Treating claudication

Mr M C HOBDAV (Chelsea School of Chiropractic, London NW8 8EN) writes: Dr E Housley (28 May, p 1483) advocates avoiding traumatic chiropractic in the treatment of claudication. It would be a mistake to interpret from this that state registered chiropractors have nothing to offer in the treatment of ischaemic feet. Many state registered chiropractors have good links with vascular and diabetic clinics, are frequently the first to recognise and refer patients with severe vascular impairment, and are trained in the use of non-invasive vascular assessment techniques. I cannot speak for unregistered chiropractors, but the skills of registered chiropractors can and should be used to the full for the benefit of these patients.

Dr BRIAN MAURER (St Vincent's Hospital, Dublin 4) writes: In his otherwise admirable leading article Dr E Housley falls into the trap of regarding angina as a disease (28 May, p 1483). He argues that operation is contraindicated because angina limits life expectancy and the benefits of operation. Angina is a symptom, not a disease. Prognosis depends on the extent of the underlying coronary artery disease and in many patients is excellent. The symptom of angina can be relieved by appropriate medical or surgical treatment. To deny all patients with angina consideration for surgical relief of claudication is unacceptable and bad practice.

Treating the discharging ear

Dr R G WALKER (Glasgow G61 2SZ) writes: Mr R C Bickerton and others (11 June, p 1649) state that "a high proportion of doctors are unduly concerned about potential ototoxicity when the discharging ear also has a perforation and thus withhold topical treatment." Contrary to what the authors state, the latest edition of the *British National Formulary* is quite clear on the subject—it warns specifically against using topical preparations containing chlorhexidine, aminoglycosides, and polymyxins in patients who have a perforation of the tympanic membrane and advises doctors to make sure that there is no perforation before prescribing these preparations. This is also the advice of the Committee on Safety of Medicines. In the light of this advice I suggest that the general practitioners' concern is justified.

Mr H O L WILLIAMS (Royal National Nose, Throat, and Ear Hospital, London WC1) writes: Professor John Bain and Mr Ian Williamson (11 June, p 1617) rightly state that aural toilet is an important aspect of the management of otorrhoea. It is best performed with an operating microscope and microsuction apparatus. This is not practical in general practice, and using a head mirror, speculum, and cotton tipped probe offers a useful alternative. This is a skill which is not widely acquired in general medical training and even when performed well has limitations. Serous or purulent discharge is easily cleaned away, but the more important squamous debris with which it is often associated is more difficult to remove. The presence of otorrhoea implies inflammation of either the external auditory meatus or the middle ear with an associated perforation. Antiseptic or combined antibiotic and steroid ear drops are beneficial in such cases and should be used alone or with aural toilet if this is available.¹ Many cases respond well to this approach, and at the very least it will allow easier, less painful, and more effective aural toilet during any follow up consultations.

1 Picozzi GL, Browning GG, Calder IT. Controlled trial of gentamicin and hydrocortisone ear drops in the treatment of active chronic otitis media. *Clin Otolaryngol* 1983;8:367-8.

Messrs NEIL B SOLOMONS and GERARD J MADDEN (Royal Free Hospital, London NW3 2QG) write: Professor John Bain and Dr Ian Williamson (11 June, p 1617) state that "in acute otitis externa the discharge is usually mucoid and the tympanic membrane unaffected, whereas in chronic otitis externa the dis-

charge is usually purulent and may be associated with changes in the tympanic membrane." This is inaccurate as there are no mucus secreting glands in the external auditory meatus. In the discharging ear the presence of mucus usually indicates that there is a perforation of the tympanic membrane. The only exception is a condition known as granular myringitis, in which granulation tissue on the tympanic membrane produces mucus. This condition is an uncommon variant of otitis externa.

Penicillamine nephropathy

Dr C L HALL (Royal United Hospital, Bath BA1 3NG) writes: Drs Paul Emery and Gabriel Panayi (28 May, p 1538) draw attention to the 25-fold increased risk of toxic reactions, including nephropathy, that they observed during treatment with penicillamine or gold in patients who possess the HLA-B8 or DR3 alloantigen or who have a low sulphoxidation capacity for oral carbocysteine. Other workers have reported a lower, or even no, association of toxic reactions with HLA-B8 and DR3,^{1,2} and only half of our 54 patients (16 April, p 1083) with penicillamine or gold nephropathy possessed these antigens. The predictive power of HLA typing is insufficient to be of use clinically, and the same is likely to apply to a low sulphoxidation capacity. Furthermore, both tests are complex and expensive to perform. Penicillamine and gold are effective second line agents that continue to hold their place despite the introduction of several alternative drugs during the past decade. When faced with patients with aggressive rheumatoid arthritis few doctors would discard penicillamine and gold treatment on the basis of an HLA type or a low sulphoxidation capacity without a supervised trial to determine the efficacy and adverse effects of the drugs in the individual patient.

- 1 Dequeker J, VanWauhe P, Verdicte W. A systemic survey of HLA-A, B, C, and D antigens and drug toxicity in rheumatoid arthritis. *J Rheumatol* 1984;11:282.
- 2 Nuotio P, Nissila M, Ilonen J. HLA-D antigens in rheumatoid arthritis and toxicity to gold and penicillamine. *Scand J Rheumatol* 1986;15:255.

Anorexia nervosa and the elderly

Dr R H RATNASURIYA (Mental Health Services, Worthing District Health Authority, Worthing, West Sussex BN11 2HS) writes: Drs N Nagarathnam and D F Ghougassian (21 May, p 1443) say that there is little information about long term outcome in anorexia nervosa. A follow up study with a mean duration of eight years has been published on male patients.¹ There have also been two longer follow up studies of 20 years and more.^{2,3}

- 1 Burns T, Crisp AH. Outcome of anorexia nervosa in males. *Br J Psychiatry* 1984;145:319-25.
- 2 Theander S. Outcome and prognosis in anorexia nervosa and bulimia: some results of previous investigations, compared with those of a Swedish long term study. *J Psychiatr Res* 1985;19:493-508.
- 3 Ratnasuriya RH. Prognostic factors and outcome after 20 years in anorexia nervosa [MPhil Thesis]. London: University of London, 1986. 155 pp.

Cardiovascular risk factors

Dr ALLAN ST J DIXON (Coverack, Cornwall TR12 6TQ) writes: The usefulness of surveys of risks is to identify those who might be considered for preventive intervention. For this purpose negative risk factors are as important as positive ones. Treatment with oestrogens has been reported to reduce the relative risk of coronary heart disease in postmenopausal women to 0.3.¹ This suggests that oestrogen treatment is among the most important interventions available to reduce the risk of coronary heart disease in postmenopausal women, second only perhaps to stopping smoking. The studies by Dr J I Mann and others (18 June, p 1702) and Dr Alan Jones and others (18 June, p 1711) of risk factors for coronary heart disease in Britain offer no data on how many of the postmenopausal women were taking oestrogens or how many would be eligible for oestrogen treatment if it were generally available. It seems a missed opportunity, especially considering the reduction to 0.34 of the relative risk of fractures of the proximal femur, also an important

cause of morbidity and mortality in postmenopausal women.² The potential financial savings are also impressive.³

- 1 Stampfer MJ, Willett WC, Colditz GA, et al. A prospective study of postmenopausal estrogen therapy and coronary heart disease. *N Engl J Med* 1985;313:1044-9.
- 2 Kiel DP, Felson DT, Anderson JJ, et al. Hip fracture and the use of estrogens in postmenopausal women—the Framingham study. *N Engl J Med* 1987;317:1169-74.
- 3 Wrem BG. Cost effectiveness of hormonal replacement therapy. In: Zichella L, Whitehead M, Van Keep PA, eds. *The climacteric and beyond*. Carnforth: Parthenon, 1987:55-62.

Sunbed lentigines

Drs HYWEL C WILLIAMS, JUDITH BRETT, and ANTHONY DU VIVIER (Department of Dermatology, King's College Hospital, London SE5 9RS) write: Drs B L Diffey and P M Farr (21 May, p 1468) have misrepresented us by suggesting that we have implicated ultraviolet B radiation in the induction of sunbed lentigines. We stated quite clearly in our conclusions that these lentigines were related to the patient's excessive exposure to ultraviolet A. Drs Diffey and Farr expressed surprise at our statement that sunbeds are relatively ineffective at producing a tan. We chose to quote two well controlled studies in which independent assessment of tanning was performed.^{1,2} We did not quote Diffey's study because this was a questionnaire based survey³ and there was only a 34% response rate, which we consider to be too low for any satisfactory conclusion to be drawn.

- 1 Devgum MS, Johnson BE, Paterson CR. Tanning protection against sunburn and vitamin D formation with a UV-A "sunbed." *Br J Dermatol* 1982;107:275-84.
- 2 Rivers JK, Norris PG, Murphy GM, et al. Effects of UVA sunbeds in human subjects. *Br J Dermatol* 1986;116 (suppl 30):426.
- 3 Diffey BL. Use of UV-A sunbeds for cosmetic tanning. *Br J Dermatol* 1986;115:67-76.

Management of asthma in hospital

Dr A G ARNOLD (Hull Royal Infirmary, Hull HU3 2JZ) writes: Dr C E Bucknall and others (11 June, p 1637) state that theirs is the first prospective survey of management of asthma in hospital to be recorded. I draw their attention to our similar study eight years ago.^{1,3} Their findings resemble ours, and it is disappointing to find that there has been no great improvement in management during the intervening period despite continued attempts to educate the medical profession and patients about asthma. Our own study extended into general practice, where similar patterns of apparently suboptimal management were observed.

- 1 Arnold AG, Lane DJ, Zapata E. The speed of onset and severity of acute severe asthma. *Br J Dis Chest* 1982;76:157-63.
- 2 Arnold AG, Lane DJ, Zapata E. Acute severe asthma: factors that influence hospital referral by the general practitioner and self-referral by the patient. *Br J Dis Chest* 1983;77:51-9.
- 3 Arnold AG, Lane DJ, Zapata E. Current therapeutic practice in the management of acute severe asthma. *Br J Dis Chest* 1983;77:123-35.

Cervical cytology screening

Dr L S LEWIS (Newport, Dyfed SA42 0TJ) writes: Professor Alwyn Smith (11 June, p 1670) marshals an unassailable argument that current cervical cytology screening in Britain is absurd. I fear, however, that the screening juggernaut has too much momentum to be halted now, except perhaps by government auditors. In my own low risk rural practice of approximately 2000 patients cervical screening is well up to date. Young women are recalled by regional computer every three years, whereas older women wait five years. Cytology is not reported until three months after the test because of laboratory overload. Of 86 women screened during the past six months, 13 are still awaiting a report and 14 have been given abnormal reports requiring an immediate repeat test or referral for colposcopy. Contrast this with an expected death rate from cervical cancer among my 2000 patients of one every 13 years. No amount of screening of young women will be nearly so cost effective for the nation as the more genuine preventive measure—free condoms on the National Health Service.