In answer to Dr. R. M. Robertson (7 December, p. 642) 8 out of 48 patients (16.7%) who were not known diabetics showed glycosuria at some time prior to operation. However, Jackson *et al.*[8] have reported that "glycosuria is commonly intermittent, even in untreated diabetics, is often absent when hyperglycaemia is present and is not a good screening test even after a glucose load." It was for this reason that we have not stressed glycosuria data. Since the data from this study became available it has increasingly become the clinical practice of the urological surgeons of this hospital to perform a glucose-tolerance test in the preoperative assessment of patients with prostatism.

The clinical observation that cardiovascular disorders are frequently associated with prostatic hyperplasia was made in the last century by Sir Benjamin Brodie,[9] who wrote: "When the hair becomes grey and scanty, when specks of earthy matter begin to be deposited in the tunics of the artery, and when a white zone is formed at the margin of the cornea, at this same period the prostate gland usually—I might perhaps say invariably—becomes increased in size."—We are, etc.,

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Rejection on Medical Grounds

SIR,—I recently saw a man who had been promised a job "subject to medical examination." After the examination he was told that the firm was extremely sorry that he could not be appointed because his blood pressure was above the limit laid down. He had never been ill, was symptom-free, had no cardiac enlargement, and his blood pressure varied between 180/105 and 160/95. He had set his heart on this job and was profoundly despondent about his future, fearing that as one firm had turned him down because of his blood pressure other firms would do the same.

I have advanced the view[1] that leaving aside those such as bus drivers whose illnesses may endanger others—this kind of medical rejection is a monstrous injustice and should be forbidden by law. Those who are rejected because of creed, colour, race, or sex can at least appeal to some organization; those rejected medically are helpless.

As a profession we often complain about bureaucratic interference in the doctor–patient relationship. Yet some of us so distort that relationship that we harm the patient in the supposed interests of a prospective employer. Those who do so appear to observe the following modification of the Hippocratic Oath, "The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong, unless I am examining them on behalf of an employer, when the welfare of the patient shall count for nothing, and the interests of the employer shall be my sole concern."—I am, etc.,

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Prevention of Lumbar Puncture Headache

SIR,—I note that Dr. H. Aziz and others (December 14, p. 677) have not found vasopressin to be effective prophylactically in post-lumbar puncture headache. If I recollect correctly, it has been advocated that after lumbar puncture patients should lie prone for at least 24 hours, with one flat head pillow. The rationale appears to be that the spinal extension so produced helps to close the thecal puncture hole, while flexion tends to keep it open. I cannot quote my authority for this simple, safe, and rational suggestion, and would welcome any references.—I am, etc.,

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Neurogenic Intermittent Claudication

SIR,—"Intermittent claudication simply means intermittent limping, but it has become a term specifically applied to the interference with exercise caused by pain from an ischaemic muscle. Therefore one can designate a pain as intermittent claudication only if it is produced by exercise and relieved by rest."

This is the opening paragraph of an article in "Medicine Today" (7 December, p. 630). It implies that occlusive arterial disease of the legs is the sole cause of intermittent claudication. There is no reference to the neurogenic causes of intermittent claudication through narrowing of the lumbar spinal canal by a chronic disc prolapse or spondylitic bar. These have been so well described in your own, as well as in other journals, and can mimic the syndrome produced by chronic arterial disease so closely, that the differential diagnosis may depend upon myelography as much as upon aortography.[1–6] When correctly diagnosed, neurogenic intermittent claudication can be completely relieved by laminectomy. Why therefore ignore it?—I am, etc.,

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Hyperpyrexia during Anaesthesia

SIR,—It has been suggested by Dr. P. J. Horsey (28 September, p. 803) that malignant postoperative hyperpyrexia is related to postoperative halothane shivering, and indeed both conditions are associated with muscular rigidity of unknown cause and with anaesthesia. Furthermore, the degree of muscular rigidity occurring after halothane anaesthesia may be extreme.

We have made some observations on postoperative halothane shivering and agree with Dr. Michael Johnstone (19 October, p. 184) that methylphenidate (Ritalin) is effective in suppressing shivering occurring during emergence from a halothane anaesthetic.

In 1967 we were looking for some means of controlling the latter condition, and at that time the weight of the evidence seemed to support an association between a fall in body temperature during anaesthesia and the occurrence of shivering during the recovery phase.[1] The evidence for this was not conclusive, but we conducted a pilot trial using intravenous ethyl alcohol, which we have found effective in producing vasodilatation and suppressing shivering during controlled hypothermia.

We found alcohol of no benefit as a treatment given as a 15% solution in normal saline intravenously in doses of 40–50 ml. in six cases of established shivering; nor was it of benefit prophylactically. Of 16 patients given the same dose of alcohol as an intravenous infusion in the immediate postoperative period five developed marked shivering.

It has been reported that methylphenidate is effective in suppression of shivering from many causes.[2] We gave it in a dose of 20 mg. intravenously to 34 patients who had developed shivering following a halothane anaesthetic. It was effective within two minutes in every case. Other effects noted included flushing, a rise in pulse and respiratory rate, occasional slight rises in blood pressure, arousal, and two instances of vomiting. The last effect had been related to speed of injection.[2]

The effect of methylphenidate on post-halothane muscular rigidity is so dramatic that it would be of interest to study its action in cases of malignant hyperpyrexia.—We are, etc.,

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Eating and Corticosteroid Levels

SIR,—I have found that the concentration of 11-hydroxycorticosteroids (11-OHCS) in plasma of healthy men and women is usually quickly increased to up to 300% of its initial level by lunch. Less pronounced increases were found after glucose, alcohol, and unsweetened white coffee. Intravenous infusion of ethyl alcohol was recently reported to increase the plasma 11-OHCS (29 June, p. 804).