any drug, even if marketed for many years, should be reported: its motto is "when in doubt report."[5] We have done this. It is for others to decide its importance. We, however, still find the association of such a rare disorder with a drug used much less commonly than aspirin or multivitamin preparations a cause for concern and further vigilance, especially as three cases have been reported from Edinburgh alone. It is notable that other authors have also found this association worthy of comment.[6-10]

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Role of drugs in fractures of the femoral neck

SIR,—We are grateful for the helpful comments of Drs A J H Stevens and Cindy Mulrow and of Dr W J Boyce and Professor M P Vessey (May 17, p 1335). As we have emphasised, the aim of our study was to test two particular hypotheses—namely, that drugs which could disturb postural stability were associated with femoral neck fractures and that thiazide diuretics were protective. We are therefore reassured by the report of Drs Stevens and Mulrow that they too could find no positive association between fractures and drug use.

Dr Boyce and Professor Vessey suggest that our surprising finding of reduced drug prescribing to patients with fractures may be explained by the case series being biased towards less frail patients. We had considered this possibility but such a selection bias would have to be massive to reverse our conclusions. If one makes the extreme assumption that all of the 40 patients not included were being prescribed drugs then the number having drugs prescribed rises to 81 (57%) of 142 cases, a figure similar to the 56% found to be taking drugs in the General Household Survey. The selection of cases from general practices within a 10 km limit was dictated by the resources available (a bicycle) and there was insufficient time to search for the names of general practitioners when the case records were not immediately available.

The mean age of 78 years of the 40 patients not included was the same as that of the 102 other cases. We have now examined the case records of 23 of the 27 patients who were initially excluded because the general practitioner was not known. Of the 23 two lived beyond the 10 km limit and one had a femoral shaft fracture after a traffic accident. Four of the remaining patients lived in old people's homes and three others had sustained their fractures during acute hospital admissions. A drug history was available from the case records in 17 cases, and 10 patients were noted to be taking various drugs including frusemide (4), oral hypoglycaemic agents (3), prednisolone (1), phenytoin (1), and chlorpromazine (1). No patient was taking thiazide diuretics. While the excluded patients were possibly more frail than the original case series the difference in drugs prescribed was not impressive and not sufficient to reverse our findings.

Dr Boyce and Professor Vessey suggest that the more frail will be consuming many more drugs, but Drs Stevens and Mulrow say they did not find this to be true even though their patients with fracture were more frail than the controls. Their suggestion that many patients with fracture are frail and isolated to a point beyond being able to request drug treatment would certainly explain our findings and needs further study.

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**This correspondence is now closed.—ED, *BMJ*.

Vegetable consumption and acute appendicitis

SIR,—I was most interested in the paper by Professor D J P Barker and others (5 April, p 927) on the rates for acute appendicitis in England and Wales in relation to the consumption of different foods.

At the end of 1946 and during the first few months of 1947 the late Anand Pardhy was the graded surgeon and I was the graded physician in a casualty clearing station in Prome in southern Burma. During this period we admitted an unusually large number of patients with acute appendicitis, all Japanese troops from the surrounding camps. All the patients were operated on by Mr Pardhy, assisted by me. We were much intrigued by this "epidemic" and attributed it to a change in diet of the Japanese troops, who were receiving mainly British rations. I do not remember admitting a case of appendicitis in any other nationality during this period. Fortunately, there was a sort of fortuitous control: in the area around Prome there were many British, Indian, and Gurkha troops, as well as some locally raised battalions from the Chin Hills; yet it was only the Japanese who developed appendicitis. Obviously, no figures were available for the incidence of acute appendicitis in Japanese troops before their surrender in 1945 but their own medical officers were as surprised as we were by the large number of cases. In the 1950s the death rate from acute appendicitis in Japan was comparable to that in most Western European countries.[1] But, even if the incidence of acute appendicitis in a normal Japanese population in the 1940s were comparable to that of a British population, this would still not have accounted for the large number of Japanese cases in Prome and the absence of cases in other nationalities, particularly in British troops.

There may be two possible factors in the aetiology of acute appendicitis. Firstly, other things being equal, each population has an incidence which remains stable over some years (I am not discussing long term trends) and which can be related to dietary factors, notably the level of consumption of fibre. This has been ably and exhaustively studied by Burkitt and others. The second factor, of which our experience in Burma may have been an example, is a sudden rise in incidence associated with a major change in diet; whether this implies a reduction in intake of fibre as the cause is a matter for discussion.

Burkitt and Trowell stated that acute appendicitis became prevalent in Sudanese troops in Africa and in African troops in Singapore when they received British and American rations.[2] Evidence for a sudden decrease in incidence probably related to dietary change was given by Van Ouwekerk, who observed that in Dutch internment camps in Indonesia during the second world war appendicitis was practically unknown; the diet consisted of "rice in insufficient quantities, unprocessed vegetables, and practically without meat and fat."[3] Clearly there is some basis for the idea that a sudden change in diet may have a considerable and almost immediate influence on the incidence of acute appendicitis.

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High costs of medical insurance

SIR,—After five years' postregistration experience in hospital medicine and general practice I was horrified to learn that next year's subscription to my medical defence society of £336 exceeds my current monthly take home pay as a part time clinical medical officer by £6. As I pay over £200 a month to provide decent child care arrangements for my son there seems little financial incentive to continue practising medicine.

Two questions therefore have to be asked. (1) When insurance premiums are now so high why should increasing litigation costs be so heavily subsidised by the lowest paid? (2) Why are salary scales attained during hospital posts not taken into consideration when transferring to community health?

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Alternative therapy

SIR,—According to your summary of its report, the board of science working party on alternative therapy concluded that a randomised controlled trial would be "totally impossible" where "treatment was alleged to be necessarily different for each individual patient" (24 May, p 1407). If this were true then randomised controlled trials could not have been used in comparing such disparate forms of medical care as home or hospital care for myocardial infarction in which "for those kept at home treatment and the amount of activity allowed were decided by the general practitioners."[1,2]

Provided a single satisfactory outcome measure—for example, cured or not cured—could be defined patients could be randomly allocated to orthodox or alternative practitioners, allowing each to attempt their best treatment tailor made to that patient (though orthodox treatment could be standardised). The interpretation of the results of such a trial would inevitably be more complex than, for example, in a conventional fixed dose comparison of two drugs. Thus if a higher proportion of patients on alternative therapy than on orthodox treatment were clearly shown to achieve "cure" it would not follow that the whole range of