The sea fish in both cases was rock cod (*Epinephelus areolatus*) locally known as hamoor. This particular fish was selected because it is known to live longer out of water and is therefore easily available while still alive.—I am, etc.,

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Total Replacement of the Hip

SIR,—Drs. R. H. Ellis and J. T. Mulvein (27 May, p. 528) have failed to draw the distinction between patients undergoing total hip replacement and those receiving prosthetic femoral heads for subcapital fractures. Transient hypotension following the insertion of acrylic cement into the femoral medulla is common.[1] Rarely is the hypotension severe. We have shown[2] that the hypotension corresponds in time with high levels of mono methyl methacrylate measured in the circulation during total hip replacement in man. We do not doubt that a similar relationship exists in anaesthetized greyhounds.

Occasionally, more severe hypotensive episodes have been seen during implantation of acrylic cement into the femoral shaft in patients undergoing total hip replacement. Drs. Ellis and Mulvein quite rightly draw our attention to these patients. However, cardiac arrest and death during operation are very uncommon,[3] and have for the most part been in patients undergoing femoral head replacement for subcapital fracture.[4-6]

We would agree that femoral head replacement in these unfit and elderly fracture patients may be attended by considerable risk, but we doubt that the use of acrylic cement in patients undergoing total hip replacement is cause for alarm.—We are, etc.,

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1 Phillips, H., Cole, P. V., and Lettin, A. W. F., *British Medical Journal*, 1971, 3, 460.
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Coalminers' Pneumoconiosis

SIR,—Dr. J. P. Lyons and others (18 March, p. 713) criticize conclusions reached by Carpenter and his colleagues[1] and Cochrane and his colleagues[2] on the basis of representative samples from defined communities that, although miners and ex-miners had lower ventilatory lung function than non-miners, this was not attributable to simple pneumoconiosis. They maintain on the contrary that simple pneumoconiosis does cause impairment of ventilation. They suggest this is due to emphysema which is undetected radiologically. Table 1 from their paper shows mean emphysema counts at necropsy in relation to the final radiological category of pneumoconiosis during life. The relevant figures are:

X-ray Category	Mean Emphysema Count
0	10·8
1	19·9
2 & 3	7·9
A	12·0
B	11·8
C	10·6

Since the emphysema counts were less in those miners with the more advanced categories (2 and 3) of simple pneumoconiosis than in those with either no pneumoconiosis at all or any of the other categories it would seem legitimate to conclude that the emphysema, which causes the disability in simple pneumoconiosis, is undetected at necropsy as well as radiologically. The conclusion drawn by Dr. Lyons and his colleagues seems to be in flat contradiction to their evidence. This does, however, support the view that neither ventilatory lung function nor emphysema is related to x-ray category of simple pneumoconiosis in coalminers in Glamorgan.—I am, etc.,

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Ann Arbor, Michigan, U.S.A.

1 Carpenter, R. G., Cochrane, A. L., Gilson, J. C., and Higgins, I. T. T., *British Journal of Industrial Medicine*, 1956, 13, 166.
2 Cochrane, A. L., Higgins, I. T. T., and Thomas, J., *British Journal for Social and Preventive Medicine*, 1961, 15, No. 1.

Confusion with Clofibrate

SIR,—Your leading article "Confusion with Clofibrate" (3 June, p. 547) after an interesting discussion of recent trials in Edinburgh, Newcastle, and San Francisco, concludes that "The results at present available give general support to the current practice of prescribing clofibrate for patients with any degree of hyperlipidaemia. . . ."

Without any indication at all of what cholesterol and triglyceride levels constitute "any degree" of hyperlipidaemia, the conclusion is logically meaningless.

Practically, of course, it is highly meaningful; clofibrate will be more widely prescribed, and confusion will be worse confounded.—I am, etc.,

JULIAN TUDOR HART

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Glam

SIR,—Once again[1] I write to advise caution before accepting that clofibrate affects platelet adhesiveness (3 June, p. 547). There were at least three claims[2-4] in the 'sixties that clofibrate had an effect on various platelet function tests. Subsequently one trial[5] specifically designed to repeat one of these studies failed to show any important change during treatment in 14 measurements of platelet function other than some prolongation of the bleeding time. Even this prolongation could have been due to a seasonal or methodological change, and has not been reported by others.

The concept of a double action of clofibrate on both lipid metabolism and on platelet function is attractive, but it is very noticeable that, to my knowledge, the claim of an effect on platelets has received no further support recently. Clofibrate is a fascinating drug. Its reported effects on the various aspects of cardiovascular disease are confused enough, as indicated in your leading article, without introducing the further confusion of an unproved effect on platelets.—I am, etc.,

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1 O'Brien, J. R., *Lancet*, 1968, 2, 1143.
2 Carson, P., *et al.*, *British Heart Journal*, 1966, 28, 400.
3 Gilbert, J. B., and Mustard, J. F., *Journal of Atherosclerosis Research*, 1963, 3, 623.
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Legal Detention of Psychiatric Patients

SIR,—Dr. J. T. R. Bavin and Miss Mary Applebey (3 June, p. 590) have drawn attention to a situation which has concerned me for some time—namely, the equanimity with which some of our colleagues seclude or restrain informal patients in mental subnormality hospitals during periods of violent or other uncontrolled behaviour. If the basic premise underlying the informal admission procedure is that any informal patient aged 16 or over is free to leave hospital whenever he wishes, it seems obvious to me that colleagues risk a charge of interfering with the liberty of the subject every time they do this. It is perhaps surprising that their right to to do this has never been tested in the courts.

In this Stoke Park Group, where only 2% of our 1,700 patients are under order, we try to avoid this risk by using Section 30 (2) Mental Health Act, 1959, normally followed by Section 25, whenever an informal patient requires seclusion or restraint. If this practice is followed I submit that there is no need to consider any additional formula or legislation as Miss Applebey and Dr. Bavin suggest.—I am, etc.,

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Value of Thermography

SIR,—Dr. B. E. Nathan and others (6 May, p. 316) made a generalized conclusion that "mammary thermography is of no practical value in the differential diagnosis of symptomatic mammary disease."

The two infra-red scanning systems they used differ considerably in their specifications and the results obtained are not therefore comparable.[1] Simple resolution tests indicate that scanning a patient at 3 feet distance is likely to produce low definition thermograms with no clear distinction made between the superficial vascular pattern of the breast and the suspected hot spot.[2]

These thermograms, if read from Polaroid film by the radiologists without reference to the cathode ray screen image, are likely to introduce further loss of detail. On the basis of their evidence, the authors have