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SATURDAY 2 JANUARY 1982

LEADING ARTICLES

Dissolving gall stones M C BATESON	1
Reiter's disease P FISK	3
Regular Review: Computed tomography of the body: when should it be used? JANET E HUSBAND, STEPHEN J GOLDRING	4

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Experience with selective venous sampling in diagnosis of ACTH-dependent Cushing's syndrome P L DRURY, SALLY RATTER, SUSAN TOMLIN, JULIA WILLIAMS, JANET E DACIE, LESLEY H REES, G M BESSER	9
Phenytoin-valproate interaction: importance of saliva monitoring in epilepsy CHRISTINE KNOTT, ANNE HAMSHAW-THOMAS, FELICITY REYNOLDS	13
Intravenous amiodarone in atrial fibrillation complicating myocardial infarction ROGER L BLANDFORD, JOHN CRAMPTON, HANA KUDLAC	16
Thrombocytopenia and haemolytic anaemia due to feprazone P M BELL, CAROLINE A HUMPHREY	17
Failure with the new triphasic oral contraceptive Logynon R A FAY	17
Inaccuracy of London School of Hygiene sphygmomanometer DESMOND J FITZGERALD, KEVIN O'MALLEY, EOIN T O'BRIEN	18
Mask for continuous positive airway pressure: does it cause corneal abrasions? GAYNOR F COLE, P RAY CHAUDHURI, LIAM P CARROLL	19
Perverse T waves and chronic beta-blocker treatment T M GRIFFITH, J J DALAL, W J PENNY, A M DART, A H HENDERSON	19
Insect-sting encephalopathy A N GALE	20
Paracetamol-induced acute renal failure in the absence of fulminant liver damage I COBDEN, C O RECORD, M K WARD, D N S KERR	21
Bilateral renal carcinoma C P ST J NEWMAN, D M ESSENHIGH	22
Correction: Prognosis of isolated seizures in adult life CLELAND ET AL	22
Organising a Practice: Three is the magic number J F M NEWMAN	23
Do patients cash prescriptions? ALY RASHID	24

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JAN 16 1982

Trends in management of acute cholecystitis ANDREW MITCHELL, PETER J MORRIS	27
Careers of medical women AUDREY W M WARD	31
Battling with motor neurone disease BARBARA WILSON	34
Lesson of the Week: Hyperosmolar non-ketotic diabetic syndrome precipitated by treatment with dantrolene VIVIAN FONSECA, DAVID N PHEAR	36
Letter from Poland: Too few drugs, too many poppies RICHARD SMITH	38
Any Questions?	30, 33, 35, 39
Materia Non Medica—Contribution from FRANK WELLS	37
Medicine and Books	40
Personal View TIM CROSSLEY	45

CORRESPONDENCE—List of Contents

46

OBITUARY

59

NEWS AND NOTES

Views	56
Parliament	57
Medical News	57
BMA Notices	58

SUPPLEMENT

GMSC studies regional advisory machinery proposals	63
Report of Joint Working Group on Regional Medical Advisory Machinery	64
NHS reorganisation: Employment of medical staff	68
GMC's Professional Conduct Committee	68
Armed Forces: request for one review body	68
BMA Notices: Petition for the formation of the Special Group for Civil Service Medical Officers	68

CORRESPONDENCE

Is bran useful in diverticular disease?	
Sir Austin Bradford Hill, PHD, FRS; Sir Francis Avery Jones, FRCP	46
Misplaced confidence in nebulised bronchodilators in severe asthmatic attacks	
I Gregg, FRCP	46
Bronchial hyperreactivity after inhalation of distilled water and saline	
R A Lewis, MRCP, and Anne E Tattersfield, FRCP	47
The secret technical defence: a case for changing the law	
R A Goodbody, FRCPATH, and J J Smyth, QC; D E B Powell, MRCPATH; G V Jaffé, MB; J E Horrocks, FRCPATH	47
Day hospital care by general practitioners	
W B Wright, FRCP	48
Primary health care in residential homes for the elderly	
Ann P Bowling, PHD	48
Blood pressure reduction in the elderly	
C W I Owens, MRCP, and T E Sensky, MB	

J R Coope, MB, and D G Beevers, MD; Mary R Bliss, MRCP; C P Petch, FRCP; J S Milne, FRCSED	49
Hyperglycaemic effect of nifedipine	
R H Greenwood, MRCP	50
Dental health in patients susceptible to infective endocarditis	
Celia M Oakley, FRCP, and J H Darrell, MRCPATH	50
Alcohol and alcoholism	
K A Harden, MRCP	51
ABC of alcohol	
D B Jack, PHD; B M Wright, MB; R C Peveler, DPHIL; Jennifer J Waterton, MSC	51
Rectal examination and acid phosphatase	
A S Daar, FRCSED	52
Hepatitis B infection in glomerulonephritis	
J S O'Neill, MB	52
Spirochaetosis: a remediable cause of diarrhoea and rectal bleeding?	
D S Tompkins, MB, and others	52
Facial burns due to fan heater	
J M Morfitt, MFCMI	52
The handicapped child	
Helene F Bell, BA	53
Confidentiality and informed consent	
D H Howe, FRCS	53
Audit in general practice	
R K Brown, MRCGP and others	53
Postgraduate training in general practice	
Captain T O Jefferson, DMS	54
Part-time medical training—and afterwards	
Angela R Cunningham, FRCR; Frances Margaret Ulyatt, FFARCS; J M Cundy, FFARCS	54
The Oxford part-time scheme	
J M Potter, FRCS	54
Excessive working hours for junior doctors	
A M Kaiser, MB	55
Treating overseas visitors	
A D Brittlebank	55
Changes in DCH examination	
D A Pyke, FRCP	55
Embattled and impoverished	
P V Scott, FFARCS	55
Olympic doctors	
H J Ross, FRCS	55

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.

Is bran useful in diverticular disease?

SIR,—Discussing your subject for debate "Is bran useful in diverticular disease?" (5 December, p 1523), Dr K W Heaton writes, "A problem with all controlled trials of bran is that the use of a standardised dose ignores the pronounced variability in people's response to bran and prevents the investigator from treating each patient as an individual, which is how he is treated in clinical practice."

It is nearly 30 years¹ since I maintained that statistically there is no reason against a trial with a variable dose. One merely changes the question asked from (a) "What is the upshot if some fixed dose of a drug (or foodstuff) is given uniformly to all patients?" to (b) "What is the upshot if clinicians in charge of patients give such varying amounts as seem, in their judgment, to be advisable?" In both cases the results in the group as a whole can be compared with those in a control group.

The only proviso, perhaps needless, is that one can certainly not subdivide the treated group to measure the effects of the different amounts, since those amounts have already been determined by the conditions and responses of the individual patients. That would be circular reasoning.

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¹ Hill AB. *N Engl J Med* 1952;247:113.

SIR,—Increasingly it becomes apparent that well-conducted clinical trials fail to provide the

clinicians with clearcut answers which can be reproduced. The frustrations arising from the bluntness of this potentially most important research tool have been the subject of recent comment.¹⁻³ This difficulty has been highlighted again by the recent contradictory papers on the treatment of diverticular disease with bran. In his analysis of this problem Dr K W Heaton (5 December, p 1523) draws attention to the need for different series to relate to patients with similar degree of clinical severity.

I believe that this is an important general point and that clinical trials should relate to patients where further therapeutic help is really needed and exclude those whose symptoms settle spontaneously with non-specific care. It is these quick responders who can blur the difference between controls and

those receiving the treatment under study. This point was appreciated by Sir Richard Doll⁴ in his early classic studies on the factors influencing the rate of healing of gastric ulcer. He excluded the rapid healers by a second x-ray examination two weeks after the first one; and the remainder, where further help was really needed, were admitted into his series. The failure of so many later trials to follow this example I believe explains the difficulty of interpreting the significance of many peptic ulcer studies.

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¹ Sherry S. *Eur J Clin Pharmacol* 1980;17:79-80.

² Ritter JM. *Lancet* 1980;i:1126-27.

³ Sancho, H, Hayat M. *Biomedicine* 1973;18:173-6.

⁴ Doll R. *Scot Med J* 1964;9:183-96.

Misplaced confidence in nebulised bronchodilators in severe asthmatic attacks

SIR,—Dr A E Gale (14 November, p 1336) has described a hand-operated pump for nebulising a bronchodilator, which asthmatic patients can use if they have to travel long distances from home. Although his letter made no reference to death, the use of the running heading for this correspondence ("Deaths from asthma on holiday") might seem to imply that a nebulised bronchodilator is the most effective form of treatment in severe or life-threatening attacks. This is a misconception which it is essential to correct, particularly since an increasing number

of general practitioners are considering the purchase of a compressor.

There is no doubt about the value of nebulised bronchodilators for treating mild attacks in young children^{1,2} since the only form of bronchodilator which they may have taken already is tablets or syrup. Older children and adults, on the other hand, will almost invariably have taken a bronchodilator aerosol: provided that this has been taken correctly, it is difficult to understand why nebulising the same or another bronchodilator should be much more