Points

Fractures during ice and snow

Mr LAURENCE WOOD (Accident and Emergency Department, Royal Liverpool Hospital, Liverpool L7 8XP) writes: In the first very cold spell in the latter half of December 1981 Liverpool City Council, in common with many others, decided to spend less than normal on salting, gritting, and snow clearing. The result was that, as the snow unexpectedly persisted and gradually turned to ice, pavements and roads became treacherous. As Dr J G Avery (23 January, p 270) says, the cost to the NHS in terms of the resulting injuries is very great, as is the cost to the patients in suffering and loss of productivity. I have reviewed our figures for patients presenting to the Royal Liverpool Hospital's accident and emergency department with distal radial fractures during the cold period and during a representative week prior to the snow, and the results are initially surprising. In the first three days of snow the number of these fractures was remarkably low—2, 1, and 5 (compared with a daily average of 3·4 the week before the snow). On 12 December, however, it rose to 18, and for 14-20 December the average was 16·6. There was plenty of time, therefore, in view of the forecasts of the likely continuation of conditions, to have instituted preventive measures. Liverpool, like other places, has many unemployed, plenty of whom would have been happy to help with clearing the snow —but again financial constraints dictated. Surely such obviously beneficial preventive medicine should not be stifled by the politics of local resource allocations? The cost to the community and the country is too great, especially as these figures show that we have several days' grace to "man the shovels." Would it not be sensible to have a centrally funded organisation responsible for such contingencies, not restrained by short-term local financial considerations like our councils?

Outlook for hip replacement

Dr PETER H FITTON (St George's Hospital Medical School, London SW17 0RE) writes: Am I alone in objecting to the practice of presenting data from small samples as percentages, and also to presenting percentages without stating the sample size? Examples of both these sins occurred in Mr A J Harrold's leading article "Outlook for hip replacement" (16 January, p 139). ". . . a review of 100 Charnley hips after 10 years showed that 88% of the 67 survivors still rated their condition clinically as excellent or good. Again, of 301 hips four to seven years later, eight (3%) had needed revision. . . . Mueller . . . reported a 17% revision rate for loosening in 81 hips followed up for 10 to 12 years. The Stanmore prosthesis . . . has shown 88% survival after eight years." These practices can produce spurious precision (88% of 67 survivors = 58·960 survivors) and, less seriously, sentences with too many numbers in them to be intelligible.

Frozen shoulder: adhesive capsulitis

MR R G GREY (Queen Mary's Hospital, Sidcup, Kent) writes: Professor M I V Jayson has written a clear review of the condition of frozen shoulder (17 October, p 1005). He refers to the fact that this is usually a self-limiting condition but has no reference to support this statement.

In 1977[1] I reviewed 25 cases of idiopathic frozen shoulder treated by reassurance and simple analgesics alone and found that 24 out of 25 made a full recovery within two years from the onset of the condition. So far as I know, this is the only study of the natural history of frozen shoulder and should be included in any comprehensive review of the condition.

[1] Grey RG. *J Bone Joint Surg* 1977;**60A**:964.

How is gastroenteritis treated?

Dr JOHN RAWLINSON (Huntingdon, Cambs PE18 0HD) writes: Dr Andrew R Potter of Benin Republic is right to stress the value of intraperitoneal rehydration in gastroenteritis (9 January, p 115). My experience with scores of severely dehydrated infants in the Yemen was that after a morning in the clinic with 500 ml of dextrose-saline slowly infusing intraperitoneally a sparkle of survival would return to many a sunken eye. The mothers would thus be encouraged to abandon their fatalistic belief that their child was half way to Allah, who wished the journey done, and would return the following morning for further treatment. This was usually oral rehydration, which was then feasible for the strengthening child. It took very little time for our more able Yemeni nurses to learn the technique of setting up and supervising an intraperitoneal drip.

Agoraphobia

Dr PETER BLYTHE (Institute for Neuro-Physiological Psychology, Chester) writes: In his review of *Agoraphobia* by Ruth Hurst Vose Dr Henry R Rollin (28 November, p 1454) mentions our work in relation to agoraphobia. Mrs Vose was quoted as stating "that it was the correction of a spinal (Galant) reflex on the right side of my spine plus a defective labyrinthine righting reflex that was instrumental in achieving the last stage of her cure." This statement gives the wrong impression about our findings. It is our experience that a large percentage of agoraphobics who appear resistant to the therapy of choice have definite visual-perceptual problems, co-ordinational problems, and detectable balance problems, plus the presence of aberrant primitive reflexes. In Mrs Vose's case the retained spinal Galant caused her extreme tension in the lower abdomen and this particular symptom was secondary to the primary agoraphobia.

Medspeak made simplifax

Dr TAMÁS FENYVESI (third Medical Department, Semmelweis University, Budapest 1121, Hungary) writes: It is an impertinence to challenge the linguistics of one of your papers from this side—which is the other side—of the Channel. Mr James Robb's "Medspeak made simplifax" was very enjoyable (19-26 December, p 1683). I disagree, however, with his statement that the second -at is superfluous in "dilatation." "Dilatation" is indeed correct. It is the action or process of dilating, derived from the Latin *dilatatio*, from the verb *dilatare*.[1] Dilation means (*a*) delay, procrastination, derived from the Latin *dilatio*, from the verb *differre*; and (*b*), improperly, from "dilate," better "dilatation."[1] So I think that dilatation has not been dilated by an -at. . . . Sorry for dilating so long on this matter.

[1] *Oxford International Dictionary of the English Language*. Unabridged. Toronto: Leland Publications Company, 1958.

De senectute

Dr IAN MACQUEEN (Painswick, Stroud, Glos GL6 6RQ) writes: Please let a retired community medicine specialist congratulate Dr William Evans on a fascinating article (19-26 December, p 1642) but also remind him of the importance of checking his references. Unless Cowper in "Retirement" has purloined from Pope in a way deserving inclusion in Dr T Hamblin's article "Fake" (p 1671), it would seem that the lines "Absence of occupation is not rest;/A mind quite vacant is a mind distressed" are attributable to him rather than to the earlier "wicked wasp of Twickenham."

Proposals for a trial marriage between primary and secondary health care

Dr MELVYN H BROOKS (Pardess Hannakarkur, Israel) writes: I heartily support the sentiments of Dr C Gazidis (31 October, p 1189) in his reply to Professor C J Dickinson (3 October, p 920). Hackney is a world apart from St Bartholomew's Hospital, and anyone who follows the local newspaper, the *Hackney Gazette*, realises the resentment of Hackney people. Although its origins stem more from the workhouse, Hackney Hospital was looked on as a local institution with pride by many East Enders who had had their babies there and lost their loved ones there. It was their local hospital and they had communication with their doctors. Unfortunately three local hospitals—the German, St Leonard's, and the Metropolitan—have either closed or had their services severely restricted in the last 10 years. This, with the obvious patronising attitude of Bart's, has in no small way, I feel, led to a degradation in the local people and has added to their feelings of despair. . . .

Episiotomy

Dr S M COCKERSELL (Lee-on-the-Solent, Hants PO13 9AL) writes: With all due respect to Professor J K Russell in his leading article on episiotomy (23 January, p 220), surely the choice is not between an episiotomy or a perineal tear but between an episiotomy and the *risk* of a tear or even the *likelihood* of a tear, which is not the same thing at all.

Correction

Meal frequency and duration of overnight fast: a role in gall-stone formation?

In the letter by Dr M V Math (16 January, p 194) "mmol/l" in line 5 of p 195 should be "μmol/l."