Points

Retroperitoneal fibrosis associated with metoprolol

Mr J K McCollum (Newcastle upon Tyne NE4 9DU) writes: It is appreciated that in reporting their patient with retroperitoneal fibrosis Dr J Thompson and Professor D G Julian's (9 January, p 83) purpose was to draw attention to the possible aetiological role of metoprolol and other drugs. But the case history as stated prompts the question, "Why was steroid therapy not tried in this instance?" In the case of retroperitoneal fibrosis reported by Dr Apalakis and myself[1] a bilateral ureterolysis had resulted in rapid restoration of normal renal function, but six months later the patient became ill again and there was recurrence of renal failure. Corticosteroid therapy begun then produced a dramatic improvement and obviated the need for surgery. Ten-year follow-up has shown that the patient is well and that the steroid therapy was stopped three and a half years ago.

[1] Apalakis A, McCollum JK. *Br Med J* 1972;iv:791.

Treatment with propranolol after myocardial infarction

Dr T Y Lee (Department of Biostatistics and Clinical Programming, Ayerst Laboratories, New York, NY 10017, USA) writes: . . . As a devoted reader of your journal, I would like to point out that in the paper by Dr V Hansteen and others (16 January, p 155) the title of figure 2 should be changed from "Life table for cumulated sudden cardiac death rate (intention to treat)" to "The cumulated survival rate from life table for sudden cardiac death (intention to treat)." Similarly, the title of figure 3 should be changed from "Life table for cumulated total death rate (intention to treat)" to "The cumulated survival rate from life table for total deaths (intention to treat)." . . .

Frozen shoulder: adhesive capsulitis

Dr Douglas Golding (Harlow, Essex CM20 1QX) writes: I agree with the remarks of Dr S Roy and others (9 January, p 117) with the following provisos. (1) Pericapsular steroid injection often (not always) relieves pain in the acute stage, but shoulder movements are not usually increased. (2) Stiff shoulders selected for manipulation under anaesthetic should not be painful, night pain especially being a contraindication to manipulation. . . . Professor Malcolm I V Jayson suggests (p 118) controlled studies of the treatment of capsulitis and I wonder how he proposes to set up such a trial.

Mr Cyril Kaplan (Durban 4001, South Africa) writes: While agreeing with the admirable leading article by Professor M I V Jayson (17 October, p 1005), I feel that one point might be added to his review of the treatment. Mobilising physiotherapy and intra-articular injection of steroid are certainly helpful in many cases but manipulation under an anaesthetic must be withheld until the shoulder is no longer painful. The test for this is whether the patient can sleep on the affected shoulder at night without disturbance. If this does cause pain and disturbance of sleep, the shoulder is not ready for manipulation under anaesthetic and doing such a thing at this stage will certainly make matters worse and prolong the duration of the condition. Once the shoulder is painless and in fact "frozen" it is then ripe for manipulation, followed immediately by intra-articular steroid, and this should lead to very early resolution.

Excessive belching

Dr S Minc (Perth, Western Australia 6000) writes . . . One does observe long spells of belching (5 December, p 1528) in nervous or neurotic patients. The belching may go on for a long time, fed by the air swallowing which follows every eructation. In my experience a prompt way of stopping it is to advise the patient to bite on to a pencil or handkerchief. The act of biting precludes air (or any other) swallowing and stops the attack. The holding of the chin on to the chest (as suggested in Dr D A W Edwards's note) also makes swallowing difficult, but is probably less effective.

Preventing pedestrian accidents

Dr A O Diver (London SE19) writes: The mixture of wit, genius, aphorism, and female illogicality makes Minerva (9 January, p 123) compelling reading. Her prescription for the prevention of the epidemic, all too serious, of pedestrian slaughter on the roads will certainly join venesection, purges, emetics, etc, in the annals of medicine under "grim humour." Telling pedestrians to get off the roads to save their skins seems like saying that chimney boys would not have suffered burns to their feet if they had been more obedient and got up the chimney faster. Speed limits, pedestrian crossings, amber lights, yellow lines are treated with equal contempt by motorist and police to the cost of the pedestrian. It is common now not to be able to walk on pavements because of cars parked on them. Indeed at the local bus stop it is difficult to stand in a queue sometimes because of cars parked on the pavement. But I suppose that it is stupid of them to stand in such dangerous places.

Use of library resources

Ms Valerie F Baker (Bronglais General Hospital, Aberystwyth) and Mr David Matthews (College of Librarianship Wales, Aberystwyth, Dyfed) write: We read with interest Mr John L Thornton's review (2 January, p 40) of the British Library Report *Information and the practice of medicine*. . . . He wrote: ". . . no library can provide an adequate service without sufficient funds to pay for trained staff (qualified if necessary, mainly by experience), books, periodicals, and sufficient technical equipment to serve the needs of its readers." We would agree with most of that sentence, with perhaps the addition of audio-visual material and access at least to a MEDLINE terminal. The words in parenthesis, however, with their implication that formal qualifications are not really necessary, seem to us unfortunate and misguided. Medical and other health care staff, wherever they may be working, require and deserve a professionally qualified librarian who will know how to exploit resources nationally, regionally, and locally and have a professional commitment to her library users and to his or her calling. It is no more acceptable, in our view, for medical information to be in the hands of unqualified librarians than for sick people to be in the hands of unqualified doctors.

Consultants and their future

Dr Cynthia Illingworth (Accident and Emergency Department, Children's Hospital, Sheffield S10 2TH) writes: In all the recent discussions and correspondence about numbers of consultants, etc, there seems to have been little recognition of the fact that many well-trained women doctors (and possibly some men), would be entirely happy with and in many cases prefer a job which has some permanence and gives them work satisfaction without being of consultant grade. I come into contact with many young, well-qualified women doctors and I am certain that this is correct.

Excessive working hours

Dr Stephen Szanto (Plaistow Hospital, London E13) writes: In his Personal View Dr Tim Crossley (2 January, p 45) blamed his exhaustion as the cause of negative feelings towards his profession. During the course of my recent "busman's holiday" in a Saudi Arabian hospital jet lag and lack of sleep made me look with a very jaundiced eye at the American system as practised in a lavishly equipped, chromium-plated hospital. To sit round a conference table with a dozen or so fellow "internists" at 7 am after a long and sleepless night and defend my case . . . was a harrowing experience. As a consultant in the NHS I was not used to being audited, and certainly not at 7 am in a state of exhaustion. Why then should a middle-aged doctor find himself in such a predicament, too much even for young men like Dr Crossley? Well, he may not believe this, but it's the glamour of it all—the glamour of being in the front line again, to see the asthmatic child as he arrives with his worried retinue of relatives, or the patient brought in by the ambulance with its siren at full blast. And then getting the lab results at 3 am and "working it all out." May I submit to Dr Crossley that he will be missing all this himself 20-odd years from now? . . .

Prickly heat

Dr R C Rylance (Penrith, NSW 2750, Australia) writes: . . . With reference to the "Any Questions?" item about prickly heat (13 June, p 1946) and the subsequent correspondence (11 July, p 145; 15 August, p 502; 5 September, p 677), when I was in the RAF I suffered from this uncomfortable condition in the Far East and Middle East, until I tumbled on a wonderful prophylactic—string vests. After initial trials with the original aircrew issue, which protected me against midriff irritation, I then had some modified with short sleeves, so my axillary irritation was also cured. The vests are wonderful insulation against heat as well as cold.