568

CORRESPONDENCE

Audit in renal failure

J S Cameron, FRCP, and others; J Michael, MRCP, and D Adu, MB; R L Verwilghen, MD; V Parsons, FRCP, and Penny M Lock, BA; Beryl Large, SRN, and R Ahmad, MB... 555

Donation of kidneys

A R Luksza, MRCP... 557

Liver transplantation comes of age

Ada E Goldsmith, PHD, and others... 557

Colorectal surgery—the Cinderella specialty

R E B Taggart, FRCS; A E Carter, FRCS... 557

Pseudomembranous colitis after treatment with metronidazole

C R Pennington, MRCP... 558

Foodborne gastroenteritis of unknown aetiology: a virus infection?

J Carsons, MBIOL... 558

Benign familial tremor treated with primidone

G Procaccianti, MD, and others... 558

Poliomyelitis serosurveillance in adolescent population

S C Arya, MB... 558

Attitudes to malarial prophylaxis

C J Ellis, MRCP, and others... 559

Haematology in developing countries

M C K Chan, FRACP... 559

Emergencies in the home

T H Howells, FFARCS... 559

Paediatric emergencies

D L Cohen, MD... 560

Stridor

P M Zadik, BM, and J V Dadswell, FRCPATH; S G Siddle, MRCP... 560

Arthritis and arthralgia associated with toxocaral infestation

D H Garrow, FRCP... 560

Polycythaemia rubra vera in monozygotic twins

P Burnside, MB, and others... 560

Pindolol acts as beta-adrenoceptor agonist in orthostatic hypotension

A J Man in 't Veld, MD, and M A D H Schalekamp, MD... 561

Evaluation of laboratory tests

D B James, MRCP... 561

Toxicity of interferon

T J Priestman, FRCP, and others... 562

Red cell indices and iron stores in patients undergoing haemodialysis

A I K Short, MRCP, and R J Winney, MRCP... 562

Endocrine function and immunity

Denise White and others... 562

Calcium homeostasis during pregnancy

T F Cundy, MRCP, and J A Kanis, MRCP... 562

Rheumatoid arthritis and food: a case study

R E Williams, MRCP... 563

Pharmacists as doctors

K D Moudgil... 563

Care in the community

D A A Primrose, MD... 563

Trial marriage between primary and secondary health care

M S B Vaile, MRCP... 563

Negligence

F R Cranfield, MRCP, and Elizabeth Cranfield, LLB... 564

Junior posts and expansion of the consultant grade

E M R Critchley, FRCP... 564

Nurses' pay

D E Sharland, FRCP... 564

Points Children and parasuicide (Josephine M Lomax-Simpson); Child-resistant containers: are we kidding ourselves? (R P Yadava); No shoes best? (Margaret C Huyton); A moral dilemma (M W Eddings); Operation looking for a name (D R Sweetnam)...

564

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Audit in renal failure

SIR,—Renal physicians can justifiably claim that collectively, through the European Dialysis and Transplant Association and national transplant-sharing organisations, as well as individually they have done more than any other group to audit their practice and to provide information concerning the complications, outcome, and costs of dialysis and transplantation for end-stage renal failure. It is therefore disappointing that a professional research organisation such as the Study Group of the Royal College of Physicians should not consider the extensive literature¹⁻¹⁰ before reaching conclusions concerning the availability of resources to treat end-stage renal failure (25 July, p 282). It must be unusual for a paper with conclusions at variance with and in apparent ignorance of so much published data to be accepted by the *BMJ*. Unfortunately, the general public and their appointed representatives, who the authors claim are being misled, are more likely to be misled by the publication of such a paper, even with editorial criticism both in

your journal (p 261) and in *The Times* of 24 July to balance the issue.

While the Study Group's remit was to consider only mortality under the age of 50 years, conclusions drawn from such an analysis must be put in the context of the overall problem. It is well known, as your leading article emphasises, that facilities for treating patients over 45 years of age are less adequate in the United Kingdom than in most developed non-socialist countries and that the incidence of chronic renal failure rises logarithmically with age. Under these circumstances, to foster a feeling of complacency when the main question of treatment for those over 45 years of age has not been addressed, and when the epidemiological techniques used are unsound, is unacceptable. This begs the question of whether or not the grounds for non-treatment in individual cases cited under the age of 50 years would be unchanged given better resources, though we accept that for some people with renal failure the severity of other problems must reasonably exclude dialysis or

transplantation. The publication of details of the reasons for non-treatment of patients with renal failure is valuable, but it is wrong to broaden the conclusions drawn far beyond the limits imposed by the data given.

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¹ Leumann EP. Die chronische niereninsuffizienz in Kindersalter. *Schweiz Med Wschr* 1976;106:244-9.

² Branch RA, Clark GW, Cochrane AL, et al. Incidence