

remained. He was discharged from hospital without continuing treatment. Two weeks later he developed severe deep otalgia and an increased blood glucose concentration. Repeat computed tomography showed more extensive temporal bone erosion. Intravenous ceftazidime was given for two weeks followed by oral ciprofloxacin 500 mg twice a day for three months as outpatient treatment. He steadily improved, and the facial palsy resolved almost completely. The vagal and hypoglossal palsies remained, but there was good functional compensation. He subsequently remained well 22 months after completing treatment.

In this case diagnosis of malignant otitis externa was delayed because of failure to culture pseudomonas from the meatus. In our opinion intravenous antibiotic treatment remains the best initial treatment because these patients need inpatient assessment and effective high blood concentrations of antibiotic are best guaranteed by systemic administration. Oral ciprofloxacin should be given as continuation outpatient treatment to prevent relapse. The optimum length of treatment has not yet been defined, but two to three months after the resolution of symptoms and signs seems to be adequate.

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1 Hickey SA, Ford GR, O'Connor AFF, Eykyn SJ, Sönksen PH. Treating malignant otitis with oral ciprofloxacin. *Br Med J* 1989;299:550-1. (26 August.)

## Child abuse: case conferences

SIR,—The series on child abuse<sup>1</sup> was excellent; I was, however, disappointed to note the omission of community paediatric medical officers from the list of attenders at case conferences in Ms Jill McMurray's article.<sup>1</sup>

In the London Borough of Richmond last year community medical officers attended 132 out of 150 case conferences and general practitioners 19. Doctors in the community paediatric service give general medical advice to the case conference, as well as specific descriptions of children's injuries that they have seen. Our doctors are called to see children in schools and clinics before case conferences and as a monitoring service after conferences, and I feel that their contribution is valuable.

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1 McMurray J. Case conferences. *Br Med J* 1989;299:500-2. (19 August.)

## Athletes and drugs

SIR,—Dr Richard Feinmann's recent letter shows the widespread confusion about drug use in sport, within the sporting world and the medical profession.<sup>1</sup>

In the example Dr Feinmann gave two of the athletes were "not allowed to take any medication" for hay fever. The Scottish Sports Council's recommendations for hay fever, however, permit inhaled steroids (beclomethasone dipropionate), several antihistamines (terfenadine, chlorpheniramine maleate, etc) and sodium cromoglycate eye drops.<sup>2</sup> We assume that all the sports bodies in the United Kingdom have similar guidelines.

It is unfortunate that all concerned in sporting events are not aware of the permitted treatments. We suggest that such information be widely distributed to all those in sport.

In addition, it should be readily available to doctors so that appropriate treatment can be prescribed to athletes. A suitable place might be at the end of the *British National Formulary* in a separate appendix or in the "cautionary label" warnings.<sup>3</sup> The Scottish Sports Council is to be commended for popularising such information by producing for athletes a handy credit card sized guide to banned and permitted drugs.<sup>2</sup>

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- 1 Feinmann R. Athletes and drugs. *Br Med J* 1989;299:570. (26 August.)
- 2 Scottish Sports Council. *Drug abuse in sport: banned classes and methods with examples*. Edinburgh: Scottish Sports Council, 1988
- 3 Joint Formulary Committee. *British national formulary*. London: British Medical Association and Pharmaceutical Press, 1989.

## Lambasted on heart disease

SIR,—In reporting the verdict of the Committee of Public Accounts on Britain's attempts to reduce coronary mortality Dr Tessa Richards states that in Scotland there is a lack of any campaign tackling the problem of heart disease.<sup>1</sup> This is inaccurate.

In December 1988, amid much publicity, SHARP (Scottish Heart and Arterial disease Risk Prevention) was launched at an international symposium on coronary risk factors. This organisation has been established to tackle Scotland's deplorable record of coronary morbidity and mortality and its main aim is to promote the prevention of cardiovascular diseases in primary care, in hospital practice, and in the community. Several major projects will soon be announced, but much of the resources of time, energy, and skill of the committee has initially had to be diverted to seeking financial support. So far all funding has come from pharmaceutical companies.

Dr Richards points out that £10m is spent on prevention while £500m is spent on treating cardiovascular diseases. If organisations such as SHARP were to be properly funded not only could the latter figure be drastically reduced but also the emotional and economic devastation to individual patients and families affected by cardiovascular diseases could be alleviated.

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1 Richards T. Lambasted on heart disease. *Br Med J* 1989;299:286. (29 July.)

## Use of stents for treating obstruction of urinary outflow

SIR,—Recent correspondence has voiced reservation as to the advisability of implanting prostatic endoprostheses (the Wallstent), which cannot be moved or indeed removed without open surgery. As the main use of these stents would seem at present to be confined to unfit patients this criticism poses a potential limitation to the wider use of this technique.<sup>1,2</sup> In a previous communication<sup>3</sup> we reported our initial experience with the Wallstent, but at that time we had not had occasion to test the ease with which the stents could be removed. We have subsequently removed two stents, one being at the time of original placement as we were unsatisfied with the position of

the stent and the other being six weeks after implantation in a patient with advanced adenocarcinoma of the prostate. In both cases the stent was removed by grasping it under endoscopic control with alligator forceps and applying distal traction, thereby elongating the stent and reducing its diameter. In neither case did any urethral trauma result. To our knowledge a further three Wallstents have been removed without difficulty in other centres.

Although it is still too early to comment definitively on the use of this stent technique in managing prostate obstruction (owing to the short follow up time and small number of patients so far treated), we believe that it merits further consideration. Certainly the ability to remove these stents is of fundamental importance, and a potential application is the use of such stents to relieve obstruction due to the prostate on a trial basis in patients in whom dual pathology is suspected. The stent could then either be left in situ or be removed before a definitive transurethral prostatectomy.

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- 2 Buckley JF, Bowler GMR, Littlewood DG, Smith G, Fowler JW, Tolley DA. Treatment of obstruction of urinary outflow. *Br Med J* 1989;299:181. (15 July.)
- 3 Milroy EGJ, Chapple CR, Rickards D. Use of stents for treating obstruction of urinary outflow. *Br Med J* 1989;299:119-20. (8 July.)

## Drug Points

### Tachycardia precipitated by topical homatropine

Drs DUNCAN REID and JAMES D FULTON (Department of Geriatric Medicine, Stobhill General Hospital, Glasgow G21 3UW) write: Although rarely reaching concentrations that are clinically important, certain topical agents used in ophthalmological practice can be systemically absorbed.<sup>1</sup> For example, timolol eyedrops may rarely cause  $\beta$  adrenoceptor blockade<sup>2</sup> or interact with drugs such as verapamil to cause profound bradycardia.<sup>3</sup> Topical homatropine also has been reported to cause confusion in an elderly man.<sup>4</sup>

An 84 year old woman was admitted to our wards after an episode of dizziness and palpitations culminating in virtual syncope. Her radial pulse rate was initially 160-180 beats/min but settled spontaneously to a rate of 80 beats/min. Physical examination showed partial blindness due to cataract and glaucoma, for which she was receiving topical homatropine eyedrops. She was taking no other medication and her only additional relevant history was of several similar episodes of palpitations and lightheadedness over the preceding four months. These attacks occurred in the morning or evening within an hour of instilling the drops, though she had been taking homatropine for about two years. Routine biochemical, haematological, and thyroid function tests; chest x ray film; and resting and 24 hour electrocardiograms were all normal. Homatropine was discontinued and she remained well when reviewed two and four months after discharge with no further symptoms suggestive of an arrhythmia. Rechallenge with homatropine was considered unethical.

Although possibly coincidental, the administration of homatropine eyedrops, at recommended therapeutic doses, seemed to precipitate tachycardia in this otherwise fit, elderly woman. Neither the Committee on Safety of Medicines nor the