them. Firstly, the disappearing punctuation mark. Will someone, in the name of heaven, tell me how an author can make his meaning clear between a man-eating shark and a man eating shark without the lowly hyphen? Secondly, the deplorable ignorance of capital letters. Without capitals and without punctuation marks will dph eventually mean Diploma in Public Health or Doctor of Philosophy?

This is what Loewe and Lerner, in "My Fair Lady," made Professor Higgins call "the cold-blooded murder of the English tongue."

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Police surgeons and child abuse

SIR,—In their article on legal aspects of child injury or neglect (13 October, p 910) Dr J A Black and Mr F Hughes do not mention the useful and valuable part to be played by the police surgeon. If all cases of suspected and actual child abuse were reported to him he could deal with the legal aspects, leaving the paediatricians free to solve the medical problems. Perhaps it is time that the police surgeon was appointed consultant forensic physician (part-time) to local hospitals and then these difficulties would not arise.

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Fetal hazards of altering hypotensive regimens in pregnancy

SIR,—Following our article (16 June, p 1591) we were disappointed to read a letter from Dr A M Nysenbaum and others (4 August, p 331) regarding the use of oxprenolol in pregnancy. This letter demonstrates clearly all of the problems of poorly documented anecdotal reports; despite the presence of at least four clear-cut high-risk factors for fetal death in the case described, a fifth cause is proposed.

The authors do not state the nature of the diabetic control nor the adequacy of blood pressure control on either of their regimens of treatment. They give no information regarding the presence of proteinuria or of renal function or impairment, and there are no data regarding fetal heart rate or its variability pre- or post-amniocentesis, a procedure which itself carries a considerable risk of fetal morbidity and mortality.

The fetus was clearly at risk of intrauterine death at least two weeks before its occurrence; all of the risk factors operative at that time continued and at least one, hypertension, became worse. Close fetal monitoring and measurement of the lecithin to sphingomyelin ratio at 30 weeks' gestation may have been advisable. If it were then decided that it was not in the best interests of the fetus to effect delivery, perhaps better control of hypertension by adjusting the dosage of the existing therapeutic regimen or by the addition of appropriate drugs to those already in use would have been the most appropriate course of action rather than merely switching to a new agent.

We feel strongly that the use of any pharmacological agent in human pregnancy must be subjected to close critical scrutiny. This must also include close critical scrutiny of the clinical situation in which the drug is used and

of all the other variables in management that produce an effect. Only by consideration of the whole picture can the importance of a particular observation be assessed correctly.

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Work of a day-bed unit 1972-8

SIR,—The article by Dr J B Rainey and Mr C V Ruckley (22 September, p 714) on the work of a day-bed unit in Edinburgh was most interesting, and the authors must be congratulated on having one of the best day-bed units in the country. In commenting unfavourably, however, on the work done in the Coventry Surgical Day Unit reported by me in 1972, they are not comparing like with like. With his lavish accommodation—24 beds, twin theatres, two endoscopy rooms, etc—Mr Ruckley clearly had no option but to persuade all the specialties to use it, and the high numbers of gastroenterological and haematological investigations pay tribute to his success. But in Coventry the physicians already had an excellent endoscopy clinic, and the day unit was set up specifically for surgery, with 12 beds and one operating theatre.

In its first year (1971) 2475 operations were done, divided among general surgery (1020), ear, nose, and throat (575), urology (510), and orthopaedic surgery (225), with 89 cases of dental surgery. In addition, some 400 patients were treated for varicose veins by sclerotherapy, without operation. No gynaecology was done, mainly because the gynaecological unit was situated in another hospital five miles away. I am surprised that no ENT work is done in the Edinburgh unit; those in Coventry were mainly children, for whom, of course, day surgery is ideal. There may be advantages in carrying out both medical and surgical measures in one unit, but bigger is not always better, and there is much to be said for a specifically surgical day unit. I submit that with less than half the accommodation in Coventry, the figure of some 2900 cases (1971) compares most favourably with the Edinburgh figure of 3600 (1972).

On a personal note: after my article in the *BMJ* in 1972 I was reproved by Dr H G Calwill for having mis-spelt Nicoll. Mr Nicoll, surely the patron saint of day surgery, was, alas, long since dead and could not complain. I can, and do.

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Too few necropsies . . . sarcoid heart disease

SIR,—I was very interested to see Professor J R Anderson's reply (13 October, p 932) to my letter (25 August, p 501). Of course I very much agreed with what he said and perhaps I might be permitted briefly to make a few points.

(1) Early in my training as a physician I worked for a year as a pathologist and 30 years later I still regard this as some of the most valuable time I have spent. I am disturbed to

find frequently the lack of interest shown in necropsies by otherwise good junior medical staff.

(2) Indeed, some of my complaints do arise from coroners' necropsies and my letter was finally precipitated by one such example. It is quite evident that the pathologist in question was under the sort of pressure mentioned by Professor Anderson, as he has been most courteous and helpful about the information he has provided—disappointing though it is. He had no clinical details even though the patient was a relatively young woman with a pace-maker.

(3) I would like to make it clear that my comments do not apply to East Anglian pathologists, from whom I have collected a disproportionate number of cases of sarcoid heart disease. This is helped by the habit of sending unusual hearts to the regional cardiac centre for further examination, and I would suggest that this practice might be more widespread.

(4) The continuing study on sarcoid heart disease is not just an academic one. Its importance is being increasingly recognised and the matter has arisen in connection with flying personnel.¹ I know that other important cases are under consideration in more than one country.

(5) Could I finally suggest that sarcoid heart disease should not be overlooked in any case of sudden death or unusual heart disease? I would urge the busy pathologist at least to take a few sections from the interventricular septum. If his duties do not permit these to be examined in his own laboratory, my pathological colleague, Dr P G I Stovin of the same address, would be happy to receive them.

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¹ Pettyjohn, F S, *et al*, *Aviation, Space and Environmental Medicine*, 1977, 48, 955.

Reversible renal failure during treatment with captopril

SIR,—We were interested to read the report from Dr P Collste and others (8 September, p 612) of another case of renal failure in a patient with renal artery stenosis treated with captopril. We have already given our reasons for concluding that in our case the renal failure was more likely to be due to direct nephrotoxicity than to ischaemia (23 June, p 1680), but I would agree that in the patient they describe ischaemia was the likely cause. We have since treated another patient with captopril and to our surprise again noted an increase in serum creatinine beginning at the same time as a febrile episode and returning to pretreatment levels on withdrawal of the drug.

The patient, a white woman aged 30, was found to be hypertensive in 1974. Initial investigation showed normal intravenous urogram serum creatinine (110 $\mu\text{mol/l}$ (1.2 mg/100 ml)), and urinary 4-hydroxy-3-methoxymandelic acid; and microscopic examination showed no abnormality. Control was difficult over the next year and in 1975 she developed renal failure. Peritoneal dialysis was necessary for three months, during which time her blood pressure was better controlled and renal function improved (serum creatinine 450 $\mu\text{mol/l}$ (51.1 mg/100 ml)). Renal arteriography at that time showed no abnormality. Over the next three years her blood pressure was poorly controlled despite large doses of atenolol, frusemide, prazosin, methyl dopa, and spironolactone. At that time her serum creatinine was 291 $\mu\text{mol/l}$ (3.3 mg/100 ml),