little prudent practical advice some years ago to them, and their wives, would have been appropriate since they belonged to a small group of men likely to outlive their spouses. Preventive medicine could almost certainly have helped these two men.

The elderly also deserve attention since we are often responsible as a profession for prolonging life—and this applies as well to those who live on with physical handicaps. Recently a young man walked two miles to see me using his crutches as he was unable to board a bus. The smile on his face was a great reward to me; but he said that my comment "You have a young head on those shoulders" meant more to him than the superb diagnosis and neurosurgery which had left him with organic impotence but a normal expectation of life. What a joy to be able to return him to a doctor who can continue to understand, which helps him even if, sadly, we cannot hope to do any more.

Prevalent unemployment is throwing up yet more problems—those with perversions who coped when reasonably busy are now in potential trouble. Recently I saw two men, one a respected professional man made redundant who had coped well in a family atmosphere until he had more time on his hands to practice his transvestitism; the other a manual labourer who, again, had managed to control his wish to expose himself indecently when he was physically tired by work. Both live in fear of bringing shame on their families. An understanding doctor can help patients over these bad times.

Certainly the more of us who as doctors can leave ourselves out and not make facile assumptions about which are patients' worst problems the better. Doctors will then be helping more patients, thus leaving that minority of difficult cases to be seen by specialists trained to have a more analytical approach. Part of my training with the Institute of Psychosexual Medicine was shared with a neurological registrar at an old London teaching hospital who developed a special interest in psychosexual problems, sadly so often occurring with neurological disorders. His senior registrar was very disturbed by the intimate consultations audible from the adjacent cloth cubicle, but undoubtedly that caring registrar became a very special doctor.

What vastly better medicine we would all practice if the door was left open, even if only a crack, for patients to feel that they could voice sexual problems and be allowed to do what they do in all other areas of medicine—asking only those questions to which they really want answers.

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Non-rheumatic mitral regurgitation

SIR,—I found that your leading article "Non-rheumatic mitral regurgitation" (27 June, p 2076) gives an excellent up-to-date review on the subject, including the pathophysiology, diagnosis, prognosis, and therapy. It is on the last aspect that I wish to comment.

While it is generally agreed that the treatment for patients with symptomatic mitral regurgitation is surgery, the best type of operation is still not universally agreed on. Valve replacement is technically easier and more fashionable nowadays than repair. However,

prosthetic valves require long-term anti-coagulant therapy, which carries a risk in itself. Although porcine heterograft obviates the need for anticoagulation, its uncertain long-term durability makes it a less-than-ideal substitute especially in the young.¹ Therefore reconstructive surgery still has its place, especially if done by experienced surgeons like Carpentier² and Kay.³ No matter how much improvement in design a prosthetic or biological valve may achieve, there is nothing better than one's own heart valve. So let us keep it in if at all possible; we can always replace it later when a "perfect" artificial valve is found.

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¹ Kirklin JW. *N Engl J Med* 1981;304:291-2.

² Carpentier A, Chauvaud S, Fabiani JN, et al. *J Thorac Cardiovasc Surg* 1980;79:338-48.

³ Kay JH, Zubiate P, Mendez MA, et al. *Am Heart J* 1978;96:253-62.

Prickly heat

SIR,—Your answer on prickly heat ("Any Questions?" 13 June, p 1946) and Dr G G Sherriff's letter (11 July, p 145) in my opinion omit the most important factor in the prevention of this condition.

Prevention is achieved by avoiding the use of soap. The average expatriate taking one, two, or more showers or baths in hot climates automatically reaches for the soap, as he has always done, and washes out the natural oils and waxes from the skin. The shower or bath without soap is equally refreshing and cleansing; soap applied to the crutch and axillas very sparingly and well washed off once daily is all that is needed.

In general, Indians suffer from the heat like anyone else but rarely from prickly heat. They bathe frequently but use soap minimally. I followed this method and never suffered from prickly heat during my last eight years in India. Light clothing should be worn, preferably of cotton and not man-made fibre.

It seems to be a contradiction to say that prickly heat is due to "obstruction of sweat pores by keratin plugs," as is repeated in many text books.

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Rectal examination and acid phosphatase

SIR,—For years controversy has existed on the effect of rectal examination on serum levels of acid phosphatase enzyme activity. Recently Dr A S Daar and others (25 April, p 1378) concluded that rectal examination did not cause elevations of the tartrate-inhibited fraction of this enzyme in serum as measured by its catalytic activity. A radioimmunoassay which directly measures the mass of enzyme protein has recently become available to quantify this enzyme. Here we show for the first time that rectal examination can cause an increase in immunoreactive acid phosphatase.

Thirty-four patients ranging in age from 12 to 86 years with prostatic and non-prostatic disease had a rectal examination for a period of approximately 30 seconds. Blood was taken before and 30 minutes after examination. Immunoreactive acid phosphatase was determined using a commercial kit (Clinical

Assays). The normal range was taken as 0-2 µg/l. Twenty-eight out of 34 (82%) patients showed a rise from the normal range to the above-normal range following rectal examination. The increase ranged from 0 to 14-fold with a mean increase of 4.3-fold.

We conclude that for the majority of patients rectal examination causes elevations in the serum level of immunoreactive acid phosphatase at least after 30 minutes.

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Treatment of anaphylactic shock

SIR,—We feel that we must respond to the letter from Dr L J F Youtlen and his colleagues (18 July, p 231) in the same way as we responded (18 April, p 1319) to your original leading article on the treatment of anaphylactic shock (28 March, p 1011). We do not deny that adrenaline is the most effective treatment. The point is that it is also the most dangerous, and if this condition can be treated successfully with safer drugs then adrenaline should be avoided.

Dr Youtlen and his colleagues support their advocacy of adrenaline by telling us that many patients seen at their allergy clinic report a poor response to conservative drug treatment. We find it hard to believe that any patient ill enough genuinely to require adrenaline can remember which drug they did or did not respond to. However, if that is the case the fact that they have all apparently lived to tell the tale suggests that the policy (advocated by us in our previous letter) of using steroids and antihistamines first, and progressing to the use of adrenaline only if there is no response, is safe. To challenge this policy Dr Youtlen and colleagues should publish details of patients who have not survived anaphylactic shock because adrenaline was not given as first-line therapy.

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Oldest case of sarcoidosis in the world

SIR,—The report of Dr F G Brown and others (18 July, p 190) was interesting and stimulates me to mention an 88-year-old patient with histologically proved sarcoidosis.

This woman was admitted to hospital in King's Lynn following a fall at home which fractured her femur. Before this was pinned an electrocardiogram (ECG) was taken, which showed first-degree heart block with left bundle-branch block. She died some hours after operation and at necropsy her heart weighed 420 grams; the coronary arteries were remarkably normal; and there were sarcoid granulomatous infiltration and fibrosis in the myocardium and granulomas also in the lymph nodes, lungs, liver, and spleen.

Retrospective view of her case notes showed that four years previously she had had a cholecystectomy