Elementary barefoot waterskiing

caused a tottering, wide based gait inclined forward at 20 degrees during rare periods of ambulation. I resembled someone who had just got off his horse walking into a force eight gale.

Massive muscle breakdown

Tests of renal function were taken four days after the incident. All electrolyte concentrations were normal, but the measurements of muscle breakdown aspartate transaminase and creatinine kinase were 1540 IU/l (normal 2-40 IU/l) and 45 860 IU/l (normal <170 IU/l)

respectively, indicating massive muscle breakdown. Death from acute tubular necrosis because of traumatic myolysis has resulted following concentrations of creatinine kinase as low as 3500 IU/l.⁵ The creatinine clearance as a result was 148 ml/min.

Friday saw some recovery as I was now able to stand unsupported for up to five minutes at a time. The urine had returned to a normal colour and I was able to put my socks on (with difficulty).

I had clearly "pulled" a large mass of muscles in my chest, shoulders, and abdomen caused by my strenuous efforts to stand on the water and the prolonged high speed battering while in the water. Massive release of myoglobin occurred as it does in the crush syndrome,⁶ and there was a risk of blocking the glomerulus of the kidney with the sequelae of acute tubular necrosis. Fortunately, this was avoided. This potentially severe injury has not been previously reported in barefoot waterskiing yet is a real possibility given the speed and trauma that the torso suffers as it is pulled through the water. Adequate body protection must be worn and repeated exposure to many high speed attempts should not be permitted.

Doctors are often accused of playing God in their dealings with patients. This is one orthopaedic surgeon who will no longer attempt to walk on water.

- 1 McCarthy GF. Hazards of waterskiing. *Med J Aust* 1969;1(9):481.
- 2 Paterson DC. Waterskiing injuries. *Practitioner* 1971;206:655.
- 3 Morton DC. Gynaecological complications of waterskiing. *Med J Aust* 1970;1(25):1256.
- 4 Ramey JR. Intrarectal tear with bleeding from a waterskiing accident. *J Fla Med Assoc* 1974;61:162.
- 5 Lonka L, Pedersen RS. Fatal rhabdomyolysis in a marathon runner. *Lancet* 1987;ii:857.
- 6 Bywaters EGL, Beall D. Crush injuries with impairment of renal function. *BMJ* 1941;ii:427.

Diet, diabetes, and male chauvinism

C S J Probert, W Maddison, J M Roland

We have suspected that diabetic men receive more support from their wives than diabetic women get from their husbands. Patients attending our diabetic clinic are often accompanied by their spouses. Patients' wives often contribute to dietary histories and tend to say "our diet" and "we eat," suggesting that diabetic men and their wives eat the same food. We report an investigation of the effect of diabetes on the diet of the patients' spouses.

Patients, methods, and results

We asked 58 consecutive married patients attending our diabetic clinic to complete a questionnaire and requested that they ask their spouse to complete an identical questionnaire. Patients whose spouses were diabetic or ate other "special" diets were excluded. Age and sex matched controls were recruited from a general medical clinic in a similar manner.

The questionnaire required the subject to tick a box against a food item if he or she ate it at home or elsewhere. A total of 63 items containing varying amounts of sugar, fibre, and fat were arranged at random.

The analysis compared the number of items that couples chose differently. The discordant items were counted to give a discordance score for couples in whom the woman was diabetic and for those in whom the man was diabetic and for their corresponding control couples. These scores were compared by Student's *t* test.

In all, 56 control questionnaires were returned; 51 were complete. They were matched with completed case replies (28 diabetic men and 21 diabetic women). The cases and controls were well matched for age (age range 31-73 for diabetic men, 28-74 for controls, SD 2.6 years; age range 26-73 for diabetic women and controls, SD 4.1 years). Fifteen men and 15 women were receiving insulin. The discordance scores for couples in which the woman was diabetic were compared with those in control couples ($t=3.2$, $p<0.001$) and the scores of couples in which the man was diabetic were compared with those in control couples ($t=0.46$, NS) (table).

Mean (SD) discordance scores with respect to food items eaten by couples in whom the man or woman was diabetic and their matched control couples

	Case couples	Control couples
Man	13.8 (7.0)	13.0 (6.1)
Woman	17.0 (7.4)	10.6 (5.5)

Scrutiny of the questionnaires satisfied us that the similarity in the couple's diet in the diabetic man's home is because both members are eating "diabetic" diets.

Retrospective analysis of the attendance at our diabetic support and discussion group over 10 months showed that diabetic men were more likely to be accompanied to the groups by their spouse than were diabetic women (63/77 men compared with 12/70

Peterborough District Hospital, Peterborough, Cambridgeshire PE3 6DA
C S J Probert, MRCP, registrar
W Maddison, RGN, diabetes nurse specialist
J M Roland, DM, consultant

Correspondence to:
Dr C S J Probert, Leicester General Hospital, Leicester LE5 4PW.

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women; $\chi^2=61.3$, $p<0.001$). This lends support to the hypothesis. These data could, however, be biased by the meetings having been held at times more convenient to women.

Comment

We found that there is no more dietary discordance between wives and husbands when the man is diabetic than in control couples. When a woman is diabetic her husband is less likely to eat the same food as her. This suggests that the wife of the diabetic man adopts his diet, whereas the husband of the diabetic woman does not. The wife of the diabetic man possibly takes on his diet to support and encourage him. Schafer *et al* have shown that lack of family support may be related to reduced adherence to regimen and poor control.¹

Other explanations for the wives' eating pattern are available. The bias may originate with the dietitians, who, in assuming that the woman in the couple will be preparing the food, directs the dietary advice to the wife of the diabetic man, thus appearing to suggest to her that she should eat the same as her husband. The wife may find it easier to cook diabetic food for herself as well as for her diabetic husband. The converse does not seem to occur, possibly reflecting the unwillingness

Jack Sprat had to watch his diet—with the help of his wife

of a man to eat his wife's "special" diet, or perhaps reflecting female altruism.

In conclusion, male chauvinism may play a part in the way that women seem to support their diabetic husbands better than men support their diabetic wives.

¹ Schafer LC, McCaul KD, Glasgow RE. Supportive and nonsupportive family behaviours: relationship to adherence and metabolic control in persons with type 1 diabetes. *Diabetes Care* 1986;9:179-85.

A trip to Jersey with a ventilator

R D Croft

All children love a seaside holiday and I recently learnt that it is possible to provide a worthwhile seaside holiday for even the most severely disabled and dependent youngsters.

Every summer Chailey Heritage arranges holidays for parties of disabled children. Last year a group of four severely disabled youngsters spent a week in Jersey accompanied by nine nursing staff and me. All four were confined to wheelchairs, although Corrine, aged 15, with severe cerebral palsy, can take a few steps assisted by one or two helpers. Christopher, aged 8, is paralysed from the neck down and has to be mechanically ventilated via a tracheostomy. Victoria, 13, and Vicki, 19, both have spastic quadriplegia. Vicki in addition has a tracheostomy and gastrostomy. Our minibus went ahead by boat with an advance party of nurses and the equipment. The main party went by

air; we needed an extra seat in the aeroplane for Chris's battery driven ventilator.

It had not been easy to find a suitable hotel. The rooms had to be at ground level with easy access for wheelchairs. We also needed a room with an electric power point for Chris's ventilator. This facility is not provided in holiday camp chalets, which meant that we were limited to a hotel holiday. Some hotels had politely declined; perhaps they thought that people on holiday don't wish to see handicapped people in wheelchairs. The hotel that accepted us made us welcome in every way, and we did not seem to bother the other guests at all. I had initially suspected that our expedition was slightly overstaffed. Two nurses took turns at night duty, mainly to watch over Christopher, leaving two staff members for each disabled youngster by day. It took two people up to an hour each morning to bath, toilet, and dress and equip each disabled young person. Feeding, entertaining, handling wheelchairs across beaches and theme parks, giving gastrostomy feeds, and other nursing procedures easily occupied eight staff members by day. We made daily trips in our minibus to places of interest—the zoo, shops, theme parks, a model farm. Shopping for pearls was popular with the girls, while at the model farm Victoria and Christopher had a ride in a hay cart pulled by a shire horse. The other passengers were friendly and not at all alarmed at sharing a ride with a child who was being hand ventilated. Christopher also had a donkey ride, with a nurse on one side to support him and another on the other side to ventilate him. We feel this may be a record of some kind.

This was my first experience pushing wheelchairs in public. I was surprised to find how self conscious I felt. I can only guess at how a disabled person feels. The public mostly ignored us politely, but a few people stared, sometimes in a rather hostile way. One woman barged us in a shop queue but was soon disposed of with a jab from a wheelchair. I learnt that it is

North Chailey, East Sussex
BN8 4EF
R D Croft, MRCP, clinical
medical officer

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Christopher being ventilated in his sand car