dependent of the area of liposclerosis at the beginning of treatment.

With leg ulcers there is some evidence¹ that healing follows a logarithmic curve, large ulcers healing faster than small ones. This biological phenomenon may well apply to the healing of liposclerosis; if so transformation of the data is essential before paired comparisons are made. In the discussion the authors mention that other methods of assessing healing, such as percentage change, appeared to offer no advantages, but in what respect?

HAYDN L MUSTON

Skin Hospital,
Manchester M3 3HL

¹ Perdrup A. *Acta Derm Venereol (Stockh)* 1972;52:136-140.

Misericordiae medicinae

SIR,—Following Dr James Dunlop's interesting paper on misericords (22-29 December, p 1673), your readers may like to know of another "medical" misericord. This is to be found in Malvern Priory Church.¹ It depicts a patient in bed flanked by a worried looking female (wife?) and a physician holding a wine flask in the left hand; with the right hand he is taking another such flask offered him by the patient. He seems to be comparing the two specimens, which are likely to be from the previous and the present day respectively.

M LIVIA OSBORN

Institute of Family Psychiatry,
Ipswich, Suffolk

¹ Kraus B, Kraus H. *The hidden world of misericords*. London, Michael Joseph, 1976.

Prognosis after myocardial infarction

SIR,—I was puzzled by your leading article (24 November, p 1311) "Prognosis after myocardial infarction." After noting that ventricular premature beats are associated with increased mortality, you state that "such observations are of epidemiological rather than individual importance." No one could fault your epidemiology, since it is clear that the majority of deaths in persons with coronary disease are sudden, and almost always due to ventricular fibrillation, usually without new thrombosis or infarction (in those who are promptly resuscitated).^{1,2} Lown has put forward the thesis that ventricular fibrillation is an "electrical accident" which is predictable and preventable—by suppression of high-grade "warning" arrhythmias.³ Others have considered these arrhythmias,⁴ as you put it, "probably an indication of heart disease rather than a direct cause of death," since there is a good correlation between ventricular impairment and arrhythmia. However, there are at least six prospective multi-variate studies which have demonstrated that ventricular premature beats, especially very early beats and couplets, predict mortality independently of both clinical and ventriculographic indices of heart failure.^{3,5} Furthermore, even very poor left ventricular function does not prevent suppression of ventricular tachycardia and consequent prolongation of survival.^{2,6}

Admittedly it is not yet proved to everyone's satisfaction that suppression of malignant

arrhythmias reduces mortality, though there are recent data which suggest this. Circumstantial evidence includes the secondary prevention trials with beta-blockers¹⁰ and with sulpinpyrazone,¹¹ both of which are effective antiarrhythmic agents in addition to having other salutary properties.¹² More direct evidence is found in studies by Green *et al*,⁷ Spielman *et al*,⁹ and Lown,² though large-scale randomised trials have yet to be conducted.

Exactly how much evidence is enough is a matter each physician resolves individually, but it is worth noting, in comparison, how little evidence we have that digitalis, diuretics, or afterload reduction prolongs survival. In fact, very few of the things we do have been proved in prospective, double-blind trials. The rest we do because they make sense and because experienced clinicians have found them to work. Thus, until there is evidence to the contrary, it seems reasonable to continue to treat high-grade arrhythmias in the post-infarction patient as a matter of individual, and not merely epidemiological, importance.

WARD CASSCELLS

Beth Israel Hospital,
Harvard Medical School,
Boston, MA 02215, USA

- ¹ Schaffer WA, *et al*. *N Engl J Med* 1975;293:259-62.
- ² Lown B. *Am J Cardiol* 1979;43:313-28.
- ³ Coronary Drug Project Research Group. *JAMA* 1973;223:1116-24.
- ⁴ Schulze R. *Am J Med* 1977;62:192-9.
- ⁵ Ruberman W, *et al*. *N Engl J Med* 1977;297:750-7.
- ⁶ Hammermeister KE, *et al*. *Circulation* 1979;59:421-30.
- ⁷ Greene HL, *et al*. *N Engl J Med* 1978;299:729-34.
- ⁸ Moss AJ, *et al*. *Circulation* 1979;60:998-1003.
- ⁹ Spielman SR, *et al*. *Clin Res* 1979;27:569A.
- ¹⁰ Wilhelmsen L. *Cardiovasc Med* 1978;3:557.
- ¹¹ Anturan Reinfection Trial Research Group. *N Engl J Med* 1978;298:289-95.
- ¹² Moschos C, *et al*. *Am J Cardiol* 1979;43:372.

Tardive dyskinesia

SIR,—In your leading article (24 November, p 1313) under this heading you end with the sentence "The ghost of Voltaire is there to remind us that, even if further trials confirm the safety of clozapine in respect of tardive dyskinesia, it may turn out to produce other, as yet unknown, side effects in long-term use."

Long-term? Clozapine had to be withdrawn from the market after only six months' use in Finland in 1975 because, of the 3160 patients already treated, 17 developed severe bone marrow depression. Eight died of agranulocytosis and one of leukaemia.¹

PETER ELMES

MRC Pneumoconiosis Unit,
Llandough Hospital,
Penarth, S Glam CF6 1XW

¹ Idanpaan-Heikkilä J. In: *Studies in drug utilisation*. WHO Regional Publications, European Series, No 8. Copenhagen, WHO, 1979.

* * * Decisions on drugs vary from country to country. Clozapine was undergoing clinical trial in several countries when our leading article was published.—ED, *BMJ*.

Iron treatment in the elderly

SIR,—Dr Peter Reizenstein and others (20 October, p 962) reported on the overprescribing of iron tablets to elderly people in Sweden. They concluded that in Sweden one in 10 women over 65 were prescribed iron tablets. When investigating the situation at a rural

health centre, they commented on the numbers who did not, in fact, have iron deficiency anaemia and concluded that iron should not be prescribed until the possibility of a bleeding gastrointestinal tumour has been excluded.

We have obtained data on iron prescribing in England and Wales on the basis of one in 10 sample of prescribing general practitioners. From this it appears that in 1977 2.8% of elderly people (men over 65, women over 60) were prescribed iron therapy. This is considerably less than the Swedish figure of 10%. There is, however, a wide variation between different prescribers. It is not known how many of these have been investigated for the exclusion of a bleeding gastrointestinal tumour.

It is difficult to make valid comparisons between the United Kingdom data and those from Sweden, and indeed the methods used to study the question are different. Dr Reizenstein and his colleagues compare the use of iron between different countries on the basis of Swedish crowns expended per person. This method is a complex one which would be influenced by marketing and economic conditions as well as by the prescribing methods used in the different countries. Our findings suggest that up to 400 000 people of retirement age in England and Wales could have been treated for iron-deficiency anaemia in 1977.

B N C LITTLEPAGE
R MAPES

West Glamorgan Health Authority,
Medical Sociology Research Unit,
Swansea

The practice nurse

SIR,—Dr W H R Waters and others (12 January, p 87) in their excellent paper on the work of the practice nurse make in their summary the statement "... this would not have been possible if the staff concerned had been attached nurses requiring area health authority authorisation for procedures carried out..."

It is unfortunate that this summary, probably unintentionally, conveys the impression that all NHS area health authorities would inhibit in this way. Our practice for one has carried out the procedures listed with attached staff and a treatment room fully staffed by attached nurses for over 10 years, allowing direct access to nurses by patients.^{1,2} But one does know that there are many others.

E V KUENSSBERG

Edinburgh EH5 2NT

¹ McGregor SW, Heaseman MA, Kuenssberg EV. *The evaluation of a direct nursing attachment in a North Edinburgh practice*. Scottish Health Service Studies No 18. Edinburgh: Scottish Home and Health Department, 1971.

² Kuenssberg EV. *Practitioner* 1971;206:129-45.

In defence of clinical freedom

SIR,—At a time when the concept of clinical freedom is under attack on economic and other grounds, I would like the opportunity to point out to your readers a distinct advantage to the provision of services arising from this freedom. I refer to the modern hospital geriatric service with its active and energetic approach to rehabilitation resulting in a rapid turnover of patients, many being discharged home after only a short time in hospital. Such a policy has enabled the hospital services to