Dysphagia in acute stroke

Sir,—The article on dysphagia in acute stroke by Dr Caroline Gordon and colleagues (15 August, p 411) does not mention the findings on oesophageal manometry in such patients.

The cause of dysphagia associated with strokes may be oropharyngeal, owing to inability to initiate the act of swallowing, or pharyngoesophageal, owing to lack of coordination at the cricopharyngeal level. These are probably due to an upper motor neurone lesion of the lower cranial nerves (IX, X, and XI), and, as Dr Gordon and coworkers suggest, lower cranial nerve lesions are more common in patients with dysphagia associated with stroke (brain stem strokes). The lack of coordination at the pharyngoesophageal level shown by manometry when the cricopharyngeal relaxation fails to occur at the same time as the pharyngeal contractions results in dysphagia and aspiration into the tracheobronchial tree. This manometric finding is similar to that seen in patients with cricopharyngeal diverticulae. In association with a stroke, however, the coordination is, as shown by Dr Gordon and colleagues, self-limiting to a few days, and full recovery usually follows. Therefore, while chest infections are common, a cricopharyngeal diverticulum does not develop.

The patients need to have their nutrition maintained, and the dysphagia as well as having their lungs protected from aspiration and pneumonitis. In the occasional case where the coordination is not restored a cricopharyngeal sphincterotomy ensures normal swallowing and is a fairly minor procedure.

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Mobilising anger against tobacco

Sir,—Several years ago, in the USA, some mothers whose teenage children had been killed in road accidents became angry because little was done by those in authority to combat the problem. So they got together and formed MADD—Mothers Against Drunken Driving. In those states where they have been active they have been effective. We need a similar angry group in Britain of relatives, friends, and carers against cigarettes and tobacco.

The tactics of the tobacco industry never fail to outrage me. Your news item of 12 September (p 679) showed the continuing problem of sport sponsorship by tobacco companies, who need to recruit at least 200 new smokers daily to replace the number dying prematurely from smoking related diseases each day in the United Kingdom.

Dr Colin Campbell, describing the death of a young woman from lung cancer said, "I cannot tell you how angry I am that cigarettes stubbed out this woman's life. Perhaps the time has come to subvert this pious nonsense about freedom of choice and the right to smoke in a free country" (25 July, p 265). Dr Campbell is right of course. Perhaps we haven't been angry enough. By using a lot of our energy trying to get a better voluntary agreement on tobacco advertising, we have lost sight of the real problem.

We need to channel our anger and do as the mothers of MADD have done. I cannot think of an acronym. If anyone has any suggestions please write and tell me.

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Surgery of morbid obesity

Sir,—With regard to the reply by Mr J C Gazet and Professor T R E Pilkington to our letter (5 September, p 605) we believe that further clarification is necessary. We agree that patience is necessary before conclusions are drawn after gastric restrictive procedures, but it should also be emphasised that successful results are going to be achieved only if this surgery is performed by surgeons with a special interest and patients are selected very carefully. It is not correct that only Scopinaro has substantial experience of biliopancreatic bypass; there are now several reports of other centres' experience with this procedure.

Gastric restrictive procedures improve presh餐 weight loss in selected patients. Pouches are now much smaller than 50 ml (often 10-20 ml), and these do not impair normal eating for life. Restriction persists for only to two or three years at best. Hence, unless the patient develops some complication, such as outlet stomal stenosis, we did not state that gastric bypass is easy to reverse but that vertical banded gastroplasty is. This was done on one occasion without morbidities and it was technically easy to perform a gastro-gastrostomy between the proximal pouch and distal stomach. We have also revised four of our earlier 5-5 cm vertical banded gastropasties by a technique previously described. This proved straightforward on all occasions, the only morbidity being wound sepsis in one case.

Finally, with the advent of more sophisticated stapling instruments, such as the four row stapler, barbitrating stapling procedures have become safer, and the consequent reduction in morbidity and mortality has made them more acceptable.

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Cardiovascular effects of training for a marathon run

Sir,—With reference to the paper by Dr Iain N Findlay and colleagues (29 August, p 521), I would like to point out that lowering total serum cholesterol and low density lipoprotein cholesterol concentrations may be achieved by less dramatic means than those used in their study.

We conducted a study in which 16 subjects ran an average of 5-8 miles weekly (range 3-7 to 10 miles) in contrast to the average of 22-1 miles weekly (range 12 to 35 miles) of the subjects in the study by Dr Findlay and coworkers. We found falls of 5% in total serum cholesterol concentrations and 8% in low density lipoprotein cholesterol concentration (p<0.02). These effects were most pronounced in those running over 6 miles weekly. Like Dr Findlay and colleagues, we found no significant change in serum high density lipoprotein cholesterol or triglyceride concentration, although other studies in which joggers have run over 11 miles weekly have shown increases in high density lipoprotein cholesterol concentration.

Though we did not detect as great a reduction in total serum cholesterol as the 12% found by Dr Findlay and colleagues, it seems that useful improvement in blood lipid concentrations may be achieved by jogging without the need to undertake marathon training for many or all cases or for this form of exercise to be more acceptable to more people.

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Sir,—Since the observation in 1953 that bus drivers and postal clerks were more prone to heart disease than conductors and postmen,1 there has been a continuing interest in the protective effects against heart disease of physical activity.

The results reported by Dr Iain N Findlay and colleagues (29 August, p 521) are in general with those of other studies and show time related reductions in plasma lipid concentrations and blood pressure. Dr Findlay and coworkers concluded that there was an independent effect of exercise on blood pressure and noted that their results implied a "continuing reduction in peripheral vascular resistance." A comparable study by Australian workers showed that total peripheral resistance and mean arterial pressure decreased in parallel with increased frequency of exercise.2 Furthermore they concluded that the change in arterial blood pressure was due entirely to the reduction in total peripheral resistance. They speculated that changes in size or an increase in the number of skeletal muscle capillaries might explain the reduction in peripheral resistance, although they were not sure that the time involved was long enough for such changes to occur.

It is not necessary, however, for vascular changes to occur to increase peripheral resistance. Increased blood viscosity with reduced red cell deformability also increases peripheral resistance, and hypertension associated with increased blood viscosity has been reported by several groups.3,4 When a diet is changed to eliminate animal products or to increase fish intake or when fish oil is taken as a dietary supplement blood pressure is reduced.5 Such dietary changes also reduce blood viscosity. It seems that the beneficial effects of exercise are
also due to the lowering of blood viscosity. Charm et al reported that plasma viscosity in joggers is lower than that in those who do not jog.7 The Munich group headed by Ernst has published several studies showing that exercise increased red cell deformability and reduced blood viscosity.7,14 Several studies also show that many factors, including cholesterol and norepinephrine, reduce red cell deformability.

Exercise lowers plasma cholesterol and normalises lipoprotein concentrations,15 and these changes seem to be shown by improved red cell deformability, which lowers blood viscosity. This concept provides a basis for understanding why both increased physical activity and appropriate dietary changes may lower blood pressure. Therefore, those who by choice, or because of disability, do not exercise regularly can obtain haemorrhoidal benefits through diet alone that are similar to those induced by exercise.

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The cost of nursing

Sir,—I have every sympathy with Dr K W M Scott and colleagues in Wolverhampton (8 August, p 393) in their difficulties resulting from the impact of nursing shortages—but it is essential that public boards should insist on training programmes of practical, in-service training. Ms Lorraine K M Brooks (29 August, p 555) may be dismayed at this attitude of medical staff—shared by many trained nurses—but Dr George Day’s Personal View (22 August, p 498) unfortunately suggests that proper traditional nursing is what patients actually require. Ms Brooks seem to be more obsessed by the status of nurses than the welfare of patients; I would suggest that the one depends more on diligent attention to the other than increasing the period of classroom instruction by 70%. The rather petulant comment that “Nurses have been handmaids to the medical profession for too long, following orders without thought or knowledge” perhaps gives an insight into the true motive behind the proposed changes and hardly does justice to the intelligence of Ms Brooks’ colleagues. Good nursing certainly requires knowledge—and understanding of implications—but it is essential that nursing staff be sufficiently well prepared for their duties.

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Visual analogue scores and urinary incontinence

Sir,—Dr M J Frazier and colleagues (5 September, p 582) correlate visual analogue scores with diagnoses of detrusor instability and genuine stress incontinence. They show a significant difference between the mean scores in the two groups but note that there was no clinically useful separation of the groups as the area of overlap was large. Furthermore, there was a large discrepancy between the results of this study and a previous study that used visual analogue scales.

Dr Frazier and colleagues comment that the psychological profiles of the two groups show clear differences. Recent work in this department, however, strongly suggests that this is not, in fact, the case. Personality testing using the Eysenck personality inventory has shown a high level of neuroticism in both groups of patients.1 A further study, recently completed, shows a high level of psychiatric morbidity (47.9% using the general health questionnaire), and no relation has been found between the urodynamic findings and the degree or type of psychiatric morbidity. Therefore, it seems that women with urinary incontinence of all types are equally likely to have psychiatric problems. Another interesting finding in our study was that urine loss, as measured by the ‘nappy’ test, was unrelated to urodynamic or psychiatric results.

Our findings suggest that the relationships among detrusor instability, anxiety, and demonstrable urine loss are not straightforward as has previously been thought. This may help to explain the large overlap of results on visual analogue testing.

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Old and new causes of superficial dyspareunia

Sir,—I was pleased to see Drs Alan J Riley and Peter Bromwich (29 August, p 513) emphasising the importance of a thorough examination of the vulva in cases of superficial dyspareunia and mentioning the recently recognised but poorly understood focal vulvitis. I am concerned, however, that while attention was given to the rare vulvitis circumscripta plasmacellularis, the much more common problem of lichen simplex and atrophicus was not mentioned. In this inflammatory, atrophic disorder the vulva has an ivory white appearance and lesions may become haemorrhagic. In time atrophy becomes pronounced, affecting the inner aspects of the labia majora, labia minora, clitoris, and vestibule, and the vaginal introitus often becomes constricted. The primary symptoms are itching and soreness, but dyspareunia results from the soreness and introital constriction.

Over seven years 345 patients (aged 20-75) were referred to a dermatology clinic with undiagnosed vulval problems by general practitioners, departments of genito-urinary medicine, family planning clinics, and gynaecologists. Of these, 183 (53%) had lichen sclerosis et atrophicus and 159 (47%) of these experienced dyspareunia, graded as severe by more than half. The condition rapidly responds to the application of fluorinated steroid preparations, and all but two of my patients were completely cured of dyspareunia after three months’ treatment.

Other vulval dermatoses causing dyspareunia as a primary or associated symptom in this series were lichen simplex, intertrigo, contact dermatitis (75% due to local anaesthetic preparations), infections, eczema, flexural psoriasis, lichen planus, and Crohn’s disease. It is thus important to be aware of dermatological disorders of the vulva as a cause of dyspareunia. But it may be necessary to confirm the diagnosis and should not be delayed as early treatment not only relieves symptoms and often much suffering but may prevent complications such as introital constriction, psychological problems, and malignant change.

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Arterial thrombosis associated with graduated pressure antimobic stockings

Sir,—Mr Dugal I Heath and colleagues (5 September, p 580) report two cases of arterial occlusion resulting from mishaps with graduated compression stockings. A thigh length stocking was responsible in their case 2, and it seems likely that a thigh length stocking was, as commonly recommended by manufacturers, also fitted in case 1.

We have recently completed a study of 110 patients undergoing major abdominal surgery who were randomly allocated to be fitted preoperatively with thigh length (54) or knee length (56) stockings, which were worn until discharge. There was no significant difference (p=0.05) in the incidence of deep vein thrombosis detected by fibrinogen labelled with iodine-125 (thigh length three; knee length one). Knee length stockings were more acceptable to both patients and nursing staff.

We agree with the suggestions made by Mr Heath and colleagues but would suggest that arterial occlusion would have been avoided in their reported case 2 and might have been avoided in case 1 had knee length stockings, with their advantages of cost and acceptability, been substituted.

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How to start in private practice

Sir,—Mr Anthony E Young runs an otherwise lucid and humorous account of private practice (5 September, p 593) with some naive comments that beg criticism.

On the one hand, he reminds practitioners not to let their enthusiasm for private practice nibble into their National Health Service time, while, on the other, he seems to expect his National Health Service junior staff to help in the care of patients admitted to National Health Service hospitals. I would contend that junior staff do much more than recent time spent with these patients and that they know perfectly well that the so called educational value in the patient’s con-