doctors. The management committees of hospitals will also substantiate this figure.

The Merrison Committee has acted as prosecutor, jury, and judge of the overseas doctors, who now constitute 16% of general practitioners and 40% of junior hospital doctors in Britain. It is felt that the committee has given in to the pressure groups who wish to restrict immigration of doctors for political reasons. It is well known that there has always been a vocal group who felt that their bargaining position was weakened by the presence of overseas doctors here.

Is it too much to expect the Department of Health and Social Services and the BMA to dissociate themselves publicly from these findings?

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¹ Report of the Committee of Inquiry into the Regulation of the Medical Profession, Cmnd 6018. London, HMSO, 1975.

Miliary tuberculosis presenting with polymyalgia rheumatica

SIR,—Dr C R McGavin's letter (4 October, p 44) asks for a clarifying reply. The term "polymyalgia rheumatica" literally means "many aching muscles"; these are normally central and proximal limb muscles mainly around the limb girdles, and the presence of the syndrome is confirmed when the appropriate spinal and proximal muscles or joints are found to be restricted. The syndrome has many causes, most of which produce elevation of the erythrocyte sedimentation rate (ESR). In the case described (miliary tuberculosis) the syndrome was suspected from the history and signs before the ESR became elevated. Once its cause was found to be widespread tuberculous infection steroids were not indicated and not given. The symptoms and signs resolved following a course of antituberculosis therapy.

The fact that polymyalgia rheumatica is a syndrome with many causes needs emphasis. As many patients arrive in clinics without blood test results it is preferable to confine definition of the syndrome to its clinical features.

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Renal stones and coronary heart disease

SIR,—Coronary heart disease and renal stones are both disorders increasing in frequency in the Western world, to some extent presumably owing to the raised standard of living. An association between the two diseases has been reported, with a higher stone prevalence in patients with myocardial infarction.^{1,2} Risk factors for coronary disease have not been systematically investigated in renal stone formers, but raised serum cholesterol¹ and high blood pressure³ have been reported. Over-consumption of vitamin D has also been suggested as a precipitating cause.²

In a health survey of more than 2000 middle-aged men in Uppsala, Sweden, 13.7% were found to have a history of previous renal stone disease.⁴ Some of the clinical and laboratory findings in stone

	Stone formers	Controls
Serum cholesterol (mmol/l)	6.1 ± 1.1	6.0 ± 1.0
Serum triglycerides (mmol/l)	17.5 ± 10.0	17.9 ± 11.1
Serum urate (mmol/l)	0.25 ± 0.06	0.26 ± 0.06
Glucose tolerance (K value)	1.78 ± 0.70	1.68 ± 0.69
Weight index (actual/ideal weight)	1.09 ± 0.15	1.09 ± 0.13
Systolic blood pressure (mm Hg)	134 ± 19	131 ± 15
Diastolic blood pressure (mm Hg)	85 ± 12	83 ± 10

Conversion: SI to traditional units—cholesterol: 1 mmol/l $\approx$ 38.6 mg/100 ml; triglycerides: 1 mmol/l $\approx$ 88.5 mg/100 ml; urate: 1 mmol/l $\approx$ 16.8 mg/700 ml.

formers and their matched controls are listed in the table. Only in diastolic blood pressure was a significant difference found ($P < 0.05$). This was primarily due to a greater number of individuals in the highest ranges. Thus 7.4% of stone formers had an untreated diastolic pressure of 105 mm Hg or more compared with 2.0% of controls. Stone prevalence was also investigated in a consecutive series of 102 male survivors of myocardial infarction and was found to be 12.8%, which is much the same as in the health survey, though the survivors were somewhat older (mean age 59 years). The vitamin D intake in survivors of myocardial infarction, renal stone formers, and their matched controls was also studied. The average daily consumption was below 10 μ g in all groups and there were no differences between them.

In conclusion, the coronary risk profile was similar among renal stone formers and carefully matched controls in this study of a well-defined male population. Furthermore, individuals surviving myocardial infarction did not have a higher prevalence of renal stones than expected. This is in contrast to some other reports. Compared with the Norwegian studies^{1,2} cited above differences in dietary habits, including vitamin D consumption, could be part of the explanation for this contrast.

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Health Service administration

SIR,—Mr P H Lord (15 November, p 405) is unfortunately not alone in talking of the "tiers" of district, area, region, and Department of Health and Social Security as though these were comparable bodies at different levels. Mr Lord may be equating "districts" with the previous hospital management committees. The only levels of authority are the Secretary of State, the regional health authority, and the area health authority. "District" is a geographical part of an area in which the services are managed by the district management team—a group of officers and clinicians who are accountable to the AHA.

Mr Lord describes the area as a "political gimmick." Areas were deliberately created coterminous with the new counties (or in conurbations with the metropolitan districts) to facilitate collaboration with the

local authorities with which the NHS shares responsibility for services for large groups of patients with real needs, such as the elderly, psychiatrically ill, and handicapped. The AHAs (with their family practitioner committees) have replaced a much larger number of local health authorities, hospital management committees, and executive councils. To abolish the lowest level of authority, as Mr Lord suggests, would make control remote indeed. It would also mean a large number of senior officers directly accountable to the RHA—a daunting prospect even in a region as small as the one in which he and I work.

Finally, Mr Lord assumes that the demise of the HMC has resulted in the loss of the voice of the consumer. Has he overlooked the new community health councils, whose sole job is to represent the viewpoint of patients in each district?

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Antibiotic diarrhoea

SIR,—In your leading article on this subject (1 November, p 243) you omitted to mention a recent report¹ on the successful use of cholestyramine in lincomycin- and clindamycin-induced pseudomembranous enterocolitis (PME). These drugs cause diarrhoea in 10-50% of patients treated^{2,3} and PME allegedly in 10%.⁴

These are such widely used and useful drugs, especially in the treatment of Gram-negative anaerobic infections, that it would be worth while doing a double-blind study to investigate the use of bile-salt-binding resins and their mode of action in antibiotic-induced diarrhoea and PME.

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Clonidine overdose

SIR,—A man aged 44 years was given 50 tablets of clonidine, each of 100 μ g—that is, a total of 5000 μ g—dissolved in his soup. He slept heavily that day and sweated a lot. The following four days were troubled by diarrhoea, after which he consulted me. Clinical examination revealed no abnormality and his blood pressure was 120/80 mm Hg. His usual range was 180/110-150/100 mm Hg on 100 μ g of clonidine three times a day.

The *British National Formulary* includes constipation and fluid retention among the side effects of clonidine. This case suggests that the reverse may also be true. Forced frusemide diuresis in clonidine overdosage was recommended by Dr S N Hunyor and others (4 October, p 23). I support the view of Dr L M H Wing and his colleagues (15 November, p 408) that this is unnecessary as the excess clonidine is excreted in the urine and eliminated extrarenally.

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