morphology, the altered signalling of common diseases, the need to recognise as normal things that were once always abnormal, such as loss of lower limb reflexes and vibration sense. My only comfort has been to see others, consultants in general medicine, flounder at the bedside like myself and conclude the consultation with the words, "I'll have to take him in"—but to a ward where no one had studied the height of beds and chairs and where the more abundant nursing staff got by with charm and kindness but could be seen dragging the stroke patient up the bed by the fulcrum of the axilla, watched by the ward sister.

I don't mind whether one specialty swallows another. I do not like to envisage a situation where dog eats dog. I would like to see everyone taught the principles now known about the management of elderly patients from the beginning of his career. General medicine has become rather old hat, and not to be trusted when 40% of surgery and home consultations are concerned with pensioners I am more afraid of making mistakes in patient management than of words to describe the specialty into which it might best be fitted.

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Echocardiography in mitral valve prolapse

SIR,—The echocardiogram published as part of the short report by Dr D Krikler and others (22 May, p 1257) is not diagnostic of mitral valve prolapse. In order to make a confident diagnosis of this condition from the echogram it is necessary that the anterior and posterior leaflets be displayed throughout the whole of the cardiac cycle and that the two leaflets shall be seen to come together at the beginning and the end of systole.

In the normal subject echoes from the two cusps can be separated in systole if the echoing point is not at the free margin of the two cusps which come into apposition (point A in the figure). If the echoes are derived from a position nearer the valve ring, such as point B, they will be separated in systole. During the course of echography it is possible, owing to the rotation of the heart about a horizontal as well as a vertical axis, for the transducer beam to move from point A to point B and back again. In order to be sure that all the echoes come from the free margin it is therefore imperative that apposition shall be demonstrated both at the beginning and the end of systole; unless these strict criteria are used over-diagnosis of mitral valve prolapse will occur.

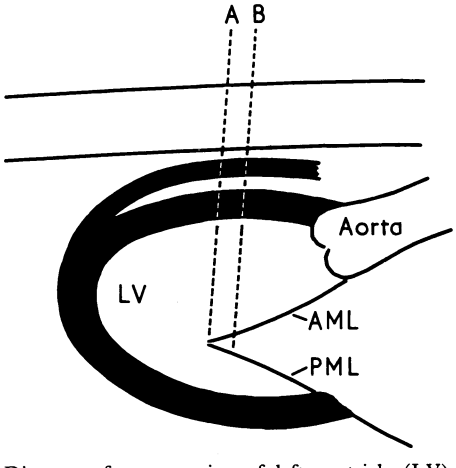

Diagram of cross-section of left ventricle (LV). A = Direction of an ultrasound beam in which anterior and posterior mitral cusps come into apposition at the beginning and end of systole. B = Beam position with separation of cusps. AML = Anterior mitral leaflets. PML = Posterior mitral leaflets.

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Bites from black snakes

SIR,—Encounters between people and snakes, either accidental or provoked, become more frequent as the summer holidays bring people into the countryside. In the management of snake bite it is important to ascertain whether or not the snake was an adder, and it is said that adders can be identified by the bold V-shaped marks on their backs. The following case history may be of interest.

In May last year a 23-year-old man saw a snake in the New Forest and tried to pick it up. He was bitten on the left index finger. The snake was about one foot (30 cm) long and black, and the man, who had a keen amateur interest in snakes, was sure that it did not have the markings of an adder. A few days previously considerable publicity had been given to the discovery of an escaped tropical snake in a Southampton garden, and it was with this in mind that in the casualty department we gave the patient intramuscular hydrocortisone. Two hours after the bite the finger became inflamed and inflammation then extended to the entire arm. The resulting painful and grossly swollen arm necessitated the patient spending four days in hospital before it resolved sufficiently to permit his discharge.

Subsequent inquiry revealed that melanistic forms of adder are known, and are said to be particularly common in the New Forest. This, together with the severity of the reaction, leads us to conclude that our patient was bitten by an adder. We intend to treat any future bites from black snakes as adder bites.

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K J FOSTER

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Driving and medical fitness

SIR,—Dr G W Roberts (15 May, p 1210) expresses concern about the medical consequences of issuing driving licences valid to the age of 70 with three-year renewals thereafter. He mentions that the law now requires drivers to inform the Licensing Centre as soon as they become aware that they are suffering from any condition which may affect their ability to drive either now or in the future. Under the new rules there is of course no statutory obligation on doctors to notify the Licensing Centre, but doctors are asked to advise their patients about their obligation in this respect.

I can happily reassure Dr Roberts that his fears that the whole procedure would not work are in practice ill founded. Already during our first six months' experience with the new arrangements we have found that they are in fact working extremely well, thanks to the interest shown by clinicians both in general and in hospital practice. I am pleased to report that doctors are raising the question of driving with patients, who are in turn notifying their complaints in accordance with the new rules. The effective procedures which worked previously are continuing to operate and in fact are operating most successfully.

Dr Roberts makes the ingenious but I fear impracticable suggestion that health declarations should be made in relation to the annual licensing of vehicles. Registered keepers of vehicles are not necessarily drivers, nor are they necessarily related to drivers of the vehicles registered. It would be quite unreasonable to impose a legal obligation on these keepers to make inquiries into the health of drivers. Finally, Dr Roberts refers to the value of "an independent driving test." One of the improvements in the new arrangements is that driving examiners are no longer asked to make recommendations beyond their competence. The 1974 Road Traffic Act placed the responsibility to make recommendations in respect of fitness to drive in progressive medical conditions on doctors and not on driving examiners. Previously the examiner had been expected to assess the effect of disabilities on fitness to drive at the time of the driving test in complaints which could change dramatically subsequently—multiple sclerosis is a good example.

The implication in Dr Roberts's letter is that the matter of checking disabilities is left entirely to the discretion of the driver. But this is certainly not the case. Licences until the age of 70 are not issued to persons who are found to have medical disabilities relevant or prospectively relevant to driving safety. These persons have licences issued with a validity of one, two, or three years.

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Fits and fitness to drive

SIR,—Occasionally British journals would be well advised to adopt the transatlantic practice of the signed leading article so that readers can more readily gauge its gravitas. Your leading article (22 May, p 1235) on fits and fitness to drive epitomises the desirability of the signed presentation. It was clearly designed to be more authoritative than an annotation of the new edition of *Medical Aspects of Fitness to Drive*[1] yet is uneven in the treatment of the issues involved.

The presentation leaves one wondering whether in future these regulations will be applied automatically or whether there is a continuing need for expert medical judgment and the evaluation of specialist reports in determining the reliability of the evidence or, for example, in deciding whether a person with nocturnal status epilepticus can be considered safe to drive. There is the need for a straightforward explanation of the present laws and regulations, but this will fail to satisfy those closely involved with the medical problems of fitness to drive. We await a comprehensive distillation of the case experience of the medical advisers to the Department of the Environment so that the practicality of recent rulings may be adequately assessed.

One of the weaker features of the article is the apparent support for the empirical approach to improving seizure control by a casual increase in dosage or the addition of another drug. Wherever possible, medical