

failure, those in wards and renal clinics, and, for that matter, general medical patients for those nephrologists with non-renal medical duties as well. In workload terms it is more meaningful to count all these excluded patients in relation to a finite time interval—that is, the number of patients seen or transplantations performed within a specified period (incidence). The patients undergoing dialysis at one moment in time can be counted as a prevalence. The prevalence of patients with functioning grafts should not be equated with the prevalence of patients on dialysis as the workload is quite different. An analysis of the total nephrological service in the UK was beyond the resources of our unit, nor did we wish to burden our respondents with a time consuming detailed questionnaire. The non-inclusion of the transplant load seems to have irked people most. But it could be argued that the transplanted patient when well becomes part of the renal clinic load, when ill part of the ward load, and after rejection part of the dialysed load. Even these units without a local transplantation service look after transplanted patients, who become a variable proportion of the renal clinic workload. A two monthly outpatient check up should not constitute such a major work commitment, especially in these days of improved results. It seems counterproductive to give equal weighting to the load of patients with well functioning grafts. After all, transplantation is meant to lessen the cost and load on the medical services in comparison to dialysis.

If Drs Ogg and Jones dislike our arbitrary scoring system the raw data (the replies we were given) are published as well, and readers can apply any other scoring system they choose to the raw data. Their confidence in the data may be restored by a look at a copy of the return for the unit they mention listing "three university staff" since that was the reply given to us. Naturally we were dependent on the accuracy of the replies, as in any survey. We intended to count a consultant with two sessions of nephrology as one person, the same as a consultant with 11 sessions. Alternative units of account such as whole time equivalents can also be deceptive, since they hide the actual numbers of people involved. It is not easy to extract meaning from lists of fractions, sessions, or aggregated whole time equivalents. The reader may well want to know also how many individuals have contributed to one whole time equivalent. There is also a role for surveys which look simply at pairs of hands, irrespective of time commitments—that is, the people available for the tasks that arise. We do not believe this invalidates our survey. It merely looks at the data in a simpler way. This we explained in our paper. If you happen to be the sole renal and general medical consultant in a busy dialysis unit in a university teaching hospital (as one of us is) you do not have the luxury of dividing out your time into official sessions for non-renal, teaching, research, and dialysis duties. Irrespective of what is meant to be undertaken sessionwise (never defined in our unit anyway by either health board or university), you spend most of the working week and a great deal of your own free time as well on the renal workload. There is no one else to share "sessions" with. Units with several pairs of hands should consider themselves fortunate. It is remarkable that it is the staff of these better provided units who are most anxious to emphasise that they spend only a fraction of their time on "renal" duties. How lucky they are.

We look forward to the publication of the "careful" survey of 1986 manpower by the Royal College of Physicians' committee on renal medicine. The information so provided will no doubt be useful when it eventually appears. However, in the last two surveys Scotland appeared anomalously as a "region."^{2,3} The information is therefore not particularly helpful to individual Scottish dialysis units. Surely there is a place for smaller individual unit orientated surveys emphasising staff numbers as well as the larger regional ones emphasising sessions.

W K STEWART
LAURA W FLEMING

Department of Medicine,
Ninewells Hospital and Medical School,
Dundee DD1 9SY

- 1 Sells RA, Macpherson S, Salaman JR. Assessment of resources for renal transplantation in the United Kingdom. *Lancet* 1985;ii:195-7.
- 2 de Wardener HE, Peart WS, Cattell WR, et al. Distribution of nephrological services for adults in Great Britain. *Br Med J* 1976;ii:903-6.
- 3 Jones NF, Goodwin FJ, Roberts AP. Manpower and workload in adult renal medicine in the United Kingdom 1975-82. *Br Med J* 1984;288:992-4.

A limited role for manipulation?

SIR,—Professor Malcolm Jayson appeared to draw general conclusions about the role of manipulation which were based largely on studies limited to the treatment of low back pain (6 December, p 1454).

Manipulation is not, of course, concerned only with pain in the low back and it is used at all levels of the vertebral column (as well as for peripheral joints). In addition, not all manipulation uses a "system of diagnosis which is not that of conventional medicine"; one needs only to refer to some of the standard medical texts on orthopaedic medicine to confirm this.^{1,2}

Medical manipulation involves more than just the application of forces to joints and it incorporates conventional systems of examination and diagnosis. Properly constituted within the framework of orthopaedic medicine it can be combined with other forms of treatment to offer a level of skill in relation to the musculoskeletal system which is not normally available. The importance, for example, of a thorough examination of the whole back is exemplified in the diagnosis of the cause of such seemingly unrelated symptoms as chest and abdominal pain.^{3,4}

There are many patients with musculoskeletal symptoms who require neither surgery nor intensive anti-inflammatory or immunodepressive medication. Much more work needs to be done to assess the possible benefits of a whole range of treatments for this group. The field is, however, inhibited by the lack of any department of orthopaedic medicine within the NHS, and patients are often caught in a limbo between orthopaedic surgeon and rheumatologist. What is needed is a research orientated teaching department such as that in France at Université Paris VI, where orthopaedic medicine is recognised as a postgraduate specialty. This would then perhaps offer an opportunity to investigate properly the merits of a treatment which dates back several thousand years and which still remains with us despite the advances of modern medical technology.

ADAM WARD

Tunbridge Wells,
Kent TN2 5LF

- 1 Maigne R. *Orthopedic medicine*. Springfield, Illinois: Charles C Thomas, 1979.
- 2 Cyriax J. *Textbook of orthopaedic medicine*. Vol 1. London: Baillière Tindall, 1980.
- 3 Ward A. Somatic component to myocardial infarction. *Br Med J* 1985;291:603.
- 4 Ashby EC. Abdominal pain of spinal origin. *Ann R Coll Surg Eng* 1977;59:242-6.

Non-invasive femoropopliteal assessment: is that angiogram really necessary?

SIR,—Mr A R Baker and colleagues raise two issues regarding our non-invasive scoring system (6 December, p 1505).

Assessment of inflow is undoubtedly difficult, but palpation of the femoral pulse remains as good as most non-invasive methods for detecting aortoiliac stenoses of greater than 50%.¹ Although stenoses of less than 50% may be "haemodynamically significant," their relevance to clinical practice is uncertain. On this unit in the previous two years 148 femorodistal bypass operations have been

performed for critical ischaemia. Forty eight (32%) required a synchronous inflow procedure. In the remainder, in whom inflow was judged adequate on our clinical assessment of the femoral pulse, 24 had a preoperative angiogram and 76 had only an intraoperative distal angiogram or no angiogram at all. To date the crude patency rate of this group (87%) is no different from that of those who had a preoperative angiogram (85%). This concurs with the experimental observation that the increase in flow secondary to a femorodistal graft is unlikely to change a subcritical iliac stenosis into a critical one.²

While being impressed by the results of percutaneous transluminal angioplasty in selected cases, we have not found that many patients with critical leg ischaemia have lesions suitable for percutaneous transluminal angioplasty. In 87 cases in which intraoperative distal angiograms were obtained extensive atherosclerotic occlusions were shown extending distal to the popliteal artery in 74 limbs (85%). A proximal inflow procedure was required in 11 of the 13 limbs in which the popliteal trunk was suitable for the distal anastomosis. When feasible in such cases percutaneous transluminal angioplasty requires multiple dilations and is associated with a restenosis rate over 50%.³ Claims that 40% of patients with arterial disease of the leg currently requiring surgical intervention could be treated by percutaneous transluminal angioplasty are speculative.⁴ The relative roles of surgical vascular reconstruction and percutaneous transluminal angioplasty in limb salvage have yet to be defined.

C P SHEARMAN
B R GWYNN
M H SIMMS

Selly Oak Hospital,
Birmingham B29 6JD

- 1 Campbell WB, Cole SEA, Skidmore R, Baird RN. The clinician and the vascular laboratory in the diagnosis of aortoiliac stenosis. *Br J Surg* 1984;71:302-6.
- 2 Williams LR, Flanagan DP. Alterations in femoral artery haemodynamics associated with femoropopliteal bypass. *J Surg Res* 1984;36:97-101.
- 3 Rush DS, Gewertz BL, Lu C-T, Ball DG, Zarins CK. Limb salvage in poor-risk patients using transluminal angioplasty. *Arch Surg* 1983;118:1209-12.
- 4 Doubilet P, Abrams HL. The cost of underutilization: percutaneous transluminal angioplasty for peripheral vascular disease. *N Engl J Med* 1984;310:95-102.

Depression after stroke

SIR,—Dr Allan House's review (10 January, p 76) is welcome, but in view of the perpetual struggle for NHS financial priorities it is doubtful if the necessary research that he proposes will ever be carried out. And so we shall continue to be in ignorance of whether depression after stroke is underdiagnosed or undertreated. As a survivor of a haemorrhagic stroke four years ago, mercifully spared substantial intellectual dysfunction (I can still edit a monthly medical journal), there remains plenty to feel depressed about.

If you can only stand for a minute or two and walk less than 100 yards you have to redesign your lifestyle considerably if feeling depressed does not progress to withdrawal and frank depression. Drugs never can and never will redesign lifestyles. Two practical things could make the stroke victim feel less depressed. The first of these is better provision for the physically handicapped. This is probably outside our control and maybe we, the stroke victims, will need to wait for our own Bob Geldof on this score, for Britain pays only lip service to the needs of disabled citizens. What is also needed, and here the solution is more within the profession's power to act, is surely the development of a stroke expert or consultant.

I have received many kindnesses and help from many colleagues who have done their various bests to help me cope with the problems of stroke illness, with a lot of success, and I am very grateful to them. The problem of pain management in the hemiplegic limb and trunk is a depressing cross to bear long term, and this, together with the management of trophic problems in the limb, seems to need a therapeutic synergy that medicine has not yet succeeded in providing in any speciality that I have come across.

Pathological emotionalism is probably present in many more stroke victims than is realised. (Men are not allowed to cry publicly in our culture.) But this seems partially to heal itself in time. I can now usually survive the relatively non-emotional experience of the reception of the Eucharist without tears. But if I want to listen to *La Bohème* then alone in my study is the only way.

ERIC TRIMMER

Loudwater, Herts WD3 4JE

Blythburgh Hospital

SIR,—What a pleasure it was to some of us in Suffolk to see the painting of Blythburgh Hospital by Anne Bruce adorning the front cover of your excellent Christmas number. Blythburgh is much honoured. That old hospital has been a vital part of the active geriatric department in east Suffolk for just 30 years. It was built as a "house of industry"

and so were some dozen others in Suffolk as a result of individual acts of parliament, and it was opened on 13 October 1766. (This was before the general act of 1782 which permitted such large establishments and which led on to the Victorian "unions.") The story still circulates that the local villagers, not liking the thought of such a "prison" near them, each night pulled down the work of the bricklayers—until the militia was called out and the Riot Act was read to them, threatening deportation. A prison it almost was, and the plight of the inmates was sad. Nevertheless, it helped form the basis of a geriatric service nearly 200 years later, so Suffolk was unwittingly pioneering.

After the war we were able, thanks to public opinion, benign authorities, and a touch or two of opportunism, quickly to upgrade it into a bright, spacious, cheerful, and colourful longer stay unit with every normal amenity. It has the bonus of quiet rural surroundings and views of a splendid Suffolk estuary. If the need arose I would be content to be nursed there or to have any member of my family nursed there sine die, such are the virtues of Blythburgh and its devoted staff. On places like this have many of Britain's geriatric departments been founded for later development. We were not alone in this, but we were lucky that the embryo NHS took over this formidable old place in 1948, and we are still proud of our hospital in 1987, its 222nd year.

JOHN AGATE

Chattisham,
Ipswich IP8 3PY

Points

Impact of a handicapped child on mental health of parents

Dr J NEWCOMBE (Mental Handicap Services Unit, Meanwood Park Hospital, Leeds LS6 4QD) writes: Dr Sarah Romans-Clarkson and others (29 November, p 1395) appear to accept that the parents of mentally handicapped children were less able and successful than the parents of non-handicapped children. This, surely, would be correct only if you included the subcultural group where nothing has gone wrong and the children are simply chips off the old block. If we take the more handicapped group, including children with Down's syndrome, we find no difference between the two groups of parents. Severe mental handicap is no respecter of wealth and success in the parents. The authors seemed surprised that mothers rather than fathers show the greatest strain from looking after a severely mentally handicapped child in the family. This is not surprising; the mother looks after the child by day and by night. The father, however, can go out to work by day and retire to the pub or club at night. The article made no mention of a group which is seldom mentioned but which is most affected by the presence of a severely mentally handicapped child in the house: the normal brothers and sisters. They suffer because the handicapped child gets most of the attention and they are left to fend for themselves and because normal children do not like to invite their friends to their house and they themselves are not invited to other children's houses. Those who press for severely mentally handicapped children to remain at home should remember that they are robbing the normal brothers and sisters of their childhood.

Coffee, cholesterol, and colon cancer

Drs M N CLIFFORD, R WALKER, and J WRIGHT (Department of Biochemistry, University of Surrey, Guildford GU2 5XH) write: Dr Bjamak Jacobsen and Professor Dag S Thelle suggested that there may be a positive relation between coffee consumption and serum total cholesterol concentration and a reduced risk for cancer of the colon (3 January, p 4). They point out that they are not aware of any data in man on

the effect of coffee consumption on bile acid and neutral sterol excretion from the liver. We are not aware of any definite studies on this either, although we have indicated the need.¹ We wish, however, to draw your attention to a substantial collection of data which seems to have passed unnoticed. A drink of coffee supplies appreciable quantities of chlorogenic acids—for example, a 200 ml cup prepared from 2 g of instant coffee as available in the UK could supply between 70 mg and 200 mg, and 200 ml of a beverage prepared from roast and ground coffee could supply over 600 mg.²⁻⁴ There is evidence from clinical studies that chlorogenic acids (500-1500 mg/day) can increase the elimination of bile acids by a factor of three⁵ as well as reducing serum concentrations of total cholesterol (−13 to −31%), β lipoprotein (−12 to −28%), the β : α lipoprotein ratio, triglycerides (−11 to −30%), free fatty acids (−29%), and glycerol (−24%).⁶⁻¹² We agree with the authors that there is a very good case for examining in man the interrelation between coffee (brewed in different ways), bile excretion, and cholesterol metabolism, but in any such study the composition of the coffee must be controlled and the chlorogenic acid content defined.

- 1 Clifford MN, Walker R. Chlorogenic acids—confounders of coffee-serum cholesterol relationships. *Food Chem* (in press).
- 2 Clifford MN. Chemical and physical aspects of green coffee and coffee products. In: Clifford MN, Willson KC, eds. *Coffee: botany, biochemistry and production of bean and beverage*. London: Croom Helm, 1985:305-374.
- 3 Clarke RJ, Macrae R. *Coffee 1. Chemistry*. London: Elsevier Applied Science, 1985.
- 4 Maier HG, Grimschl A. Die Säuren des Kaffees IV. Chlorogensäuren in Kaffeeaufgüssen. *KTM* 1982;32:3-6.
- 5 Schreiber J, Erb W, Wildgrube J, Böhle E. Die fäkale Ausscheidung von Gallensäuren und Lipiden des Menschen bei normaler und medikamentös gesteigerter Cholesterese. *Z Gastroenterologie* 1970;8:230-9.
- 6 Hammerl H, Kindler K, Kränzl Ch, Nebosis G, Pichler O, Studler M. Über den Einfluss von Cynarin auf Hyperlipidämien unter besonderer Berücksichtigung des Typs II (Hypercholesterinämie). *Wien Med Wochenschr* 1973;123: 601-5.
- 7 Mancini M, Oriente P, D'andrea L. Hypocholesterolemic effects of quinic acid 1,4-dicaffeate in atherosclerotic patients. In: Garattini S, Paoletti R, eds. *Proceedings of the symposium on drugs affecting lipid metabolism*. London: Elsevier, 1961:533-7.
- 8 Cairella M, Volpari B. Osservazioni cliniche sull'azione ipocolesterolemizzante dell'acido 1,5-dicaffeilchinico. *Clin Ter* 1971;57:541-52.

- 9 Montini M, Levoni P, Ongaro A, Pagani G. Kontrollierte Anwendung von Cynarin in der Behandlung hyperlipämischer Syndrome. Beobachtungen von 60 Fällen. *Arzneim Forsch* 1975;25:1311-4.
- 10 Wojcicki J, Kadykow M. The influence of Cynarin on serum lipids in patients affected with diabetes mellitus. *Minerva Med* 1974;16:127-9.
- 11 Wojcicki J, Olejak B, Pieczul-Mroz J, Torbus-Liesiecka B, Bukowska H, Gregorczyk J. Zastosowanie Kwasu 1,5-dwukawowocinowego u cecczeniu hipertroglucydemii. *Preszl Lek* 1982;39:601-6.
- 12 Caruzzo C, Carnaghi R, Enrico-Bena L, De Marco G. Considerazioni sull'attività dell'acido 1,4-dicaffeilchinico sulle frazioni lipidiche dell'arteriosclerosi. *Minerva Med* 1969;60:4514-8.

Contact tracing in pelvic inflammatory disease

Mr JULIAN PAMPIGLIONE (Department of Obstetrics and Gynaecology, King's College School of Medicine and Dentistry, London SE5 8RX) writes: Mr M J Hare (8 November, p 1225) provides a concise and accurate account of how pelvic inflammatory disease should be managed. A major treatment failure in the UK is that of contact tracing and examination of the partner. Twenty five contacts of 42 women clinically diagnosed as having pelvic inflammatory disease at the Whitechapel Clinic (London Hospital) over six months were examined. Of these, six had gonococcal infections, 15 had non-specific urethritis, and three had both gonorrhoea and post-gonococcal urethritis. While these figures are uncontrolled and there may be a bias towards sexually transmitted disease, many partners of patients with pelvic inflammatory disease may well be infected. Many patients are treated by general practitioners, casualty officers, and junior gynaecological staff as outpatients. There are usually no formal contact tracing facilities available. Unless these can be provided in the form of available contact tracing cards, routine reporting of cases to genitourinary clinics, and follow up and counselling then there is a good case for treating the partner, if traceable, immediately and empirically. If this is not done reinfection may well result. Treatment should be the same for both male and female partners. Some early recurrence of pelvic inflammatory disease is no doubt due to reinfection resulting from failure of initial contact tracing and treatment.

Contraception

Dr RICHARD PAISEY (Medical Centre, Torbay Hospital, Torquay TQ2 7AA) writes: "Fertility awareness" and "natural methods of family planning" are mentioned briefly by Mr Alia Kubba and Mr John Guillebaud (6 December, p 1491) with an accurate description of the symptoms diagnostic of the post-ovulatory infertile phase. Unfortunately they suggest in their flow diagram that women with irregular cycles cannot use this method and that a preovulatory infertile phase can never be relied on. With proper teaching, women in the premenopause, those breast feeding, and those with irregular cycle lengths can use these methods, and in many a preovulatory infertile phase is perceptible. The main problem for couples wishing to adopt natural methods of contraception is accessibility to trained teachers, as the vast majority of Family Planning Association doctors and nurses are not properly qualified to teach these methods. It is hoped that this situation will change in the future; in the mean time couples may be referred to the Natural Family Planning Centre, Birmingham Maternity Hospital, for the address of their nearest teacher.

Saint Who's?

Dr TERENCE MORRIS (Prince Charles Hospital, Merthyr Tydfil C47 9DT) writes: May I add another saint to Sir John Dewhurst's list? St Tydfil's Hospital is the oldest in Merthyr Tydfil and recently reopened after modernisation. St Tydfil (Tudvyl) was a Celtic Christian, daughter of a local Welsh chieftain, Brychan Brycheiniog. She and her family are believed to have been killed by a group of marauding Picts some time between AD 450 and 480. Tydfil is believed to have knelt in prayer before her death and this is the origin of the tradition of her martyrdom.