

patients), carnitine palmitoyl transferase deficiency, and a fatty acid oxidation disorder. In none of these was dialysis needed, and the renal failure resolved on conservative treatment. A further patient has had recurrent episodes of muscle pain with myoglobinuria and raised creatine kinase activity without any evidence of renal failure. In this case we have been unable to make a specific diagnosis so far.

In view of the wide range of conditions which may precipitate myoglobinuria we recommend that all patients presenting with this abnormality should have a muscle biopsy performed, even when the diagnosis is apparently clear cut.<sup>2</sup> This obviates a problem that can occur if the patient presents some years later with an imprecise initial diagnosis and muscle weakness that could be a consequence of excessive steroid treatment. In the absence of a precise initial diagnosis and baseline assessment management is extremely difficult. In patients like the authors' third case there is an enormous range of potential causes which should have been excluded, particularly as the treatment might have been different.<sup>3</sup>

We use the percutaneous needle or conchotome technique for biopsy, which allows safe, easy, and repeatable access to muscle tissue.<sup>2</sup> The main advantage of percutaneous techniques is that adequate tissue is obtained for nearly all diagnostic purposes with minimal scarring and discomfort. Furthermore, in cases of diagnostic doubt additional biopsy specimens can be obtained for biochemical screening for some of the rarer muscle metabolic diseases. In proved cases of polymyositis where weakness persists or worsens despite steroid treatment further muscle biopsy may allow a diagnosis of steroid myopathy to be made when on clinical grounds a decision might be made to increase the steroid dose.

We agree that it is important to monitor respiratory function in any patient presenting with acute muscle weakness but would like to emphasise the importance of measuring skeletal muscle function more accurately than is possible clinically. We measure muscle force objectively using a strain gauge.<sup>4</sup> We agree that apparent haematuria may indicate the presence of myoglobinuria, but the underlying causes of this are more numerous than indicated in the article.

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## "Plan for Action"

The past few years have seen much effort by politicians, the medical profession, and hospital administrators to solve the difficult manpower equations of hospital medical staffing. This has culminated in *Achieving a Balance* and the more specific proposals in *Plan for Action*.<sup>1,2</sup> The important factor of early retirement has at last been considered. The DHSS has previously evaded the issue despite approaches by the profession over the years.

A reduction in the length of career service of consultants would have an immediate and long lasting effect on the manpower situation by increasing the annual number of consultant

vacancies. Reducing the age of retirement to 60 or 62 would provide an extra five or six vacancies annually in general surgery. Aside from manpower consequences there are other sound reasons for an earlier retirement. A time has been reached when the career service of many consultants has been covered completely by the superannuation scheme, and some of them have purchased added years. If their pension state is such and their personal circumstances permit they can choose voluntary early retirement. This is a hidden factor that does not seem to have been taken into account in manpower calculations.

In 1985 the specialist advisory committee in general surgery, under my chairmanship, surveyed the retirement plans of general surgeons over the age of 50 in seven regions in England and Wales. We found that about half of them had made definite plans to retire at 60 or soon after. Those who were not definite but thought it likely were excluded from the count. Voluntary early retirement was thus a popular course of action and at this rate would mean an immediate bulge of about 15 extra consultant general surgical posts annually for about five years, with fewer thereafter if the trend continued among junior colleagues as seems likely.

It is encouraging that early retirement has now been recognised officially as contributing to the solution of the manpower equation but, alas, not without "strings" being attached. When the new proposals are explored serious limitations and concerns are uncovered. The granting of early retirement will be entirely at the discretion of central and peripheral administrators and committees. The plan is thus for discretionary, not voluntary, early retirement. There is the attraction of enhancement of pension service by up to 10 years to a maximum of 40. Is this to be a "golden handshake" to us all for long and faithful service to the NHS? It will not be so for many consultants who have been prudent in improving their pension prospects by the purchase of added years. Under the enhancement proposals added years are to be included in the reckoning of total pensionable service. Thus those retiring in their early 60s may equal or exceed the maximum of 40 years and will not qualify for any enhancement.

The "golden handshake" will apply only to the chosen few who have had a shorter length of service to the NHS or have not invested in pension improvements. Those with longer service who have been prudent in the past will be left to count the cost of subsidising their more fortunate colleagues. An unjust flaw has been exposed which requires further consideration.

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- Department of Health and Social Security, Joint Consultants' Committee, chairmen of regional health authorities. *Hospital medical staffing: achieving a balance*. London: DHSS, 1986.
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\*\*The secretary writes: "Although the usual retirement age in the NHS is 65, retirement at 60 is not usually considered to be 'early' retirement as it does not require any special arrangements or agreement by the health authority. It was always known that discretionary early retirement with enhancement would offer greater advantages to some than others, and the Central Committee for Hospital Medical Services fought hard to obtain special provisions such as compensation for added years purchased. Such provisions, however, were not obtainable, and it was ascertained that of the consultants who had bought added years only 3% would stand to gain no benefit from the new scheme, 46% would gain partial benefit, and 51% would gain full benefit. It was therefore thought that the scheme was a valuable contribution to

alleviating the manpower problems and should be welcomed as such."—Ed, *BMJ*.

## Children in Third World slums

The recommendations of Dr William A M Cutting and Professor Gopa Kothari (18 June, p 1683) are laudable and realistic in the context of the attitudes of many governments in developing countries. I studied infant nutrition in southern India, and some of my findings may help to identify the most expedient avenues for input of resources in other regions.

At a non-government district hospital in Kottayam District, Kerala, 52 consecutive attenders with children aged 6-12 months were interviewed in the paediatric outpatient department. The mean age of the women was 27.2 years, and their mean number of children was 1.8 (virtually identical with findings of a survey of women from all social classes in Blaydon, Tyne and Wear, England). In Kerala 92% of mothers were still breast feeding their babies when the mean age of the babies was 8.5 months. Solids were introduced at an average age of 4.6 months. Thus traditional breast feeding and weaning practices have been retained despite the change to more "Western" practices for age at childbirth and size of families.

The infant mortality in Kerala has fallen to 26/1000 compared with the average of 115 in India as a whole. (In some states it exceeds 150/1000.) These changes in infant mortality and child rearing practices coincide with and are attributed to the greater amount of education of women in Kerala compared with the average in India. In this study 75% of the women had completed secondary school and 93% had attended school up to the "seventh standard" (that is, for seven years). These values are similar to the officially estimated 95% literacy rate for the younger generations in Kerala. Kerala is below the Indian averages for per caput income and health expenditure. Education spending is substantially different from that in the rest of India—86% of the total education budget is allocated to primary and secondary education whereas in the rest of the country 47% of the total outlay goes towards universities, providing an education enjoyed by only 0.02% of the population.<sup>1</sup>

The widespread education of people in Kerala has increased their awareness of health issues, and better education makes cooperation and enthusiasm for preventive medicine more feasible. Health changes in a developing country can be achieved by concentrating limited resources on primary and secondary education, and, as Dr Cutting and Professor Kothari suggest, the education should be made appropriate and practical.

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## Correction

### BRL 26830A and weight loss

An error occurred in this letter by Dr J F Munro and others (18 June, p 1737). The fourth sentence of the second paragraph should read, "The results of this study were at variance with those obtained by Zed *et al*, which were reported at the same time,<sup>1</sup> and the possible reasons for this variance have been discussed."

- Zed CA, Harris GS, Harrison PJ, Robb GH. Anti-obesity activity of a novel  $\beta$ -adrenoceptor agonist (BRL 26830A) in diet-restricted obese subjects. *Int J Obes* 1985;9:231.
- Munro JF, Chapman BJ, Robb GH, Zed C. Clinical studies with thermogenic drugs. In: Berr EM, Blondheim SH, Eliahou HE, Shafirif E, eds. *Recent advances in obesity research: V*. London: John Libbey, 1988:155.