hypertension who were switched from nifedipine to placebo.[1] They note that the size of this acute sodium retention was similar to the extent of initial natriuresis that had been reported when nifedipine was introduced and then infer that nifedipine induces a long term reduction in sodium balance and that this is a "possible additional mechanism whereby nifedipine lowers blood pressure." They mention anecdotal reports that oedema of the legs induced by nifedipine is unresponsive to diuretics.

They imply, but do not state, that no other drugs were given during the overall course of their study. This should be made clear. Dr Pevahouse and colleagues did not perform any long term measurements, and their conclusions are speculative. Curiously, they do not quote some studies that examined the problem directly, the results of which do not support their inferences.

Marone *et al*[2] found that treatment with nifedipine 10 to 20 mg three times daily for six to eight weeks in 10 patients increased the total exchangeable sodium concentration by an average of 27% compared with the concentration in patients taking placebo. The subsequent addition of chlorthalidone 25 to 50 mg daily for six to eight weeks corrected the sodium retention and led to significant further reduction in several measures of arterial pressure. The introduction of chlorthalidone also corrected leg oedema in the two patients who had developed it while taking nifedipine. In another study no significant change in mean body sodium concentration was found in 16 patients with essential hypertension taking nicardipine 30 mg three times daily for 12 weeks compared with those taking placebo; individual values fell slightly in nine patients, rose slightly in six, and were unaltered in one.[3]

Dr Pevahouse and colleagues make extensive extrapolations from their data concerning the effects of class II calcium antagonists in general, and nifedipine in particular, in essential hypertension. In view of the above comments a more cautious approach might be more appropriate.

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1 Pevahouse JB, Markandu ND, Cappuccio FP, Buckley MG, Sagnella GA, MacGregor GA. Long term reduction in sodium balance: possible additional mechanism whereby nifedipine lowers blood pressure. *BMJ* 1990;**301**:580-4. (22 September.)
2 Marone C, Luisoli S, Bomio F, Beretta-Piccoli C, Bianchetti MG, Weidmann P. Body sodium-blood volume state, aldosterone, and cardiovascular responsiveness after calcium entry blockade with nifedipine. *Kidney Int* 1985;**28**:658-65.
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How to save lives

SIR,—Mr Peter K Plunkett wrote in his review[1] of Dr P J F Baskett's resuscitation handbook[2] that "a central venous monitor as the sole indicator of the volume and pump state of the patient is virtually antediluvian," and he denigrates Baskett's suggestion that pulmonary artery flotation catheters are rarely useful in the early stages of resuscitation.

Though many old treatments are of no value or have been superseded, the fact that a treatment is old is not in itself a measure of lack of value: foxglove, admittedly in a somewhat more secure formulation, is still the correct treatment for fast, established atrial fibrillation.[3] And not everyone would share Mr Plunkett's enthusiasm for Swan-Ganz catheters, which were described by Robin and Morin as accounting for "almost 1% (0·75%) of all personal health care costs in the United States in 1983! This for a test of unestablished benefit and with major risks!"[4] Commenting on the debate, Winterbauer writes of the false sense of scientific elitism that follows the adoption of certain treatments and patterns of practice:[4] One practice we must beware of in this time of limited resources coupled with availability of expensive equipment is the substitution of clinical measurement for clinical management.

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1 Plunkett PK. How to save lives. *BMJ* 1990;**301**:675. (29 September.)
2 Baskett PJF. *Resuscitation handbook*. Philadelphia: Lippincott/ London: Gower Medical, 1989.
3 British Medical Association and Royal Pharmaceutical Society of Great Britain. *British national formulary*. No 20. London: Pharmaceutical Press, September 1990:52.
4 Matthay MA, Robin ED, Morin M, Winterbauer RH. A pulmonary artery catheter should be used in patients with respiratory failure. In: Gitnick G, Barnes HV, Duffy TP, Winterbauer RH, eds. *Debates in medicine*. Vol 2. Chicago: Year Book Publishers, 1989.

Forensic pathology

SIR,—The negative tenor of Dr J D J Havard's editorial is difficult to comprehend,[1] in particular because nowhere does he state what he considers to be "the main problems" or "inevitable and radical reorganisation," which the report fails either to tackle or to propose. We believe that attention should be drawn to apparent errors and interpretations that render several of the implied or overt criticisms inappropriate or invalid.

The Home Office forensic science service (itself the subject of a different report) may undertake work for parties other than the police,[3] although, admittedly, the reluctance of other parties to use the service may be related to the fact that evidence has to be submitted by the police and that the results of analysis are made available to the prosecution. Such a practice, however, is not contrary to the spirit of current Crown Court rules[4] and, therefore, should not constitute an unfair advantage.

Although undergraduate training in forensic medicine was not within the remit of the working party, it is difficult to see how funding of new senior lectureships in university departments can have other than a beneficial effect on this neglected part of the medical curriculum.[5] Such criticism would be better directed at the General Medical Council.

Comparison with European medicolegal institutes is invalid. The legal basis of the investigation of deaths within the community differ between countries—in one country, at least, the decision on whether to perform a necropsy rests solely with the police. Experience with the bodies of British nationals repatriated from several European countries does not allow wholehearted confidence in their medicolegal systems.

When, as a consequence of the deliberations of the working party, the provision of forensic pathological services for the police in London has not been free for several months and now stands on firmer foundation than ever before, pessimism seems unwarranted. The revitalisation of university departments outside London makes other practising forensic pathologists optimistic that they can build on these foundations. If there are any hard data on which the confident prediction of Dr Havard's final sentence is based perhaps we should be told.

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1 Havard JDJ. Forensic pathology: a blinkered report. *BMJ* 1990;**301**:943-4. (27 October.)
2 Home Office. *Report of the working party on forensic pathology*. London: HMSO, 1989.
3 House of Commons Home Affairs Committee. *The forensic science service*. London: HMSO, 1989.
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5 Knight B, McKim Thompson I. The teaching of legal medicine in British medical schools. *Med Educ* 1986;**20**:246-58.

SIR,—We were disappointed by Dr J D J Havard's editorial on the report of the working party on forensic pathology.[1] He attacks the report for not advocating the setting up in Britain of medicolegal institutes similar to those in Germany, which deal not only with forensic pathology but with forensic science and most aspects of forensic medicine, including examining the victims of assault, industrial injuries, and diseases. In most of the English speaking world these disciplines have grown apart. There is now little connection between the scientific aspects of forensic pathology and the techniques of forensic science. We see little justification for setting up multidisciplinary medicolegal institutes, although we do welcome the increasingly close links with clinical forensic medicine and academic departments of law and public health.

The aim of the medical members of the working party, of which we were two, was to strengthen university departments of forensic pathology and to ensure the continuing availability of pathologists with a special interest in forensic work in those subjects in which a university service is impracticable. In our view this is the most sensible way to provide a forensic pathology service and is not merely an interim solution.

Given the government's financial restraints and political views, we believe that the working party's package is as much as could be expected and will substantially help solve the difficulties of forensic pathology in this country. The working party believes that its proposals will result in a considerable improvement in forensic pathology services to London, and there are already signs that this is taking place. Financial negotiations between the University of London and the police authorities concerned have recently been satisfactorily concluded. Similar expansion of the university departments in Sheffield and Cardiff is also well under way.

There are other aspects of the editorial that we are inclined to criticise, but we might be accused of nit picking. It was clearly written by a bystander rather than a player, and we hope that it will not be generally regarded as representing the profession's view. We must draw attention, however, to a seriously misleading misprint. The Home Office is setting up a policy advisory board, not a police advisory board.

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1 Havard JDJ. Forensic pathology: a blinkered report. *BMJ* 1990;**301**:943-4. (27 October.)

SIR,—Dr J D J Havard's criticisms of the working party prompt me, not being a member, to write in the working party's defence.[1] Advocating the development of medicolegal institutes in this country, similar to those found on the Continent, raises two important and distinct questions: the future of forensic medicine and the future of forensic science. Forensic science was not in the remit of the working party.

There has been much disquiet about the forensic science service over the past decade. The Home Affairs Committee's latest report in 1989 lists 10 other reports since 1981.[2] In common with