Similarly, we have found that mastectomy with immediate latissimus dorsi reconstruction is useful for treatment of recurrent carcinoma in a breast previously treated conservatively by primary excision and radiotherapy. We have found immediate latissimus dorsi reconstruction readily acceptable by our patients compared with standard mastectomy. In our opinion the cosmetic results are comparable to those for primary excision and radiotherapy with the added advantage of not requiring 4-6 weeks of treatment. It seems that direct evaluation of this procedure by randomised clinical trials is not possible until the ethical problems of such trials, particularly in relation to informed consent, are resolved.

Endocrine myopathies

Dr DOUGLAS GOLDING (Princess Alexandra Hospital, Harlow, Essex CM20 1QX) writes: Dr P Kendall-Taylor and Dr D M Turnbull (10 September, p 705) mention mitochondrial abnormalities in steroid myopathy but do not emphasise that these represent the profound abnormalities often found in "muscle poisoning" by drugs, as opposed to the much less prominent changes seen in polymyositis complicating rheumatoid arthritis and other connective tissue disorders. When studying the ultrastructure of steroid myopathy we found the mitochondria very enlarged, irregular, and probably functionless, though some normal forms were seen adjacent to those myofibrils remaining intact.[1]

[1] Golding DN, Murray SM, Pearce GW, Thompson M. Corticosteroid myopathy. *Annals of Physical Medicine* 1961;**6**:171-7.

Allergy to Brazil nut

Dr DOUGLAS G BLACK (Newark Hospital, Newark on Trent, Nottinghamshire NG24 1TG) writes: I am able to add a further case of allergy to Brazil nut in an atopic individual to the four cases reported by Dr David W Hide (24 September, p 900). I have had mild atopic eczema and asthma since infancy. I vividly recall being offered a Brazil nut to eat for the first time one Christmas when I was about 8 or 9. The inside of my mouth immediately began to itch intensely, and my tongue and lips became considerably swollen. The discomfort lasted for several hours. Since then I have inadvertently eaten Brazil nuts, usually in the form of chopped nuts within toffee, on several occasions, each of which has produced a similar brisk reaction. As far as I know I am not allergic to any other substance. For years I have claimed to be allergic only to Brazil nuts. Such a statement has usually been met with scorn, and I am therefore grateful to Dr Hide for easing my peace of mind.

Falciparum malaria resistant to chloroquine and Fansidar

Dr DAVID STEVENSON (Department of International Community Health, Liverpool School of Tropical Medicine, Liverpool L3 5QA) writes: Dr C Herzog and others (1 October, p 947) mention the problem of falciparum malaria resistant to chloroquine and Fansidar (pyrimethamine and sulfadoxine) in East Africa. Working in Malawi from 1958 to 1966 I encountered several cases of falciparum malaria that did not respond to treatment with chloroquine. In two cases (myself, and one of my Malawian staff) I tried treatment with proguanil hydrochloride (Paludrine), eight 100 mg tablets the first day and six 100 mg tablets the second and third days, after which we recovered. At the time I was using proguanil hydrochloride as a prophylactic drug, 100 mg daily, later increased to 200 mg. My impression was that proguanil gave a large measure of protection against malaria in Malawi and that, although one might occasionally develop malaria while taking a prophylactic dose, a larger dose could still be effective against the infection. Although proguanil is not normally recommended for treatment, it may be worth a trial if an infection does not respond to other antimalarials.

Traumatic neuropathy of second cervical spinal nerves

Dr SIMON BEHRMAN (London W1N 1DA) writes: In a recent paper (23 April, p 1312) I listed the topographies of pain of traumatic neuropathy of the second cervical spinal nerve as follows: ipsilateral half of the scalp, periorbital temporal and suboccipital regions, and locations around the ear and the angle of the jaw. My recent personal experience of herpes zoster affecting this nerve leads me to conclude that the distribution of the neuralgia is far more extensive than our anatomical notions would suggest. The principal locations of the pain were the region below the ramus of the mandible, infra and supra clavicular regions, the lobe of the ear, the entire deltoid region, and also the nape of the neck. I believe it is important to bear in mind these aberrant areas of pain when dealing with cases of traumatic neuropathy of the second cervical nerve.

Computer security

Dr M J C BROWN (Hayes, Middlesex) writes: Confidentiality is the biggest problem confronting medical computing, yet Mr J Payton and Dr A J Asbury (1 October, p 965) dismiss it by the computer experts' usual legerdemain of including confidentiality in the general scope of security, arguing that because computer records are secure ipso facto they are confidential. Security guards against the abuse of unauthorised access to records, but confidentiality is concerned with preventing the abuse of authorised access. The report of Ontario's Royal Commission on the Confidentiality of Health Records,[1] a 1626 page inquiry into the abuse of computer medical records in Ontario, found that the principal abuses of medical records came from the state—for example, federal police, local police, and immigration authorities. Despite the proposed amendments to the Police Bill and because of the permissiveness of the Data Protection Bill, the state will have no difficulty in authorising itself to look at our medical records, which belong to the Secretary of State.

[1] Krever H, chairman. *Report of the Commission of Inquiry into the Confidentiality of Health Records.* Toronto: Government of the Province of Ontario, Canada, 1980.

Clinical experience with the oxygen concentrator

Dr HIROSHI KAWANE (Division of Respiratory Diseases, Department of Medicine, Kawasaki Medical School, Kurashiki City, Okayama 701-01, Japan) writes: In their article on the oxygen concentrator (13 August, p 459) Dr T W Evans and others did not comment on the noise of machines but this is an important consideration at night during sleep. Another type of home oxygen concentrator which uses a "semipermeable membrane" is more popular in Japan. Although output is limited to 40% oxygen by this type, both the noise and the size are smaller than those of a "molecular sieve" system. Since the Japanese live in small houses, so called "rabbit hutches," noiseless and small concentrators may be preferred. Moreover, the risk of oxygen-induced carbon dioxide narcosis can be minimised by administering low concentrations of oxygen.

The medical effects of nuclear war

Professor JOHN C WATTS (Hasketon, Nr Woodbridge, Suffolk IP13 6JL) writes: I find it difficult to understand how the Reverend John Macdonald Smith (20 August, p 562) is able to state that "all figures given in *The Medical Effects of Nuclear War* are substantially accurate" since most of the figures are hypothetical speculations based on extrapolation from experimental results. Furthermore, at least one figure is wildly inaccurate. I refer to the statement on pages 3 to 9 of the report: "A well organised surgical team might be able to perform up to seven operations in a 12 hour period under ideal conditions." Under far from ideal conditions in the western desert in 1943 the casualty clearing station to which my surgical team was attached dealt with 1394 casualties in 24 hours, the four surgeons carrying out 137 operations, my own total of 31 being below average. So, under ideal conditions the figure should exceed 16. Admittedly, these figures, while contradicting Mr Smith's use of the word "all" do not necessarily affect the corrections of other assumptions but, since the figures I quote are easily obtainable, the correctness of the other figures is at least questionable.

Donation of cadaveric kidneys

Dr L HARVEY (Department of Pathology, University of Sheffield Medical School, Sheffield S10 2RX) writes: Minerva (16 July, p 224) refers to the persistent problem of insufficient cadaveric organ donors in the United Kingdom. . . . To establish a realistic pool of donors seems to require active screening of the public without creating fears of ulterior medical motives. A possible method may be an addition to the front sheet of each patient's record adjacent to the name and address—for example, a box for their initials or signature or insertion of a yes/no sticker giving permission (or not) for their or their child's organs to be donated after death. Each individual's visit to their general practitioner's surgery thereby increases the population screened. The screening may be done—for example, on arrival at reception to minimise the time taken during consultation. Permission to donate could then be gained by access to the patient's general practitioner/family practitioner committee's records only after the diagnosis of brain death has been made and communicated to relatives.

Resuscitation services

Dr H ROBINSON (The Health Centre, Cobham, Surrey KT11 1AE) writes: Dr Roger H Jones quotes the London region as having no resuscitation services. There are in fact seven cardiac ambulances based at Cobham, Hersham, and Walton. These are equipped for intubation, infusion, and cardiac monitoring and defibrillation. £25 000 was raised by the community within a short period of time to equip these ambulances, and there was such good will that I am sure the other areas could easily emulate such schemes.

Cigarette smoking after myocardial infarction

Dr KEITH BALL (Department of Community Medicine, Middlesex Hospital Medical School, Central Middlesex Hospital, London NW10 7NS) writes: In his reply to the question on the risk of relapse after a coronary attack Dr I M Graham (1 October 1982, p 971) underemphasises the importance of continued cigarette smoking. This is surprising since much work on this matter has been reported from his group in Dublin. During 12 different studies, including his own,[1] Mulcahy found that those who continued smoking had a greater risk of relapse, varying from one and a half times to twice the risk of those who stopped. It should be more widely recognised that at present helping a patient to stop smoking is by far the most effective means of secondary prevention after a coronary attack.

[1] Mulcahy R. Influence of cigarette smoking on morbidity and mortality after myocardial infarction *Br Heart J* 1983;**49**:410-5.