we would like to suggest that at least two factors be taken into consideration. Firstly, because the activity of EFAs is now thought to rest in their conversion to the longer-chain derivatives used for cell membrane and prostaglandin production, the long-chain derivatives themselves ought to be given as part of the nutritional supplement. Secondly, the amounts of non-essential fatty acids given should be controlled because high dietary levels of these fatty acids are known to compete with EFAs for the enzyme systems that give rise to the active longer-chain derivatives.

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Cancer and arterial disease

SIR,—Minerva states (6 January, p 62) that if a cure for cancer were found this year life expectancy would increase only by two years, because most cancers occur in 70 year olds and cancer survivors would still be at risk from heart disease and stroke.

I wonder whether this is so? As a "morbid" pathologist, approximately 4000 necropsies have left me with a strong impression that the incidence of severe arterial disease is surprisingly low in patients who die of cancer—and that where death is due to atheroma anywhere in the arterial tree it is exceptional to find concomitant neoplastic disease. Perhaps some keen young registrar might investigate whether cancer and arterial disease are in any way mutually exclusive?

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New approach to treatment of recent stroke

SIR,—Dr A K Admani has reported on the use in stroke of the interesting product naftidrofuryl (16 December, p 1678). Several accounts of its effect in cerebrovascular accident have appeared since that of Eichhorn¹ in 1969, and this casts doubt on the claim that this is a "new approach to treatment of stroke." However, previous reports have suffered from failure to distinguish the diagnostic group being treated ("stroke" is not a diagnosis).

In Dr Admani's study all patients were considered to have suffered "recent ischaemic cerebral infarction," but unfortunately he gives no details of how the diagnosis was made; presumably the grounds were clinical only, and therefore up to 30% of his patients were a mixed group with cerebral haemorrhages, brainstem strokes, tumours, etc.² Confirmation that he intended the term

"cerebral" to exclude brainstem would have been helpful since, in common usage, it does not. The meaning of "recent" has to be deduced from table II: mean interval from stroke to treatment was from five to six days in both groups but, as each mean was exceeded by the standard deviation, the distributions were skew. The medians would have been more meaningful for comparison, but the upper and lower limits acceptable for entry to the trial, simply stated, would have indicated what was actually being done. It was another criterion for admission to the trial that patients were "conscious," but this term has little meaning without qualification.

Reliance was placed on randomisation to match patients, but the studies by Bauer and Tellez³ and, more recently, Mulley *et al*⁴ have demonstrated how ill advised this is in trials of this size.⁵ To state that the two groups at admission were fully comparable, with no appreciable difference in an overall assessment score derived by summing subscores for numerous neurological and neurophysical variables, is fallacious in the absence of diagnostic equability. Although each subgroup of variables was separately scored, the procedure remains statistically unsound if different parameters are included in a single comparison—for example, nystagmus, rated on a 4-point scale, with ataxia and incoordination (what, incidentally, is the distinction between the last two terms?). Nor does the rating include external ocular movements, generally accepted as an important prognostic factor.⁶

Although this trial produced a result favourable to naftidrofuryl, the finding has no greater validity than the trial design. In view of our criticisms, we feel that a definite benefit in stroke from naftidrofuryl cannot yet be claimed, but further studies are indicated.

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Management of refractory oedema

SIR,—I was interested in your leading article "Management of refractory oedema" (20 January, p 148). A trick I have found repeatedly useful in treating patients with resistant oedema due to cardiac or renal failure is that of combining metolazone or a thiazide diuretic with a loop diuretic; after seemingly adequate doses of the latter have not produced satisfactory results, the addition of metolazone or a thiazide often seems to "turn on the tap."

This observation is not uniquely personal and yet I have never seen any account of it in writing. I would be interested to hear other people's views.

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SIR,—Your leading article on the management of refractory oedema (20 January, p 148) failed

to mention continuous infusion of low doses of frusemide as a therapeutic measure. This was described by Schrire,¹ who noted that small doses of frusemide (20-60 mg) combined with aminophylline in a continuous infusion often produced a good diuretic response in refractory congestive cardiac failure. Lawson *et al*² administered frusemide at infusion rates of 4-16 mg/h and obtained effective diuresis at blood concentrations below those at which extrarenal toxic effects were seen.

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Ice age ulcers

SIR,—We write to report a topical condition which is in evidence at this time of year, and which may give rise to some confusion.

A young man reported with a linear blister on the left knee which had been present for two or three days. It was thought that this might be a hot-water bottle burn, but he denied this possibility strongly. He reappeared two weeks later with several impetiginised lesions around the joint; one was about 2.5×1.3 cm at the lateral side of the joint, and this formed a typical eschar which has been very slow to heal. The aetiology of the blisters became plain today when he attended the clinic with another blister on the lower leg. On this occasion he admitted that this was indeed a hot-water bottle burn. Like many patients he was of the opinion that if the hot-water bottle was not too hot to touch it could not burn him.

Several other patients with similar lesions on the legs have been seen during the past few weeks of the cold weather.

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Road accidents and the police

SIR,—In a recent article on road accidents (20 January, p 177) your special correspondent discussed the role of the police in accident prevention and law enforcement, but failed to mention their contribution to the management of the seriously injured.

The first task of the police at road accidents is to secure the crash scene and to communicate with the emergency services. They should then be engaged in the primary care of the severely injured until the ambulance arrives. In a scrutiny of persons present on the scene before the arrival of the ambulance in 636 cases, the police gave first-aid in 27.5%.¹

Information was obtained from five northern county police forces about first-aid training and the equipment of patrol cars. The instruction of new entrants varies from 13 to 18 hours. Refresher courses of 6-15 hours are held every 3-5 years for the first 10-15 years of service. Lectures and demonstrations are given by general practitioners and lay instructors. Modern methods of resuscitation have become so specialised that the police would be well advised to seek the help of consultants (anaesthetists and casualty