stem cut back to the point where it opened out into the bell of the funnel. This end will now slip over the illuminating tip of most pen torches (see fig.).

Transilluminating Torch with trimmed McKilroy's Inhaler fitted over light source, and intact inhaler (oxygen funnel) for comparison.

I feel prompted to describe this simply because none of the six paediatric units in which I have worked have had a comparable alternative and because many of my colleagues are still gummed up with sticking plaster.—I am, etc.,

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Beta-blockade in the Presence of Renal Disease and Hypertension

SIR,—We read with interest the paper by Dr. D. J. Warren and others (27 April, p. 193), reporting three cases of deterioration of renal function in patients with chronic renal failure following beta-blockade. We would like to report a further case, in which the sequence of events was attributable to two therapeutic agents.

A 49-year-old housewife developed chronic renal failure following analgesic abuse, having taken approximately 50 A.P.C. (aspirin, phenacetin, and codeine) tablets per day for five years. At the end of this period her serum urea level was 60 mg/100 ml and her serum creatinine 2.1 mg/100 ml. She was hypertensive with casual readings at 190/110 mm Hg. Seven days before admission she was started on prindolol 10 mg twice a day in an effort to control her hypertension. This was followed by the development of acute left ventricular failure and pulmonary oedema, with a rapid deterioration in her renal function, and when referred to our unit her serum urea was 440 mg/100 ml and her serum creatinine 16.8 mg/100 ml. The patient was treated with haemodialysis, but to date her renal function has not returned to normal (serum creatinine 9.8 mg/100 ml), though her pulmonary oedema rapidly resolved. She is being managed at present without maintenance haemodialysis. Renal biopsy showed periglomerular fibrosis, interstitial medullary fibrosis with round cell infiltration, and patchy flattening of the tubular epithelium consistent with acute tubular necrosis and chronic interstitial nephritis secondary to analgesic abuse.

As we were unable to demonstrate any other precipitating cause for her acute tubular necrosis and acute renal failure, we were left to conclude that the deterioration was caused by beta-blockade and its subsequent effects. The initial chronic renal failure was consistent with analgesic nephropathy.

We would not agree that beta-blocking drugs should not be used in severe renal failure but would rather state that their effects should be closely monitored and

dosages adjusted accordingly. We have found beta-blocking drugs extremely useful in gaining effective control of hypertension in patients with moderate to severe renal failure without previously seeing this reaction.—We are, etc.,

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Who is the Dental Anaesthetist of the Future?

SIR,—Dr. D. Hogg (18 May, p. 386) implies that there is an inexhaustible supply of medical anaesthetists. In the best of all possible worlds every general anaesthetic would be administered by a consultant anaesthetist. Regrettably we live in a world in which demand almost invariably exceeds the resources available to meet it. This is certainly so in the field of general anaesthesia.

Since it is inevitable that in the foreseeable future a large number of anaesthetics will be administered by dental practitioners, surely Dr. Hogg will agree that they should be adequately trained.—I am, etc.,

J. F. REEVES

Leicester

Beclomethasone Aerosol in Treatment of Non-specific Pulmonary Fibrosis

SIR,—A fat and apparently fit woman of 65 was found on routine chest x-ray to have multiple patches of evenly distributed, diffuse opacity in both lung fields. On direct questioning she admitted to breathlessness and some loss of weight over the previous six months. A diagnosis of interstitial non-specific pulmonary fibrosis was eventually confirmed at the Broomfield Chest Hospital after lung biopsy. By the time that the diagnosis was established she had become frankly dyspnoeic, and treatment was begun with 30 mg of oral prednisolone daily.

She began to feel better, but some 10 weeks later she was gaining excessive weight. There were purple striae and bruising on her arms and legs, florid facies and other signs characteristic of the Cushingoid state. Lung stiffness was still such that it would not have been advisable to reduce her steroid dosage, but a trained member of my ancillary nursing staff suggested at a practice discussion that beclomethasone dipropionate aerosol might conceivably be used instead.

Knowing more about the pathology, we were dubious. We felt that the aerosol would either be deposited on the alveolar epithelium or that, if some was absorbed, it would probably be carried into the blood stream. There was nothing to be lost in the attempt, however, and the patient was given a metered inhaler and instructed to continue with the oral prednisolone at the original rate for a further week while taking three puffs of the aerosol four times each day.

A week later she stated that she was feeling less breathless and her oral prednisolone was therefore reduced. Improvement has continued and we have been able to reduce oral prednisolone to 2.5 mg daily while the aerosol is now being taken at the rate of two puffs four times a day. The patient has now lost her Cushingoid appearance.

It is therefore clear that local diffusion occurs from the alveoli not only slightly into the blood stream but also, at a therapeutic level, into the interstitial fibrous tissue. This is an effective means of reversing fibrous degeneration. On reviewing sections of lung it does seem that a rather greater surface of interstitial tissue is in contact with the alveolar linings than with the capillary beds.

I should be interested to hear if any of your other readers have had similar experience of treating interstitial pulmonary fibrosis by means of metered beclomethasone dipropionate aerosol.—I am, etc.,

J. P. T. LINKLATER

Fingringhoe, Essex

Endocrine Disorders in the Elderly

SIR,—Dr. M. F. Green's statement (9 February, p. 232) that in treating elderly patients with thyrotoxicosis antithyroid drugs can be discontinued "when the disease remits, which is usually between one and two years after the onset" might be taken to imply that eventual remission is invariable. It would be more appropriate to say "if the disease remits," for, while it is well recognized that about 50% of patients with Graves's disease go into remission, as might be expected with what is probably an autoimmune disease, we know of no evidence that this ever occurs in toxic autonomous goitre ("toxic nodular goitre").

It is our experience¹ that with advancing age autonomous goitre becomes an increasingly common cause of hyperthyroidism and Graves's disease relatively less common. The actual proportion of elderly patients who are thyrotoxic because of autonomous goitre rather than Graves's disease may vary from area to area depending on factors such as iodine nutrition and pre-existing goitre. It is apparent, however, that the likelihood of remission after antithyroid drugs in the elderly is probably substantially less than 50%.—We are, etc.,

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¹ Vidor, G. I., et al., *Journal of Clinical Endocrinology and Metabolism*, 1973, 37, 901.

Foreign Doctors in London

SIR,—It is with regret that I read (*Supplement*, 1 June, p. 83) the statement reported to have been made by Drs. D. R. Cook and A. Elliott at the meeting of the General Medical Services Committee on 16 May.

It may appear regrettable to them that central London is getting depleted of British doctors because of the high cost of housing. But Dr. Cook's inference that foreign doctors who are coming in are able to do so only because they are used to a lower standard of housing appears unwarranted.

One can have views about foreigners but to express such views publicly at such a meeting might offend a large number of their colleagues throughout the country and is both divisive and a disservice to the profession. We expect moral leadership.—I am, etc.,

S. K. ROY

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