Cough associated with captopril and enalapril

Sir,—As Drs D M Coulter and I R Edwards comment (13 June, p 1521), angiotensin converting enzyme inhibiting drugs may increase concentrations of bradykinin and prostaglandins such as prostaglandin E2 in the lung, compounds known to stimulate unmyelinated afferent C fibres in animals. This raises the possibility that stimulation of lung receptors other than rapidly adapting receptors in the larger airways may produce cough.

We have recently described the induction of paroxysmal coughing in humans with central intravenous injection of capsaicin (8-methyl-N-vanillyl-6-nonenamide), a fairly selective C fibre stimulant in animals. The short latency of this response (3-9 seconds) is consistent with its origin from juxtapulmonary capillary receptors in the lung. Selective blockade of these receptors by inhalation of small particle size local anesthetic aerosol depositing at alveolar level has been suggested as a means of testing the hypothesis that captopril and enalapril might cause cough by this mechanism in humans. Unfortunately, at least in animals, small particle size local anesthetic aerosol is unable to block the effects of mass activation of C fibres with bolus injections of capsaicin, but the effect of such an aerosol on the less intense receptor activation that probably produces chronic cough with angiotensin converting enzyme inhibitors in humans might be worth trying.

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Intrag regional variation in treatment of end stage renal failure

Sir,—Dr Maureen Dalziel and Mr C Garrett (30 May, p 1382) have usefully emphasised the serious variations in the North West Thames region in treating people with terminal renal failure. There is a need to improve the knowledge and acceptance of dialysis and treatment rate. Publicity via the BMJ may help to correct these major errors and reduce the premature deaths of about 200 people each year in this region alone.

I suspect that the authors may be correct when they suggest that information related to dialysis drops in proportion to the distance from a renal unit. For example, one patient from this hospital receiving continuous ambulatory peritoneal dialysis successfully referred for treatment his neighbour, who had been told by a consultant that no treatment was available for his terminal renal failure.

Dr Dalziel and Mr Garrett are correct in stating that treatment of end stage renal failure has traditionally been provided by teaching hospitals. A glance at the map of the North West Thames Regional Health Authority shows three renal units all tucked into the extreme south east corner. Happily, there is a small minimal care haemodialysis unit in Watford General Hospital and a dialysis unit is planned for Lister Hospital, Stevenage, perhaps to open before the end of 1988. If each unit is run at maximum capacity then it should be possible to offer all patients in this region dialysis when necessary. Until then premature deaths from chronic renal failure will occur.

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Coping with sudden death

Sir,—Dr Eva Alberman's letter (6 June, p 1848) fills me with dismay as a police surgeon and a general practitioner. The fundamental mistake made by the patient's doctor (or a partner) not to attend, believing that as he was not in a position to issue a certificate there was no point. The next mistake was for the emergency service to inform the uniformed branch of the police, who have no expertise in the investigation of an unexpected death being dealt with medically.

My own procedure, having confirmed that the patient is dead and excluded violence, is to hear the story again from the relatives and offer them some words of comfort. I then speak to the coroner's officer, and between us we arrange the removal of the body in the most fitting way. I know that he may speak to the patient's own doctor the next morning in an attempt to avoid a post mortem examination. I then spare a thought for the relatives, who may need a mild sedative or even hospital admission that night. I explain the coroner's function and point out that a post-mortem examination does not necessarily mean an open inquest with headlines in the local papers. The next morning I may speak to the deceased's own general practitioner or even to the social services department.

Finally, the reason why two policemen attended was probably that one of them was a probationer. This may have been his first experience of death, and he may need some psychotherapy. All this when there is "nothing to be done."

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