

can be withdrawn from the vein. In older men with prostatic problems caution is needed with diuretic treatment as acute retention may be provoked. A preliminary rectal examination, easily carried out in the sitting position, is worth while.

Digitalis treatment—In acute left ventricular failure there may be transient beneficial effects from digitalis treatment, and digoxin 1 mg by mouth in a patient of normal build with no undue sensitivity is useful for starting treatment. If the situation is urgent half the initial dose may be given intravenously although the slow onset of action of digitalis glycosides after absorption reduces the advantages of intravenous treatment. In pulmonary oedema secondary to the rapid ventricular rate associated with the onset of atrial fibrillation as may be seen in mitral stenosis, control of the tachycardia has first priority, and the rapid action of beta-adrenergic-blocking drugs may be preferred to the more gradual action of digitalis glycosides.

Mechanical measures—The presence of a pleural effusion may critically increase dyspnoea in the patient with left ventricular failure. Effusion may arise in isolated left ventricular failure by transudation from the congested lung or secondarily to pulmonary infarction from venous thrombosis and embolism. Aspiration of a large pleural effusion may produce striking relief of breathlessness.

Venesection is a time-honoured treatment which may be appropriate if the jugular venous pressure is raised and has the effect of transferring blood from the pulmonary to the systemic venous system. Removal of too much blood too quickly may critically reduce ventricular filling. Removal of one pint (half a litre) is usually satisfactory, conventional blood donor equipment may be used, and the blood is usually suitable for transfusion. A similar effect can be produced less traumatically by venous occlusion with blood-pressure cuffs on the limbs.

Intermittent positive-pressure ventilation—Some patients with pulmonary oedema remain resistant to all these treatments. Attempts to remove froth from the airways by inhaling agents reducing surface tension have relatively little value in the pulmonary oedema of congestive heart failure, and in the intractable patient the best solution is endotracheal intubation which facilitates cleaning the airways followed

by intermittent positive-pressure ventilation. The response is not due to forcing the oedema fluid back across the alveolar-capillary membrane but to the rise in intrathoracic pressure, which tends to keep blood in the systemic venous system and reduce the volume of blood in the pulmonary veins. In patients with mitral stenosis the induction of anaesthesia for mitral valvotomy may improve pulmonary oedema in a similar way.

Acute left ventricular failure carries serious prognostic implications. In hypertension it is a prime indication for effective control of blood pressure, and, although left ventricular failure can be controlled by antihypertensive drugs alone in these patients, this is a therapeutic tour de force which need not be repeated. Diagnostic confusion is sometimes produced by the transient rise of blood pressure which often accompanies the vasoconstrictor response to left ventricular failure in myocardial disease. In aortic stenosis one attack of left ventricular failure is an indication to consider aortic valve replacement as the natural history of aortic stenosis is such that further episodes of left ventricular failure are likely even with intensive treatment and each attack is progressively more difficult to treat. The tragedy of "death on the waiting list" is avoided only by prompt referral for operation after the first episode of left ventricular failure.

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Letter from . . . Paris

Medical writing in France

J A FARFOR

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There are two schools of medical writing in France: those who want all French research to be published in English; and those who, remembering that France is the cultural head of a great francophone community, believe that not to publish in French is a betrayal. Both groups are having difficulties and disappointments because neither realises the importance of the techniques of medical writing, as distinct from the language in which reports are written.

Before submitting papers to Anglo-Saxon journals, authors in the first group generally have the English revised by someone whose mother tongue is English. Yet to their surprise editors still send the papers back for rewriting. These authors have not appreciated that the structure of a paper is one thing, the

language in which it is dressed up is another, and that a paper may be written in faultless English yet be badly written, camouflaging the message. This was understood by the distinguished medical journalist R Veylon when he commented¹ on the failure of certain French journals whose sponsors had imagined they would penetrate Anglo-Saxon medical circles simply by transposing articles into the English language while keeping the original non-structure. Of this school, the "anglicists," one might say that although they are content to throw out the baby (the French language) they insist on keeping the bath water (amateur writing).

The second group, in contrast, would keep the baby, but they too refuse to part with the bath water. Modern scientific methods in medical writing are closely linked in their minds with writing in English. The patriotic Frenchman who rejects the one must also reject the other. The confusion of method with language has been well shown by Vargues.² After criticising Anglo-Saxon papers for their simple language and detailed precision, he, firstly, recommended that French research should be reported in the form of "scholarly dissertations, with thesis, antithesis, and synthesis," and, secondly, renewed the classical

Paris, France
J A FARFOR, MD

French complaint that Anglo-Americans seem to be ignorant of French research. He appeared not to see that research reported in the way he recommends is condemned to oblivion irrespective of the language in which it is presented. He concluded by appealing to French authors to defend their language by rejecting Anglo-American methods (*les normes*) of writing.

It is true that scientific medical writing happens to have originated in America and Britain—every advance has to begin somewhere—but has not the time come to “deanglo-saxonise” it, and make it known and available to other language groups? So I should like to suggest that teaching seminars on medical writing, similar to those held by the *BMJ* in London last November, in Edinburgh in January, and in Dublin in April should now be made available in the international field. This teaching is an important advance—perhaps the first step was the publication of Sir Clifford Allbutt’s *Notes on the Composition of Scientific Papers*³—towards a general realisation that preparing medical research reports is a technique that has to be learnt.

Since the recent seminars were intended mainly for English-speaking doctors, they were oriented naturally towards composing papers in this language. In international courses the theory and principles of medical writing (which, of course, must be applied in compiling papers in any language) would be taught to all the participants, problems specific to different languages being dealt with in appropriate language groups. What better means of disseminating good scientific medical writing than a multilingual course, widely publicised in the medical journals of the EEC countries, and organised at BMA House, the seat of the EEC Medical Secretariat?

A universal technique? Yes. A universal language? No.

That the standard of research reporting in some countries is low is admitted in the countries themselves. Détrie has

written of the contempt in which French surgeons hold French medical journals.⁴ But is publication in English a logical or a practicable remedy? If researchers have never learned (for the simple reason that as yet no one has provided them with facilities for learning) how to prepare reports in their own language, why should they (or, more realistically, the tiny minority who can write in English at all) prepare them any better in a foreign one?

The adoption of the principles and practices of scientific medical writing by research workers all over the world is a logical corollary to the adoption of an international system of units. Reports prepared according to a uniform international pattern and in a simple basic vocabulary will (a) be easier for researchers with a limited knowledge of a given language than the literary productions of writers with a taste for linguistic subtleties,* and (b) lend themselves to straight translation, even by non-medical translators (generally the only kind available), without the radical editing and rewriting needed at present.

In short, that all research should be reported in the same way is feasible and desirable; that it all be reported in the same language is not feasible, and therefore the question of its desirability is academic.

*To forestall protests from the advocates of a “personal style” I should make clear that in this letter I am talking about research reports. Other kinds of medical writing—editorials, review articles, didactic material—afford scope for the stylists.

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Statistics at Square One

X—Paired alternatives

T D V SWINSCOW

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Sometimes it is possible to record the results of treatment or some sort of test or investigation as one of two alternatives. For instance, two treatments or tests might be carried out on pairs obtained by matching individuals chosen by random sampling. Or the pairs might consist of successive treatments of the same individual (see Part XIII for comparison of pairs by the *t* test). The results might then be recorded as “responded or did not

respond,” “improved or did not improve,” “positive or negative,” and so on.

This type of study yields results that can be set out as follows:

Member of pair receiving treatment A	Member of pair receiving treatment B
Responded	Responded (1)
Responded	Did not respond (2)
Did not respond	Responded (3)
Did not respond	Did not respond (4)

The significance of the results can then be simply tested by McNemar’s test in the following way.

Ignore rows (1) and (4), and examine rows (2) and (3). Let the larger number of pairs in either of rows (2) or (3) be called n_1

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T D V SWINSCOW, MSc, MB, deputy editor