

be providing them? Indeed it could have been providing them for six years if the members of the GMSC realised that you published an excellent journal in front of the supplement. Perhaps they are all so pleased with the A4 records in their own practices that they spare no thoughts for the rest of us.

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¹ Department of Health and Social Security. *Interim report of the joint working party on redesign of medical records in general practice*. London: HMSO, 1974.

² Tait IG. The clinical record in British general practice. *Br Med J* 1977;ii:683-8.

Getting a new hip joint

SIR,—Professor Philip Rhodes (10 September, p 747) is perfectly correct to emphasise how variable is the reaction of different patients to operations and, indeed, to all forms of treatment.

I had a total left hip arthroplasty eight weeks ago and am therefore just one week short of the time interval at which Professor Rhodes described his own hip replacement. My experience is substantially different from his, though I think I may claim to be just as "neurotic" as he or as any other surgeon who needs a major operation. Moreover, my lifelong interest in venous thromboembolism left no one in any doubt about my main anxiety.

In the early days after operation I was, at times, extremely uncomfortable. But, having had two myocardial infarcts and many attacks of renal colic, I would never describe the postoperative period as painful. After one opiate injection on return from the recovery ward my only analgesic was one soluble aspirin tablet up to five times a day. I declined nocturnal sedatives, preferring to be wakeful and active rather than somnolent.

I would have thought that a surgeon of Professor Rhodes's experience should realise that he must inevitably get "slightly conflicting opinions from senior and junior nurses and from physiotherapists and doctors" when there is a large staff. But I doubt whether this worries the average non-medical patient as much as he suggests. Admittedly there may be some case for agreement on a general policy about what is to be said to patients; but many might be equally disturbed by too uniform an explanation of their problems.

My surgeon and anaesthetist gave me clear information before operation, as did my physiotherapist, who also taught me how to move in bed and how to use my crutches before operation. As micturition can be a problem in my age group, and as water flows better with the aid of gravity, I secured before operation my surgeon's permission to stand up to micturate. As I have not sat on a lavatory seat for many years I had no difficulty in using a high squat for defecation. Contrary to Philip Rhodes's experience, movement for either nursing or physiotherapy was not painful, though extremes of movement certainly caused some discomfort.

Whether Professor Rhodes had his trochanter detached, as in the original Charnley technique, I do not know, though I suspect that some of his symptoms may have been related to this. I had firmly decided that my trochanter should be left intact and chose my surgeon accordingly. As to dislocation, I understand that this is quite exceptional with the type of prosthesis I have, and I never had any anxiety on this score. I therefore have no experience of the "Dutch wife" and have needed neither warning about nor any protection against possible dislocation. Getting out of bed was never difficult, and getting the operated leg back into bed was readily facilitated with the help of the opposite foot. Although I

would agree with Professor Rhodes that there is early muscular aching around the hip and in the thigh, this does progressively, if intermittently, improve. Immediately after removal of the suture movement was much helped by exercise in the hospital hydrotherapy pool, and I swam daily after my return home on the 14th day.

As after any major operation or illness there were occasional discouraging moments; but, just two months afterwards and after returning from a six day conference overseas, I am delighted with my progress and equally delighted that I did not submit to operation until I had earned it fully. There seems little doubt that Philip Rhodes fully earned his total hip arthroplasty and I hope that in due course he will find that his rate of progress has outstripped mine.

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Risk factors for severe retinopathy in non-insulin dependent diabetes

SIR,—Dr Anthony H Barnett and others report an association between female sex and severe retinopathy in non-insulin dependent diabetes (20 August, p 529). This must be interpreted cautiously for several reasons: their groups were small and may not have been representative of the whole clinic population. Our findings in a larger study differ. Over two years we performed fundoscopy through dilated pupils on 384 patients with non-insulin dependent diabetes attending a hospital clinic. The table summarises the results. Background or proliferative retinopathy were significantly more prevalent in men than women during the first 10 years of known diabetes ($p < 0.01$). The trend in patients with diabetes of longer duration was similar but did not achieve statistical significance.

Previous attempts to define the relation between sex and susceptibility to retinopathy have also produced conflicting results.¹ Are these discrepancies just due to poor patient selection, as Dr Barnett and his colleagues suggest? The evidence has come mostly from cross sectional studies of diabetic clinic populations and is therefore subject to several important biases: Danowski *et al* emphasised that referral and attendance patterns affect the composition of clinic populations and may thereby affect the apparent relation between sex and susceptibility to retinopathy.¹ Moreover, there might be an effect of selective mortality; if, for example, men with complicated diabetes were more susceptible to premature cardiovascular death than women, a cross sectional study might find a spurious association between female sex and susceptibility to retinopathy. A prospective study would provide the best evidence that sex affects susceptibility to retinopathy. Pirart carried out a large cohort study and found no such effect.²

Association between sex and prevalence of retinopathy in non-insulin dependent diabetics subdivided according to duration of diabetes

	Duration \leq 10 years		Duration $>$ 10 years	
	Men (n = 175)	Women (n = 123)	Men (n = 53)	Women (n = 33)
No (%) with no retinopathy	126 (72)	109 (89)	26 (49)	19 (58)
No (%) with background retinopathy	42 (24)	14 (11)	23 (43)	12 (36)
No (%) with proliferative retinopathy	7 (4)		4 (8)	2 (6)

$p < 0.01$ comparing prevalence of retinopathy in men and women with duration $<$ 10 years.

The search for factors that predispose to diabetic retinopathy is important. The many discrepancies in the available evidence emphasise that investigations need to be based on the whole diabetic community, not just patients who attend hospitals.

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¹ Danowski TS, Limaye NR, Cohn RE, *et al*. Sex distribution and the frequency of diabetic concomitants or complications. *Diabetes* 1965;15:507-10.

² Pirart J. Diabète et complications dégénératives. Présentation d'une étude prospective portant sur 4400 cas observés entre 1947 et 1973. *Diabète Metab* 1977;3:97-107;173-82;245-56.

Atracurium without bradycardia

SIR,—Atracurium became freely available in this group of hospitals in December 1982. An intensive search for papers describing its use in old people (over 65 years) produced only one,¹ and this was not confined to its use solely in old people. With the permission of the consultant anaesthetists in this group, I decided to carry out a survey into the use of atracurium in old people. There were so many difficulties to overcome in conducting a double blind trial that I had to settle for a survey in which I would observe and record the effects of the drug in both men and women over 65 years. The reason for choosing this age group is that there are about 12m old people in Britain, and these old people form at least half of most general surgical lists, although not all will need to be paralysed for surgery.

The survey began on 1 February 1983, and to date 68 old people (mean age 73.9 years) have been paralysed with atracurium. Many of them were ill with cardiovascular or respiratory disease, or both, and many were taking various drugs. All patients were monitored with an electrocardiograph. There were nine cases of bradycardia (heart rate of less than 50/min). Five were probably due to halothane, because considerably reducing the concentration or turning off the halothane abolished the bradycardia: all these patients had hypotension (below 90 mm Hg with bradycardia). The other four cases were probably related to either traction in the abdomen or vigorous orthopaedic manipulations: two of these needed atropine to correct the bradycardia. Although their blood pressure dropped, these four patients did not become hypotensive. It is unlikely that atracurium or its main metabolite laudanosine played any part in producing bradycardia in these patients.

Because a general anaesthetic demands several drugs and because many of them have the same unwanted effect, it is difficult to be certain which drug is responsible for a particular effect. My choice of technique has therefore been kept simple and constant. Premedication: none or pethidine 1 mg/kg; no antimuscarinic drugs. General anaesthetic: thiopentone, atracurium 0.5 mg/kg, halothane, nitrous oxide, oxygen, and