doctors. The management committees of hospitals will also substantiate this figure.

The Merrion Committee has acted as prosecutor, jury, and judge of the overseas doctors, who now constitute 16% of general practitioners and 40% of junior hospital doctors in Britain. It is felt that the committee has given in to the pressure groups who wish to restrict immigration of doctors for political reasons. It is well known that there has always been a vocal group who felt that their bargaining position was weakened by the presence of overseas doctors here.

Is it too much to expect the Department of Health and Social Services and the BMA to dissociate themselves publicly from these findings?

S K Roy

Dagenham, Essex


Military tuberculosis presenting with polymyalgia rheumatica

Sir,—Dr C R McGavin’s letter (4 October, p 44) asks for a clarifying reply. The term “polymyalgia rheumatica” literally means “many aching muscles”; these are normally central and proximal limb muscles mainly around the limb girdles, and the presence of the syndrome is confirmed when the appropriate spinal and proximal muscles or joints are found to be restricted. The syndrome has many causes, most of which produce elevation of the erythrocyte sedimentation rate (ESR). In the case described (mycobacterial tuberculosis) the syndrome was suspected from the history and signs before the ESR became elevated. Once its cause was found to be widespread tuberculous infection steroids were not indicated and not given. The symptoms and signs resolved following a course of antituberculosis therapy.

The fact that polymyalgia rheumatica is a syndrome with many causes needs emphasis. As many patients arrive in clinics without blood test results it is preferable to confine definition of the syndrome to its clinical features.

J A MATTHEWS
D L CHILD
Department of Rheumatology,
St Thomas’s Hospital,
London SE1

Renal stones and coronary heart disease

Sir,—Coronary heart disease and renal stones are both disorders increasing in frequency in the Western world, to some extent precluding owing to the raised standard of living. An association between the two diseases has been reported, with a higher stone prevalence in patients with myocardial infarction.1 2 Risk factors for coronary disease have not been systematically investigated in renal stone formers, but raised serum cholesterol3 and high blood pressure4 have been reported. Over-consumption of vitamin D has also been suggested as a precipitating cause.

In a health survey of more than 2000 middle-aged men in Uppsala, Sweden, 13.7% were found to have a history of previous renal stone disease.5 Some of the clinical and laboratory findings in stone formers and their matched controls are listed in the table. Only in diastolic blood pressure was a significant difference found (P<0.05). This was primarily due to a greater number of individuals in the highest ranges. Thus 7.4% of stone formers had an uncorrected diastolic pressure of 105 mm Hg or more compared with 2.0% of controls. Stone prevalence was also investigated in a consecutive series of 102 male survivors of myocardial infarction and was found to be 27.8%, which is much the same as in the health survey, though the survivors were somewhat older (mean age 59 years). The vitamin D intake in survivors of myocardial infarction, renal stone formers, and their matched controls was studied. The average daily consumption was below 10 μg in all groups and there were no differences between them.

In conclusion, the coronary risk profile was similar among renal stone formers and carefully matched controls in this study of a well-defined male population. Furthermore, individuals surviving myocardial infarction did not have a higher prevalence of renal stones than matched controls. This is in contrast to some other reports. Compared with the Norwegian studies2 6 cited above differences in dietary habits, including vitamin D consumption, could be part of the explanation for this contrast.

SVERRK LUNGHALL
HANS HEIDSTRAND
Department of Internal Medicine,
University Hospital,
Uppsala, Sweden

2 Lindahl, V. British Medical Journal, 1974, 3, 647.

Health Service administration

Sir,—Mr P H Lord (15 November, p 405) is unfortunately not alone in talking of the “tiers” of district, area, region, and Department of Health and Social Security as though they were completely different bodies at different levels. Mr Lord may be equating “districts” with the previous hospital management committees. The only levels of authority are the Secretary of State, the regional health authorities and the health authority. “District” is a geographical part of an area in which the services are managed by the district management team—a group of officers and clinicians who are accountable to the AHA.

Mr Lord describes the area as a “political gimmick.” Areas were deliberately created coterminous with the new counties (or in conurbations with the metropolitan districts) to facilitate collaboration with the local authorities with which the NHS shares responsibility for services for large groups of patients with real needs, such as the elderly, psychiatrically ill, and handicapped. The 28 AAs (with their family practitioner committees) have replaced a much larger number of local health authorities, hospital management committees, and executive councils. To abolish the lowest level of authority, as Mr Lord suggests, would make control remote indeed. It would also mean a large number of senior officers directly accountable to the RHA—a daunting prospect even in a region as small as the one in which he and I work.

Finally, Mr Lord assumes that the demise of the HMC has resulted in the loss of the voice of the consumer. Has he overlooked the new community health councils, whose sole job is to represent the viewpoint of patients in each district?

D E CULLINGTON
Department of Rheumatology,
Middlesex Hospital,
London W1

Antibiotic diarrhoea

Sir,—In your leading article on this subject (1 November, p 243) you omitted to mention a recent report in which the successful use of cholestyramine in lincomycin- and clindamycin-induced pseudomembranous enterocolitis (PME). These drugs cause diarrhoea in 10-50% of patients treated3 4 and PME allegedly in 10%. These are such widely used and useful drugs, especially in the treatment of Gram-negative anaerobic infections, that it would be worth while doing a double-blind study to investigate the use of bile-salt-binding resins and their mode of action in antibiotic-induced diarrhoea and PME.

P L KINSELLA
Department of Rheumatology,
Middlesex Hospital,
London W1

Clonidine overdose

Sir,—A man aged 44 years was given 50 tablets of clonidine, each of 100 μg—that is, a total of 5000 μg—dissolved in his soup. He slept heavily that day and sweated a lot. The following four days were troubled by diarrhoea (to which he was also prone) and his blood pressure was 120/80 mm Hg. His usual range was 180/110-150/100 mm Hg on 100 μg of clonidine three times a day.

The British National Formulary includes constipation and fluid retention among the side effects of clonidine. This case suggests that the warning may also be true. Forced frusenide diuresis in clonidine overdose was recommended by Dr S N Hunyor and others (4 October, p 23). I support the view of Dr L M H Wing and his colleagues (15 November, p 408) that this is unnecessary as the excess clonidine is excreted in the urine and eliminated extrarenally.

J SAPERIA
London E10