require special training before undertaking this service. Again, diabetologists and ophthalmologists are strategically placed to provide education and training for all general practitioners who wish to do this work.

If all three issues are addressed there is no reason why the problems of comprehensive shared diabetes care highlighted by Dr Day and colleagues should not be overcome. This would allow consultant diabetologists to see patients with problems and give general practitioners rapid access to consultants when problems arise with the patients who are under their care.

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SIR,—We would like to take issue with some of the points raised by Dr J L Day and colleagues (20 June, p 1590). We broadly agree with them that major problems with diabetic care lie within general practice, which may partly be resolved by an up to date practice register of diabetics and protected time for clinics. We consider the study, however, to be unfair in its attitude to general practice.

Historically, most diabetics in a district have attended a hospital clinic. This has inevitably resulted in an assumption among patients that the condition may be monitored only by a hospital and that it does not warrant concern if followed up by a general practitioner. The experience in Sheffield, where a large proportion of diabetics discharged from the hospital clinic to general practitioners considered themselves to be "cured," exemplifies this.¹ Moreover, general practitioners feel unhappy and lack confidence about following up diabetics, because their closest experience with diabetics may be a preregistration appointment 10 or 20 years previously. The recent expansion in knowledge and changes in treatment cannot simply be communicated at postgraduate meetings but require close and constant contact with specialists. We entirely agree with the suggestion of Dr Day and coworkers that the practice nurse and diabetic specialist sister in miniclinics should play a part in such care, but we believe that close communication between diabetologists and general practitioners is a prerequisite for a truly comprehensive diabetic service.

Our recent experience in Newham is similar to that in Wolverhampton, where over a third of practices have joined a shared care service.² In our system the diabetologist sits with the general practitioner in a designated diabetic surgery as part of a longer term training process. Once the general practitioner is confident the consultant attends bimonthly and thereafter quarterly. Though the scheme is time consuming for those concerned, the improvement in the general knowledge of diabetic care throughout the district and the obvious enthusiasm of patients is beginning to pay dividends. We plan to report our first two years' experience of the scheme shortly.

The continuing high morbidity and mortality from diabetes mellitus despite major advances in treatment³ highlight the shortcomings in diabetic care. We congratulate the Ipswich group on their attempt to improve matters in their district, but,

by their own admission, their system of care cannot be considered to be comprehensive. We suggest that some criticism must lie at the door of the hospital rather than the general practice surgery, and we believe that the only way of achieving a comprehensive service for all diabetics is to break down the barriers between hospital and surgery. Any system that proposes to bypass the family doctor is doomed to failure.

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Cough associated with captopril and enalapril

SIR,—As Drs D M Coulter and I R Edwards comment (13 June, p 1521), angiotensin converting enzyme inhibiting drugs may increase concentrations of bradykinin and prostaglandins such as prostaglandin E₂ in the lung, compounds known to stimulate unmyelinated afferent C fibres in animals.^{1,2} This raises the possibility that stimulation of lung receptors other than rapidly adapting receptors in the larger airways may produce cough.

We have recently described the induction of paroxysmal coughing in humans with central intravenous injection of capsaicin (8-methyl-N-vanillyl-6-nonenamide), a fairly selective C fibre stimulant in animals.³ The short latency of this response (3-9 seconds) is consistent with its origin from juxta-pulmonary capillary receptors in the lung.⁴ Selective blockade of these receptors by inhalation of small particle size local anaesthetic aerosol depositing at alveolar level has been suggested as a means of testing the hypothesis that captopril and enalapril might cause cough by this mechanism in humans.⁵ Unfortunately, at least in animals, small particle size local anaesthetic aerosol is unable to block the effects of mass activation of C fibres with bolus injections of capsaicin,⁶ but the effect of such an aerosol on the less intense receptor activation that probably produces chronic cough with angiotensin converting enzyme inhibitors in humans might be worth trying.

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Intraregional variation in treatment of end stage renal failure

SIR,—Dr Maureen Dalziel and Mr C Garrett (30 May, p 1382) have usefully emphasised the serious variations in the North West Thames region in treating people with terminal renal failure. There is an unfortunate inverse relation between distance and acceptance of dialysis and treatment rate. Publicity via the *BMJ* may help to correct these major errors and reduce the premature deaths of about 200 people each year in this region alone.

I suspect that the authors may be correct when they suggest that information related to dialysis drops in proportion to the distance from a renal unit. For example, one patient from this hospital receiving continuous ambulatory peritoneal dialysis successfully referred for treatment his neighbour, who had been told by a consultant that no treatment was available for his terminal renal failure.

Dr Dalziel and Mr Garrett are correct in stating that treatment of end stage renal failure has traditionally been provided by teaching hospitals. A glance at the map of the North West Thames Regional Health Authority shows three renal units all tucked into the extreme south east corner. Happily, there is a small minimal care haemodialysis unit in Watford General Hospital and a dialysis unit is planned for Lister Hospital, Stevenage, perhaps to open before the end of 1988. If each unit is run at maximum capacity then it should be possible to offer all patients in this region dialysis when necessary. Until then many premature deaths from chronic renal failure will occur.

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Coping with sudden death

SIR,—Dr Eva Alberman's letter (6 June, p 1484) fills me with dismay as a police surgeon and a general practitioner. The fundamental mistake was for the patient's own doctor (or a partner) not to attend, believing that as he was not in a position to issue a certificate there was no point. The next mistake was for the emergency service to inform the uniformed branch of the police, who have no function in an unexpected death being dealt with medically.

My own procedure, having confirmed that the patient is dead and excluded violence, is to hear the story again from the relatives and offer them some words of comfort. I then speak to the coroner's officer, and between us we arrange the removal of the body in the most fitting way. I know that he may speak to the patient's own doctor the next morning in an attempt to avoid a post-mortem examination. I then spare a thought for the relatives, who may need a mild sedative or even hospital admission that night. I explain the coroner's functions and point out that a post-mortem examination does not necessarily mean an open inquest with headlines in the local papers. The next morning I may speak to the deceased's own general practitioner or even to the social services department.

Finally, the reason why two policemen attended was probably that one of them was a probationer. This may have been his first experience of death, and he may need some psychotherapy.

All this when there is "nothing to be done."

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