ing a traumatic rupture of the rectum or colon. One of these died, aged 44, with an overwhelming infection associated with acquired immune deficiency syndrome three years after the event. Eight of the nine had old or concurrent syphilis with persistent raised reagin titres of more than 1/4, and I wonder whether the live treponemes in remote tissue such as the central nervous system might contribute to the depression of cellular immunity.

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Nurses and smoking

SIR,—In the article on nurses and smoking (15 January, p 233) it is not accurate to say that there has been a decline in the number of nurses who smoke. The small sample sizes of the projects used for this comparison are hardly representative of all nurses in this country.

Research at Surrey University, based on the replies of 35 830 nurses in England and Wales has shown that while 46% of male nurses smoke only 32% of female nurses do so. Thus only male nurses smoke significantly more than might be expected when compared with their counterparts in the general population. Female nurses present almost the same proportion of smokers when compared with their social equivalents.

Also, the statement "When asked why they smoked one third of the nurses in the sample surveyed . . . cited stress" is misleading. What is true is that one third of nurses who smoke say they do so to relieve stress.

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Dihydrocodeine for breathlessness in "pink puffers"

SIR,—I hope that your readers will not think it strange if I comment in anecdotal and personal terms on the article by Dr M A Johnson and others (26 February, p 675). A few years ago two of my "pink puffers" with intolerably severe respiratory disability, who had both previously been only occasional social drinkers, discovered that their exercise tolerance improved remarkably after one or two stiff whiskies. They were both so impressed by the efficacy of this treatment that their consumption of whisky steadily increased to more than a bottle a day. One of them was a senior civil servant and his feelings of guilt at becoming a chronic alcoholic prompted him to seek admission to a psychiatric hospital, where he died in misery and remorse from respiratory failure.

It is not impossible that dihydrocodeine relieves dyspnoea in "pink puffers" in much the same way as alcohol, and this prompts me to recount my personal experience with that drug (DF118). Some years ago I developed local osteomyelitis of the jaw secondary to a dental abscess and had to take large quantities of aspirin and codeine tablets for the relief of pain. I then developed a duodenal ulcer (which may or may not have been due to that treatment) and was advised to change my analgesic to dihydrocodeine. This was not particularly effective in relieving the maxillary pain, but it produced such a feeling of euphoria that I began to look forward eagerly to the next dose. Within a week or so I realised that I was becoming addicted to the drug and stopped taking it.

Although Dr Johnson and others advised their "pink puffers" to take only 15 mg of dihydrocodeine before exercise, which is probably harmless and non-addictive treatment, I wonder how many of their patients, particularly when the degree of emphysema becomes more severe, will be able to resist the temptation to take dihydrocodeine regularly in progressively larger doses. When that occurs they will have developed such a degree of tolerance to the drug (addiction is not a matter of great concern in patients with advanced emphysema) that it will cease to have any beneficial effect on exercise tolerance.

I frankly cannot believe that single doses of only 15 mg of dihydrocodeine (half of one DF118 tablet) can improve breathlessness by reducing ventilation secondary to a reduction in oxygen consumption. It seems much more likely that this drug, perhaps like alcohol, merely diminishes awareness of respiratory discomfort and thus allows the patient to exceed previous limits of exercise tolerance.

Any form of treatment which provides even minimal relief of breathlessness caused by chronic airflow obstruction is, of course, to be welcomed, but I believe that the authors should have emphasised more strongly the importance of ensuring that patients do not depart from the regimen they have recommended.

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Repeated renal failure associated with captopril

SIR,—We were gratified by the interest of Dr J C Mason and Dr P J Hilton (8 January, p 145) and Dr J F De Plaen and others (p 146) in our report of a patient with repeated renal failure associated with captopril. This child had previously undergone renal arteriography when hypertension became a problem and did not have any stenoses of the main renal artery. She did, however, have small stenoses on two small upper pole branches of the renal artery. Because of the biopsy finding of acute interstitial nephritis we did not believe that inhibition of the renin angiotensin system per se was responsible for the renal failure in our patient, and we have recently confirmed this hypothesis with the newly developed angiotensin converting enzyme inhibitor, enalapril (19 February, p 648). Blood pressure and renal function in this child have remained stable over 14 weeks of treatment.

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General practice in the year 2000

SIR,—In his article on general practice in the year 2000 Dr Alastair G Donald (26 February, p 689) begins by amusing me and ends by frightening me very badly. As long as the unilateral disarmers do not have their way all of us under 65 have a fair chance of living to see it, but if Dr Donald's Orwellian dream comes true I am not sure that I want to.

As it happens I take a lot of exercise, abstain from smoking and excessive consumption of alcohol, maintain a respectable weight, and pursue several hobbies; indeed, I have relentlessly advised countless patients along these lines. So I should qualify for "access to the full range of medical services free of charge." Free of charge? Nothing is free of charge. Even the beauties of nature, as we now know, have to be guarded and cherished at a price. If Dr Donald envisages the present National Health Service system of funding it is the patient as a taxpayer who pays. If he is denied medical services through failure to conform does he receive a rebate of tax and insurance contributions so that he can make other arrangements? Will it be possible to make other arrangements? Let us hope so.

Equally sinister is the suggestion that membership of the Royal College of General Practitioners by diploma should be mandatory thus raising the college to a position of absolute, monopolistic power. Well, we all know where that can lead to. In any case I do not believe that the skills and abilities required in general practice are demonstrable by examination, despite Dr Richard Hobbs's protestation in the same issue (p 693). Even he seemed to feel compelled to call it a "defence." In such an examination a computer would probably do better, and it is interesting that Dr Donald sees himself as being replaced by one, at least in part, but I think the patient's operation of it is likely to be dangerously misleading.

Finally, to what extent does the Royal College of General Practitioners merit such enormous authority? Certainly, its aims are worthy and it has done much to raise the standards of general practice, particularly in postgraduate education. Dr Donald's own contribution here deserves the highest praise and has been of incalculable benefit to myself and countless others. Less commendable is the welter of turgid verbiage and fatuous research that the college has generated. I think, however, that it is labouring on a false premise; to condense a generality into a specialty is such a contradiction in terms as to amount to absurdity.

It may be that Dr Donald, tongue in cheek, has depicted as the full bloom of general practice a Venus fly trap into which I have fallen headlong. But if he is serious I have to say that the flower may be impressive, but the aroma is repellent.

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Pregnancy in a patient on home parenteral nutrition

SIR,—In this short report on the successful completed pregnancy in a patient maintained on home parenteral nutrition, Mr J C Tresadern and others in their comment suggest that the inadvertent temporary reduction in energy intake during the first half of pregnancy may have resulted in the low birth weight of the baby (19 February, p 602). From the evidence of the effect of the Dutch famine on reproduction this explanation would seem unlikely.[1] Birthweight was not depressed in those infants whose mothers were exposed to the famine during the first half of pregnancy and nutritionally rehabilitated before delivery. For these women the energy content of the official rations was about 3·3 MJ (800 kcal)/day at conception, falling as low as 2·5 MJ (600 kcal)/day at the height of the famine.

It seems likely therefore that in this patient,

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