to an even more potent diuretic. This manoeuvre may produce temporary respite of the oedema but at the expense of further electrolyte derangement. It is with such clinical problems that the physician needs to be reminded that renal function (especially the concentration gradient in the medulla) is highly dependent on the ATPase activity, which is depressed in magnesium deficiency. Flogging the dying horse with more diuretics merely aggravates the magnesium deficiency and the renal dysfunction. Indeed, supplementation with magnesium infusion would correct the hyponatraemia and increase the urinary volumes.[1] Alternatively, reversal of the secondary rise of angiotensin II and aldosterone in these patients using captopril, which is also potassium- and magnesium-sparing, would show appreciable improvement.[2] The combination of these two therapeutic manoeuvres has yet to be tried.

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[1] Dyckner T, Wester PO. *Lancet* 1981;i:585-6.
[2] Montgomery AJ, Shepherd AN, Emslie-Smith D. *Br Med J* 1982;**284**:1085-6.

Alternative medicine: cost and subjective benefit in rheumatoid arthritis

SIR,—The fact that 60% of a series of 78 patients suffering from rheumatoid arthritis spent money on alternative medicine (4 December, p 1629) highlights the need for more effective conventional methods for treating this disease. The leading symptom in most cases is pain in the finger joints. This pain is usually located in the posterolateral ligaments of the proximal interphalangeal joints or the underlying synovium. The exact location of the affected tissues may be palpated with a small rubber ball fixed to the end of a ballpoint pen (the prodder). The pain is cured by injecting 0·2 ml of a mixture of triamcinolone acetonide suspension and lignocaine solution into the lesion.

The treatment may be repeated if adjacent ligaments become painful, which may occur after a pain free period of three to 12 months. In a large series of patients during the past 10 years I have not seen a single case of skin atrophy over an injection site. This is probably because the injection is always placed at the junction of ligament and underlying synovium.

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SIR,—Dr T Pullar and others (4 December, p 1629) do clinical medicine a great disservice by continuing to relegate acupuncture to the realms of alternative medicine, with the implication that it is some type of mystical folk medicine similar to the other practice they compare it with—namely, the wearing of copper bracelets.

It is true that the traditional practice of Oriental acupuncture is based on archaic concepts which most Western trained doctors find difficult to accept. In recent years, however, a number of clinicians have re-examined the subject, and contrary to the belief of Dr Pullar and others have found that it is possible to use acupuncture on a scientific basis by the application of modern principles of neurophysiology and anatomy.[1 2] It is for this reason that acupuncture for the relief of pain is becoming increasingly recognised as an accepted orthodox form of treatment both in hospital practice (including several well known teaching hospitals) and in general practice. Many of those interested in the subject are conducting controlled clinical trials and presenting papers to the recently formed British Medical Acupuncture Society.

It is, to say the least, unwise to pass judgment on acupuncture from the results of treatment in patients who have been self referred to medically non-qualified practitioners. For acupuncture to find its rightful place in clinical medicine assessment of its effectiveness should be made only when it has been used in carefully selected cases by doctors trained to use it in a scientific manner. In this context Dr Pullar and others should note that for a long time those who practise acupuncture discerningly have generally agreed that this particular form of treatment is not a panacea for rheumatoid arthritis in all of its various stages, and that the selection of suitable cases requires considerable experience and good clinical judgment.

May I therefore suggest that before influential clinicians pass judgment on this technique they should learn to practise it for themselves from someone with a scientific grasp of the subject. They will then be in a position to take part in well designed clinical trials, by which means alone can its effectiveness in the relief of pain from a variety of conditions be properly evaluated.

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[1] Mann F. *Scientific aspects of acupuncture*. London: William Heinemann, 1977
[2] Macdonald A. *Acupuncture from ancient art to modern medicine*. London: George Allen & Unwin, 1982.

Death from asthma in two regions of England

SIR,—The controversy over the use of systemic corticosteroids for treating asthma persists. The *BMJ* has published two articles with apparently opposing views, although, admittedly, the articles can in no way be compared. Dr A R Luksza and Dr D K Jones (30 October, p 1229) refer to two studies suggesting that systemic corticosteroids are ineffective in an acute attack; the British Thoracic Association (30 October, p 1251), among others, states that corticosteroids are in general underprescribed.

The studies on increasing death rates from asthma in the past 20 years have in no way resolved the problem adequately. A recent report from New Zealand[1] posed more questions than it supplied answers. If systemic corticosteroids have something to do with the increased death rate from asthma, as was suggested by Speizer and Doll[2] in 1969, it seemed a reasonable premise that avoiding this drug would prevent later troubles. Later studies have tended to show that corticosteroids have not contributed to the increased death rate. Nevertheless, the aforementioned premise was enough reason for me not to treat acute asthma attacks with systemic corticosteroids in those patients who had not received this drug previously. Further support for excluding systemic corticosteroids in the treatment of acute asthma attacks is supplied by McFadden, *et al*,[3] who concluded that hydrocortisone does not produce any immediate benefits in the treatment of acute asthma. To my knowledge there are no studies showing that the use of systemic corticosteroids prevents morbidity in asthma. I am aware that my view is contrary to the prevailing opinion, such as that expounded recently by Milner.[4]

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[1] Jackson RT, Beaglehole R, Rea HH, Sutherland D. *Br Med J* 1982;**285**:771-4.
[2] Speizer FE, Doll R, Heaf P, Strang LB, *Br Med J* 1968;i:339-43.
[3] McFadden ER, Kisir R, de Groot WJ, Holmes B, Kiker R, Visir G. *Am J Med* 1976;**60**:52-9.
[4] Milner AD. *Br Med J* 1982;**285**:155-6.

Peer review weighed in the balance

SIR,—The paper by Dr Richard Smith (30 October, p 1259) was an informative discussion of a neglected subject and could have been accepted by me were I its referee. But one aspect of it would have bothered me. Nowhere does the paper inform us of the source of the heat at this conference.

May it not have been because each referee was also an author? Like all of us each referee may have suffered rejection. The only hint of emotion is in the discussion of confidentiality and plagiarism. Were we close to the source of the heat here? Each may have suffered the experience of being rejected by the established authority on his subject. Worse still, though rarely, he may have had his hypothesis reworked and hastily published by the same person. Papers should never be sent to the prime authorities on the subject but rather to perceptive informed colleagues working close to, but detached from, the subject being evaluated. Even better, the decision can be made quickly by an informed editor or subeditor. Thus we could free ourselves from a considerable barrier to progress—the dead hand of established opinion. T H Huxley, aptly quoted in the leading article on this subject (30 October, p 1224), seems to agree.

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SIR,—The recent correspondence on peer review of papers submitted for publication (20 November, p 1501) suggests that the time has come to make a proper study of available methods. One randomly selected group of journals will receive papers without the names of their authors to avoid "big name" bias. The journal's editorial assistant, using a nom de plume for correspondence purposes, will set in motion a computer programmed by a faceless committee to select a panel of referees to review the paper. The referees will return their comments unsigned. There will be no further communication with the authors until they see, or do not see, their paper in print. This will be compared with an age, sex, and status matched selection of journals that operate in the glare of publicity; the authors of papers submitted to these journals will not only give their names but also their age, sex, degrees, honours, and hobbies. The editor will introduce himself personally to the authors and explain the reasons for his choice of referees, who will, of course, sign not only