The sea fish in both cases was rock cod (Epigonus acellatus) locally known as hamoor. This particular fish was selected because it is known to live longer out of water and is therefore easily available while still alive.—I am, etc.,

MOINUL HAQ
Al-Maktum Hospital,
Dubai, Arabian Gulf


Total Replacement of the Hip

Sir,—Dr. R. H. Ellis and J. T. Mulvein (27 May, p. 528) have failed to draw the distinction between patients undergoing total hip replacement and those receiving prosthetic femoral heads for subcapital fractures. Transient hypotension following the insertion of acrylic cement into the femoral medulla is common.1 Rarely is the hypotension severe. We have shown2 that the hypotension corresponds in time with high levels of monomethyl methacrylate measured in the circulation during total hip replacement in man. We do not doubt that a similar relationship exists in anaesthetized greyhounds.

Occasionally, more severe hypotensive episodes have been seen during implantation of acrylic cement into the femoral shaft in patients undergoing total hip replacement. Drs. Ellis and Mulvein quite rightly draw our attention to these patients. However, cardiac arrest and death during operation are very uncommon,3 and have for the most part been in patients undergoing femoral head replacement for subcapital fractures.

We would agree that femoral head replacement in these unfit and elderly fracture patients may be attended by considerable risk, but we doubt that the use of acrylic cement in patients undergoing total hip replacement is cause for alarm.—We are, etc.,

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Princess Alexandra Hospital,
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DAVID DANDY
Department of Orthopaedics,
Norfolk and Norwich Hospital,
Norwich, Norfolk

4 Dandy, D. J., Injury, 1971, 3, 45.

Coalminers' Pneumoconiosis

Sir,—Dr. J. P. Lyons and others (18 March, p. 713) criticize conclusions reached by Cochrane and his colleagues1 and Cochrane and his colleagues2 on the basis of representative samples from defined communities that, although miners and ex-miners had lower ventilatory lung function than non-miners, this was not attributable to simple pneumoconiosis. They maintain on the contrary that simple pneumoconiosis does cause impairment of ventilation. They suggest this is due to emphysema which is undetected radiologically. Table 1 from their paper shows mean emphysema counts at necropsy in relation to the final radiological category of pneumoconiosis during life. The relevant figures are:

<table>
<thead>
<tr>
<th>X-ray Category</th>
<th>Mean Emphysema Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>A</td>
<td>12</td>
</tr>
<tr>
<td>B</td>
<td>18</td>
</tr>
<tr>
<td>C</td>
<td>10</td>
</tr>
<tr>
<td>D</td>
<td>12</td>
</tr>
</tbody>
</table>

Since the emphysema counts were less in those miners with the more advanced categories (2 and 3) of simple pneumoconiosis than in those with either no pneumoconiosis at all or any of the other categories it would seem legitimate to conclude that the emphysema, which causes the disability in simple pneumoconiosis is, is undetected at necropsy as well as radiologically. The conclusion drawn by Dr. Lyons and his colleagues seems to be in flat contradiction to their evidence. This does, however, support the view that neither ventilatory lung function nor emphysema is related to x-ray category of simple pneumoconiosis in coalminers in Glamorgan.—I am, etc.,

IAN T. T. HIGGINS
School of Public Health,
University of Michigan,
Ann Arbor, Michigan, U.S.A.


Confusion with Clofibrate

Sir,—Your leading article “Confusion with Clofibrate” (3 June, p. 547) after an interesting discussion of recent trials in Edinburgh, Newcastle, and San Francisco, concludes that “The results at present available give general support to the current practice of prescribing clofibrate to patients with any degree of hyperlipidaemia. . . .”

Without any indication at all of what cholesterol and triglyceride levels constitute any degree of hyperlipidaemia, the conclusion is logically meaningless.

Practically, of course, it is highly meaningful; clofibrate will be more widely prescribed, and confusion will be worse confused.—I am, etc.,

JULIAN TUDOR HART
Port Talbot,
Glam

Stir.—Once again I write to advise caution before accepting that clofibrate affects platelet adhesiveness (3 June, p. 547). There were at least three claims4 in the ‘sixties that clofibrate had an effect on various platelet function tests. Subsequently one trial5 specifically designed to repeat one of these studies failed to show any important change during treatment in 14 measurements of platelet function other than some prolongation of the bleeding time. Even this prolongation could have been due to a seasonal or methodological change, and has not been reported by others.

Stir.—Dr. B. E. Nathan and others (6 May, p. 146) made a generalized conclusion that “primary thermography has no practical value in the differential diagnosis of mammary disease.”

The two infra-red scanning systems they used differ considerably in their specifications and the results obtained are not therefore comparable.1 Simple resolution tests indicate that scanning a patient at 3 feet distance is likely to produce low definition thermograms with no clear distinction made between the superficial vascular pattern of the breast and the suspected hot spot.2 These thermograms, if read from Polaroid film or photographs without reference to the cathode ray screen image, are likely to introduce further loss of detail. On the basis of their evidence, the authors have

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Value of Thermography

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