not stated, but when asked if this might have been due to unrelieved aortic stenosis they declined to comment. In addition, and as in the present report, most patients had significant residual aortic stenosis. Clearly these results are not as good as those which can be expected with current surgical techniques. The presenter of the French experience then went on to claim that he had not referred a patient for surgery for over a year. The mortality for this group, and the functional results, were not available. This widening indication for valvuloplasty in the absence of verifiable data and in the light of published surgical results over many years concerns us.

As a caveat we would like to point out from our own intraoperative studies that if this technique is to be used a balloon inflation time of one minute is not necessary, and is probably dangerous.⁴ Prolonged obstruction to ventricular outflow must result in further dilatation of an already overstretched myocardium. It has been known for many years that this may cause irreversible damage. Several of the reported deaths with this technique appear to have been due to this mechanism. We found that an initial inflation time of 15 seconds was sufficient to open the valve orifice by a measurable amount. Further short periods of inflation could then be used. This problem may in part be avoided by the use of trefoil shaped balloons.

We are anxious to join with Dr Jackson and colleagues to counsel against the uncontrolled and unrestricted spread of this procedure to the detriment of patients with aortic stenosis in Britain.

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SIR,—We agree with Dr Jackson and colleagues (10 January, p 83) that the experience of percutaneous transluminal valvuloplasty in patients with aortic stenosis does not support its widespread use in patients fit enough for the excellent alternative of aortic valve replacement; indeed, we believe that the authors do cardiac surgeons an injustice by quoting an operative mortality of 7-10% for this operation: in the series they cite there were only nine deaths in 190 aortic valve replacements in patients aged 65 years and older,¹ the operative mortality of 4.7% being very close to the British figure of 4.6% for all age groups in 1982 (unpublished data for 1984 show a slight further reduction to 4.1%).²

Our own experience with aortic valvuloplasty in 13 patients, aged 56-80, is encouraging, and, like the King's College Hospital group, we have some patients who are much improved, even asymptomatic, as long as nine months after the procedure. We have, however, encountered a number of important complications (table). The deaths occurred in patients in whom the procedure was attempted virtually as a "last ditch" manoeuvre in the treatment of intractable pulmonary oedema. Severe symptomatic hypotension was seen in four patients, two of whom became completely unconscious during each balloon inflation; clearly in some patients complete occlusion of the valvar orifice occurs, and in two such patients sympto-

matic hypotension was not prevented by the use of a Trefoil balloon, previously believed to allow continued blood flow during valve dilatation.³ Fortunately, we have not experienced the bursting of balloons frequently; this has happened only twice (one patient developed minor neurological symptoms that we assume were caused by air embolism, the inflation system being difficult to purge competently). The most worrying late complication was a stroke (which we assume was embolic in aetiology) in one patient 16 days after the procedure.

Complications related to aortic valvuloplasty in 13 patients

During procedure:		Early (first 24 h):	
Death	2	Bleeding from groin	2
Symptomatic hypertension	4	Femoral arterial occlusion	1
Burst balloon	2	Late:	
Perforation of left ventricular wall	1*	Stroke	1
		Claudication	1

*Successful pericardiocentesis.

As experience with the technique increases the true incidence of such complications will become apparent. The long term results of the procedure are unknown, but one of our patients, initially rendered asymptomatic for three months, recently reported a recurrence of symptoms and was referred for aortic valve replacement (he had previously refused surgery). We would heartily support the formation of an aortic valvuloplasty register to document the incidence of complications and symptomatic recurrence.

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Junior staff and waiting lists

SIR,—Dr C J O'Doherty (24 January, p 248) makes three recommendations for solving the problem of long waiting times for a dermatological outpatient appointment. Two are eminently desirable—better training of medical undergraduates and compulsory attendance in dermatological departments of those on GP vocational training schemes—so that more patients with skin disease can be managed by their GP and not need referral to hospital clinics. The third solution—more dermatological junior doctors—must be dismissed out of hand as unreasonable, impractical, and undesirable.

Nearly 60% of all newly qualified medical graduates in the United Kingdom currently intend to enter general practice. Nearly 10% of all new attendances in GPs' surgeries are for a skin problem. Nearly all medical schools in the UK devote little more than two weeks of the three year undergraduate medical curriculum to the teaching of dermatology. So it is not surprising that most GPs are ill equipped to deal with patients with skin disease. This is a disgrace and no credit to our highly regarded medical training. To state that it is no better in medical schools in other countries is no excuse. No doubt entrenched positions are adopted by those who teach in our medical schools

so that changing the time allotted to the different disciplines is resisted, but the deans of medical faculties must intervene and insist that adequate time is spent on dermatological teaching so that the public does not continue to be mistreated by inadequately trained doctors.

Once undergraduates have qualified attendance in dermatological units could be made part of the mandatory training for general practice by the Royal College of General Practitioners. Once they are fully trained as GPs further education is readily available in the form of postgraduate lectures and opportunities to observe in clinics and become members of Stiefel's skin fora in 50 centres.

The suggestion that more junior doctors should help with the problem is, however, totally unacceptable. If they were employed to help with new outpatients their services would be of no greater benefit to the patient than those already provided by the GP referring the patient to the clinic. To expect junior doctors to deal only with viral and seborrhoeic warts and to undertake procedures and biopsies would deter them from wanting to understand the problems of skin disease. In addition, an increase in the currently low ratio of junior to senior doctors in dermatology would be disastrous for the job prospects of those entering dermatology to become consultant dermatologists. The balance of posts is about right, and the present problem of finding a consultant post is the result of the large number of soft money research jobs in some professorial units, a problem that might soon be solved.

If long waiting times are a result of inadequately trained GPs referring too many patients then better training may solve this problem in time, but where outpatient referrals have risen because more patients require consultant advice then more consultant dermatologists are needed not more junior doctors.

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Mozart ear and Mozart death

SIR,—The paper by Dr Alex Paton and colleagues (20-27 December, p 1622) raises a crucial question: is there any significant relation between Mozart's "Mozart ear" and his terminal illness?

Mozart is thought to have suffered from a chronic kidney ailment and died from renal failure with a clinical picture of uraemia.¹⁻⁴ At the age of 28 he showed clinical signs of renal disease, probably pyelonephritis. From the age of 34 he showed increasing and accumulating signs of renal failure. He may have suffered from a terminal infection such as bronchopneumonia but one major immediate cause of death was the repeated blood lettings in a patient likely to be already anaemic.^{5,6} Mozart's physicians would normally draw up to three litres of blood over a week from patients suffering from severe terminal syndromes similar to his.⁶

His kidney condition is generally attributed to a hypothetical glomerulonephritis that he might have had in childhood after repeated episodes of upper respiratory tract infections.¹⁻⁴ But there is an alternate hypothesis that has never been mentioned: congenital anomalies of the urinary tract.

In 1957 Hilson showed that malformation of the ears may be a sign of malformations of the urogenital tract,⁶ and more recent publications have confirmed this association.⁷⁻⁹ Various malformations of the urinary tract have been described with this syndrome, such as renal agenesis, polycystic kidneys, pelvic obstructions, ureteral anomalies, etc.