the raised pressure, oedema, and ischaemia but that peripheral nerves are also vulnerable—sometimes with dire sequelae, as in the following case.

A 19-year-old boy, a known LSD and barbiturate addict, was found in coma in a flat, lying under the naked body of his girl friend, who was dead. He was found to have a left hemiparesis, and when he was eventually discharged from hospital after several weeks pain and weakness of the right leg became evident. He had a complete sciatic nerve palsy with extensive wasting, weakness, and foot drop accompanied by cutaneous hyperalgesia and "hyperaesthesia." These signs have failed to clear up after four years, and his life is plagued by intractable causalgic pain, the management of which is not helped by his premorbid personality—which has not materially changed since the incident.

Barbiturate overdosage was one of the drugs responsible for coma in this case, and the evidence was that he had been in this one "fixed" position for over 24 hours. One assumes that the high pressure in the posterior compartment of the thigh, probably combined with local compression of the nerve, produced irreversible ischaemic necrosis. There is abundant evidence of similar mechanisms in other peripheral nerve entrapments, the Saturday night palsy of the radial nerve being a familiar example. It is likely that even normal sleep can permit the compression of the arm or forearm by the head, and the pressure of 100-200 mm Hg in the arms is certainly an important if temporary factor in the carpal tunnel and cubital tunnel syndromes. We do not know how long such pressures are present before discomfort or paraesthesia awakens the normally sleeping subject; but the time, which may be a critical factor, will be increased by any hypnotic—perhaps even by a modest "night-cap."

J M S PEARCE

Department of Neurology,
Hull Royal Infirmary,
Hull, N Humberside

Medical charities, prevention, and the media

SIR,—We were pleased to see your leading article on the reluctance of British medical charities to fund educational and preventive initiative (22-29 December, p 1610). It is to be hoped that your comments will stimulate not only a constructive discussion of the issues raised but also changes in policy and practice. In passing we would suggest that the role of professional advisers is crucial—charities need advisers who are knowledgeable about education and prevention. There is, however, another aspect of this problem, which has been clearly illustrated in recent weeks—namely, the role of the media in fostering inappropriate ideas of how to make progress in health.

On 10 November the *BMJ* (pp 1173 and 1178) published the first major results from the Finnish North Karelia study aimed at reducing the ravages of cardiovascular disease by focusing on prevention (pp 1173 and 1178). Regrettably, very few newspapers or broadcasting organisations reported and discussed these complex but very important papers. It so happened that these were published during a period of euphoric and extensive publicity about heart transplants—ranging from Mr Castle's love of football to Mr Barlow's supper of cheese soufflé, cauliflower, and mashed potatoes. Such an imbalance in coverage by the media is, of course, highly damaging to public understanding of progress

in health. It is not surprising that the public in general and charitable foundations in particular should begin to develop some strange ideas about tackling the modern epidemic of cardiovascular disease. The National Heart Fund rushed to finance transplantation and was reported to be hoping to "persuade the government eventually to finance it on the health service."¹

The project in North Karelia was focused on preventive activities. Significantly, the actions taken were not restricted simply to exhorting individuals to behave themselves but ranged from conventional health education to measures to affect the price and availability of relevant foodstuffs. As readers of the recent reports will be aware, the precise effects of the programme are not yet known, but the prevalence of the risk factors was strikingly reduced and, more importantly, mortality from cardiovascular diseases fell significantly during the five years studied. There are difficult problems of interpretation. The Karelia papers show that mortality in the control area also fell, while Drs T Valkonen and M-L Niemi (5 January, p 46) point to the earlier decline in mortality in the more urban western countries. However, the key issue is that the toll from cardiovascular disease in Finland is falling and preventive initiative seems to have contributed, yet there has been little public discussion of this success story. If editors, producers, and journalists did not know about the Finnish results, the alerting mechanisms within the media are seriously at fault. If they did know, what prompted most of them to relegate the reports to the wastepaper bin?

We believe that the media have a strong influence on the agendas of public discussion and hence on many of the policies we eventually get, not least the funding policies of medical charities. There have been few clearer examples of distorted agenda (and consequently the likelihood of misdirected and inappropriate policies) than the recent coverage of heart transplants. The neglect of significant—albeit not glamorous—preventive initiatives and the consequences of this are aspects of "medicine and the media" which seem to deserve more attention.

JENNIE POPAY
PETER DRAPER

Unit for the Study of Health Policy,
Department of Community Medicine,
Guy's Hospital Medical School,
London SE1 1YR

¹ *Guardian*, 16 November 1979.

Drug-induced oesophageal injury

SIR,—The features of drug-induced oesophageal injury have recently been well described by Mr F J Collins and others (23 June, p 1673) and in subsequent correspondence. We would like to point out some features observed in the following case which have not been noted previously.

A 43-year-old woman with longstanding symptoms of gastro-oesophageal reflux was admitted with a five-day history of epigastric discomfort and retrosternal pain exacerbated by swallowing. Her husband had noticed that she had developed bad breath despite regular cleaning of her teeth. For the previous three months she had taken emepromium bromide intermittently and had taken a course of eight tablets (two four times a day) 10 days before admission. On examination she was pyrexial (38°C), with a tachycardia of 112 beats/min and a leucocytosis in the peripheral blood of $14.3 \times 10^9/l$ ($14\,300/\mu l$). A mild acute-

phase reaction was present on serum protein electrophoresis but her chest radiograph and urine specimen were normal. Upper alimentary endoscopy demonstrated annular ulceration in the oesophagus from 25 cm to 30 cm from the teeth. Symptomatic treatment was given for one week, at the end of which time the patient was symptom free. A barium meal demonstrated a sliding hiatus hernia with reflux but no abnormality of the oesophagus.

We infer that the halitosis and signs of systemic disturbance arose from the iatrogenic ulceration of the patient's oesophagus, which was also the cause of her dysphagia. These findings are not characteristic of reflux oesophagitis and if found in association with dysphagia should prompt a search for another cause—in particular a drug history.

J D R ROSE
G B TOBIN

Addenbrooke's Hospital,
Cambridge CB2 2QQ

Reflux oesophagitis

SIR,—I read with interest the letter from Dr B A Scobie, (17 November, p 1292) and would agree that a more detailed objective assessment of oesophagitis is required for a proper evaluation of medical treatment of the condition.

I would, however, like to draw his and your readers' attention to a paper in which a detailed grading of endoscopically determined oesophagitis was employed.¹ In contrast to Dr Scobie's experience, we see discrete shallow oesophageal ulcers rarely, the most common endoscopic manifestations of reflux being scattered areas of erythema and friability, mostly on the posterior wall of the terminal 2 cm of the oesophagus.

PETER REED

Department of Medicine,
Hammersmith Hospital,
London W12 0HS

¹ Reed, P I, and Davies, W A, *Current Medical Research and Opinion*, 1978, 5, 637.

The undiscovered country

SIR,—In your leading article "The undiscovered country" (15 December, p 1530) you quote Noyes as saying, in regard to life after death, "No one has returned from death and given an account of his experiences." It seems curious that in dealing with such an intriguing subject no mention is made of the single attested fact of resurrection of spontaneous origin recorded for us all in history—namely, that of Jesus of Nazareth. Our patients share with us understandable fears of the unknown, and we are in constant danger of projecting on to their crisis situations our own failure to come to terms with this critical reality. If there exists for us real hope, in the person of One who claims to be alive from the dead, One who has done precisely what Noyes claims not to have been done, then it would appear to be circumspect to examine the evidence afresh lest we miss the very thing calculated to give both us and our patients the peace of mind we sorely need.

MICHAEL FLOWERS

Accident Department,
General Infirmary,
Leeds LS1 3EX

¹ Noyes R. *Psychiatry* 1972;25:174-84.