weeks before this. She was ill, with pyrexia of 101°F (38.5°C) and arthritis involving the hands, wrists, feet, the left knee, right elbow, and the hips. There were widespread skin lesions. Hyperkeratotic and pustular rash covered the toes, with marked nail involvement. Similar lesions were on the heels. There were psoriasiform patches on the palms and there were also nail changes on some fingers, the affected nails occurring where there was maximal joint involvement of the fingers. Discrete psoriasiform patches were present in the scalp and on the trunk and limbs. Subsequently, she developed guttate psoriatic lesions on the trunk and rupest psoriasiform plaques on the limbs. There was no involvement of the urethra, cervix, conjunctivae, or buccal mucous membrane.

Investigations showed E.S.R. (Westergren) 100-130 mm/1 hr., W.B.C. 9,700, (polymorphs 83%, lymphocytes 13%). Blood cultures, R.A. test, and L.E. tests, were negative. X-ray of os calcis and iliosacral joints did not show abnormality. Over a long period, her general condition gradually improved. A.C.T.H. injections appear to have had a good effect. She now has minimal joint involvement and minimal skin lesions.

Without knowledge of the transient urethritis, cervicitis, and buccal lesions early in the disease, I would have accepted this as a case of arthropathic psoriasis.—I am, etc.,

RODERICK HOWELL

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Restless Legs and Latent Diabetes

SIR,—The leading article on "restless legs" (26 December, p. 758) and two original articles in the same issue need further comment with regard to the strikingly high incidence of this syndrome in cases of diabetes mellitus. Notable are the cases in which restless legs preceded the onset of diabetes. The actual number of diabetics who suffer from restless legs might be higher if one looks for the possibility of latent diabetes mellitus. In their interesting paper, Dr. N. K. Banerji and L. J. Hurwitz (p. 774) do not mention whether a glucose tolerance test was performed on the non-diabetics in their series. On the other hand, Dr. J. D. Spillane (p. 796) does not report his observations with regard to this metabolic abnormality; he states only that the neurological examinations were negative. However, as in cases of diabetic nephropathy or retinopathy, there does not necessarily have to be an intimate correlation between the restless legs syndrome and diabetes.

I have seen two patients with rather severe "restless legs," in whom a diabetic glucose tolerance test curve was found. One patient also had a moderate hypercalciuria and a mildly elevated urinary excretion of acid mucopolysaccharides.¹ All laboratory tests on the second patient were normal. The common abnormal physical findings in both was a reduction of vibration sense in the legs. This was regarded as a possible early sign of diabetic neuropathy. Both patients were treated symptomatically with a low carbohydrate diet, thiamine (200 mg/day), and a sedative (dichlorophenazone). Both showed a marked improvement. The first patient, who was followed for over a year, was able to decrease the amounts of both drugs gradually, without any significant reappearance of the previous complaints.

The possibility of restless legs heralding a (latent) diabetes mellitus and being an early expression of a diabetic neuropathy should be kept in mind.—I am, etc.,

I. MACHTEY

Hasharon Hospital,
Petah-Tiqva, Israel

¹ Machtey, I., *Harefuah*, 1969, 77, 468.

Uneasy Relations

SIR,—Dr. A. Paton's charmingly written Personal View (6 March, p. 554) reveals an attitude of mind which is common among those physicians who regard themselves as the only real doctors working in the hospital service.

Surgeons fail to meet his exacting requirements as they feel they must operate or prescribe the latest drugs. Radiologists and bacteriologists are well-meaning non-clinicians with insufficient knowledge of the patient. Anaesthetists are notorious expanders of empire.

To avoid the inevitable demarcation disputes surrounding patient care in a large hospital, Dr. Paton modestly proposes that all specialists should be subordinated to general physicians. If specialized medical knowledge is of such little value, would it not be more logical to subordinate us all to general practitioners or, better still, to medical social workers?—I am, etc.,

JAMES MCIVOR

Hillingdon Hospital,
Uxbridge, Middlesex

SIR,—I would like to add my humble dissent to the many that you must surely receive following Dr. A. Paton's Personal View (6 March, p. 554).

His reference to anaesthetists is an insult to my colleagues in the specialty and, far worse, it is untrue. Anaesthetists are medical practitioners, in addition to being "first class respiratory technicians"; they are quite capable of discussing prognosis with relatives and treating renal failure. The reason they do not normally practise this is probably on account of the ethics and etiquette that Dr. Paton sometimes finds lacking in medical practice.

The hazards of anaesthesia are no less, and often greater, than those of surgery. The pre and post operative intimacy of the anaesthetist with the patient must therefore be in the best interest of the patient, which Dr. Paton is so concerned about. His question "when do they have time to give anaesthetics?" ought really to be "when do they find time to see the patients they anaesthetize?"

Specialization has come to stay and the trend will continue in the years to come. If we can work together, with the welfare of the patient and his relatives foremost in our minds at all times, Dr. Paton will have nothing to fear.—I am, etc.,

J. L. HANDY

Department of Anaesthetics,
Freedom Fields,
Plymouth

SIR,—May an anaesthetist comment on part of the egregious Personal View propounded by Dr. A. Paton of Birmingham (6 March, p. 554)? If the seventh paragraph of my Personal View ran:

"Patients suffering from chronic bronchitis due to historical accident are frequently treated by general physicians, notorious for their deep grasp of theoretical considerations

and ineffectual floundering in the practical management of these diseases. I am sure they have high intellectual attainments but they need reminding that most of their time used to be spent in purging and bleeding dehydrated and anaemic patients. I doubt if they can really be expected to administer intravenous injections or perform lumbar punctures. And yet I hear that in addition to their treatment of respiratory disease, the giving of public health advice and medical administration generally, they are now presuming in many cases to prescribe psychotropic drugs. How do they find the time to instruct every other group of specialists, I wonder?" I could scarcely complain if my physician friends objected.

It should not be necessary to point that the publication of this sort of nonsense is likely to give offence. There are surely enough divisive tendencies in society without the gratuitous introduction to the profession of factitious interspecialty resentments. I would like my imaginary paragraph (which the saints forbend anybody take seriously) read in parallel with that of Dr. Paton to which I take exception: Can he say mine is unfair?—I am, etc.,

JOHN P. CONROY

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SIR,—Dr. Paton's Personal View (6 March, p. 554) convinces me that he is not a consultant physician but a general practitioner. I agree with everything that he says, but would add that I have paranoid delusions about consultant physicians taking over control of my patients.

I am glad that he used inverted commas when referring to "his" patients.—I am, etc.,

A. J. EARL

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near Loughborough,
Leics.

Incontinence

SIR,—The letters (23 January, p. 229) commenting on Mr. K. E. D. Shuttleworth's article (19 December, p. 727) draw attention to the importance of physiotherapy in the treatment of stress incontinence.

Since 1965 the Sphincter Research Unit at Exeter, financed by the Medical Research Council, has been investigating the extension of this treatment by electronic stimulation. I would like to stress three points.

Firstly, I have been surprised at the number of cases referred from centres all over the country and elsewhere who have been "cured" simply by conscientious management.

Secondly, the very high proportion of patients who have been told that there was no treatment for incontinence and had suffered from this condition for years.

Thirdly, the surprising number who attend with a diagnosis of "incontinence" but without the primary cause being diagnosed.

I agree with your correspondents that much more publicity should be given to the possibility of cure in all these cases; to the medical and paramedical personnel, as well as to the public. Where possible cases should be referred to centres such as the one at Exeter or the Institute of Urology which are fully equipped to screen these cases, and proceed to treat them with whatever method is applicable, including the use of electronics. I would stress that the electronic treatments are an extension of