We agree that apparent haematuria may indicate the presence of muscle underlying the consequence of excessive steroid have been management is extremely difficult. In Dietrichson grounds BMJ diagnosis and muscle weakness that could be a presents some when the diagnosis is culminated in Engel 3 1979;2:223-8. A reduction of percutaneous biopsy may have been excluded, particularly as the treatment might have been different. 1 We use the percutaneous needle or conchoitome technique for biopsy, which allows safe, easy, and, of those was dialysis 3 renal muscle under the pressure of patients), carnitine palmitoyl transferase deficiency, and a fatty acid oxidation disorder. In those with this disease can be unable to make a specific diagnosis so far.

In view of the wide range of conditions which may precipitate myoglobinuria we recommend that patients presenting with this abnormality should be subjected to muscle biopsy performed, even when the diagnosis is apparently clear cut. 2 This obviates a problem that can occur if the patient presents some years later with an imprecise initial diagnosis and muscle weakness that could be a consequence of excessive steroid treatment. In the absence of a precise initial diagnosis and baseline assessment management is extremely difficult. In patients like the authors’ third case there is an error, and cause of early emphysema. Furthermore, in cases of diagnostic doubt additional histological anastomosis which weakness persists or worsens despite steroid treatment further muscle biopsy may allow a diagnosis of steroid myopathy to be made when on clinical grounds a decision might be made to increase the steroid dose.

We agree that it is important to monitor respiratory function in any patient presenting with a possible acute muscle weakness but would like to emphasise the importance of measuring skeletal muscle function more accurately than is possible clinically. We measure muscle force objectively using a strain gauge. 2 We agree that apparent haematuria may indicate the presence of myoglobinuria, but the underlying causes of this are more numerous than indicated in the article.

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“Plan for Action”

The past few years have seen much effort by politicians, the medical profession, and hospital administrators to solve the difficult manpower equations of hospital medical staffing. This has culminated in Achieving a Balance and the more specific proposals in Plan for Action. 3,4 The importance of these proposals has already been considered. The DHSS has previously evaded the issue despite approaches by the profession over the years.

A reduction in the length of career service of doctors and nurses by an immediate and long lasting effect on the manpower situation by increasing the annual number of consultant vacancies. Reducing the age of retirement to 60 or 62 would provide an extra five or six vacancies the renal annually in general surgery. Aside from manpower consequences there are other sound reasons for an earlier retirement. A time has been reached when the career service of many consultants has been covered completely by the superannuation scheme, and some have already retired and added years. If their pension state is such and their personal circumstances permit they can choose voluntary early retirement. This is a hidden factor that does not seem to have been taken into account in manpower calculations.

In 1985 the specialist advisory committee in general surgery, under my chairmanship, surveyed the retirement plans of general surgeons over the age of 50 in seven regions in England and Wales. We found that about half of them had made definite plans to retire at 60 or soon after. Those who were not definite but thought it likely were excluded from the count. Voluntary early retirement thus is a popular course of action and at this rate would mean an immediate bulge of about 15 extra consultant general surgical posts annually for about five years, with fewer thereafter if the trend continued among junior colleagues as seems likely.

It is encouraging that early retirement has now been recognised officially as contributing to the solution of the manpower equation but, alas, not without the cost. Whether the new proposals are explored serious limitations and concerns are uncovered. The granting of early retirement will be entirely at the discretion of central and peripheral administrators and committees. The plan is thus for discretionary, not voluntary, early retirement. There is the attraction of enhancement of pension service by up to 10 years to a maximum of 40. Is this to be a “golden handshake” to us all for long and faithful service to the NHS? It will not be so for many consultants who have been prudent in improving their pension prospects by the purchase of added years. Under the enhancement proposals added years are to be included in the reckoning of total pensionable service. This is a neat, if arbitrary, approach which requires further consideration.

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The secretary writes: “Although the usual retirement age in the NHS is 65, retirement at 60 is not usually considered to be ‘early’ retirement as it does not require any special arrangements or agreement by the health authority. It was always known that discretionary early retirement with enhancement would offer greater advantages to some than others, and the Central Committee for Hospital Medical Services fought hard to obtain additional special provisions such as compensation for reduced years of service. Such provisions, however, were not obtained, and it was ascertained that of the consultants who had bought added years only 3% would stand to gain any benefit from the new scheme, of which would gain partial benefit, and 5% would gain full benefit.” It was therefore thought that the scheme was a valuable contribution to alleviating the manpower problems and should be welcomed as such.”—Ed, BMJ.

Children in Third World slums

The recommendations of Dr William A Cutting and Professor Gopa Kothari (18 June, p 1638) are laudable and realistic in the context of the attitudes of government health officials. I have studied infant nutrition in southern India, and some of my findings may help to identify the most expedient avenues for input of resources in other regions. As a non-government district hospital in Kottayam District, Kerala, 52 consecutive attendees with children aged 6-12 months were interviewed in the paediatric outpatient department. The mean age of the women was 27 years and their health expenditure of children spent (virtually identical with findings of a survey of women from all social classes in Blaydon, Tyne and Wear, England). In Kerala 92% of mothers were still breast feeding their babies when the mean age of the babies was 8.5 months. Solids were introduced at an average age of 4-6 months. Thus traditional breast feeding and weaning practices have been retained despite the change to more “Western” practices for age at childbirth and size of families.

The infant mortality in Kerala has fallen to 20/1000 compared with the average of 115 in India as a whole. (In some states it exceeds 150 1000.) There are large differences in infant mortality but health practices coincide with and are attributed to the greater amount of education of women in Kerala compared with the average in India. In this study 75% of the women had completed secondary school and 93% had attended school up to the “seventh standard” (that is, for seven years). These values are similar to the officially estimated 95% literacy rate for the younger generations in Kerala. Kerala is below the Indian averages for per capita income and health expenditure of children spending is substantially different from that in the rest of India—86% of the total education budget is allocated to primary and secondary education whereas in the rest of the country the 47% of the total outlay goes to the health services, providing an education by only 0.2% of the population. 1

The widespread education of people in Kerala has increased their awareness of health issues, and better education makes cooperation and enthusiasm for preventive medicine more feasible. Health changes in a developing country can be achieved by concentrating limited resources on primary and secondary education, and, as Dr Cutting and Professor Kothari suggest, the education should be made appropriate and practical.

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Correction

BRL 26830A and weight loss

An error occurred in this letter by Dr J F Munro and others (18 June, p 1737). The fourth sentence of the second paragraph should read, “The results of this study were at variance with the conclusions obtained by Zed et al. Their findings were reviewed at the same time and all the possible reasons for this variance have been discussed.”
