blood concentrations of lipids are only a guide in the "steady state" to what is actually happening to lipid metabolism in the body. The correlation between atheroma and abnormal blood lipids is indirect; the relationship is likely to be with the overall complex of lipid metabolism. There is certainly no evidence to suggest that arterial disease is worsened by weight reduction, and much evidence to the contrary."—Ed, *BMJ*.

¹ Glennon JA, Breech WJ, Gordon ES. *Metabolism* 1967;16:503-6.

² Levy RI, Bonne EL, Ernst NO. *J Am Diet Assoc* 1971;58:406-16.

³ Ashley FW, jun, Kannel WB. *J Chronic Dis* 1974;27:103-14.

Traction tears of the spleen

SIR,—I read with interest Mr D Ernst's report "Ruptured spleen after electric convulsion therapy" (15 March, p 763). This case would indeed fulfil Orloff and Peskin's four criteria for spontaneous rupture of the spleen,¹ but I strongly suspect that this patient suffered a traction tear of the spleen following the ECT. We reported a similar case which followed a prolonged period of vomiting,² and suggested that violent contractions of the diaphragm caused a traction tear where the diaphragmatic peritoneal reflection met the splenic capsule. Such a traction tear may well be the explanation of a number of otherwise classified "spontaneous ruptures of the spleen."

W E G THOMAS

Bristol Royal Infirmary,
Bristol BS2 8HW

¹ Orloff MJ, Peskin GW. *Int Abstr Surg* 1958;106:1-11.

² Thomas WEG. *Br Med J* 1978;i:409-10.

Career prospects in geriatric medicine

SIR,—My recent letter (15 March, 1980) on the subject of the excellent career prospects in geriatric medicine mentioned a bursary scheme to enable doctors already appointed to a senior registrar post in general medicine or related subspecialties to gain experience in geriatric medicine. Unfortunately, the reference was omitted and correspondence I have had suggests that doctors would certainly like to know more about the scheme. Details are available from all regional and area medical officers, who were informed about the bursary scheme in a letter from the DHSS medical manpower division; this was dated 24 May 1979, and has the reference code D/M 169/6D.

M J DENHAM

Northwick Park Hospital and
Clinical Research Centre,
Harrow, Middx HA1 3UJ

Postgraduate education and the doctor

SIR,—Dr David C Evered and Hilary D Williams (1 March, p 626) were guilty in their paper of two basic errors of scientific research.

Firstly, they selected for review only those papers included in "continuing medical education" in which the title suggested some methodological evaluation. As a result they omitted from consideration the work of Maguire *et al*,¹ who demonstrated that the use of audiovisual material was the most effective method of teaching medical students

the skills of interviewing techniques. It would seem likely that a method that was successful in undergraduates would also be of use in postgraduate medical education. Indeed, we have demonstrated a positive effect in a controlled trial among experienced general practitioners² and a trend among trainee general practitioners.³ We have also prepared a paper describing, on the basis of our experience, some of the problems inherent in the use of this new educational technology.⁴

Secondly, Drs Evered and Williams, having limited their material artificially, were guilty of extrapolating beyond their data. Hence their conclusions are probably not only wrong but, more importantly, dangerous in that they may deter the use of valuable techniques.

Audiovisual technology provides a unique and acceptable method of observing and providing feedback of a central part of the clinical process of the consultation. Commerce has been rather quicker than the medical profession to recognise its usefulness in training. The value of this paper by Drs Evered and Williams is that it highlights the inadequacy of a great deal of currently published work.

R HARVARD DAVIS

Department of General Practice,
Welsh National School of
Medicine,
Health Centre, Maelfa,
Cardiff CF3 7PN

¹ Maguire P, Rowe P, Goldberg D, Jones S, Hyde C, O'Dowd T. *Psychol Med* 1978;8:695.

² Verby JE, Holden P, Davis RH. *Br Med J* 1979;i:1686-8.

³ Verby JE, Davis RH, Holden P. *Excerpta Medica* (in press).

⁴ Davis RH, Jenkins M, Smail SA, Stott NCH, Verby J, Wallace BB. *J R Coll Gen Pract* (in press).

Interaction between lithium and carbamazepine

SIR,—I was interested to see that Dr W A G MacCallum's patient, during maintained lithium therapy, not only tolerated carbamazepine, but was better with this treatment (1 March, p 610). Dr E Perruca and Dr A Riches suggested that this could be due to carbamazepine's antidiuretic property (22 March, p 863). My clinical experience, however, is somewhat different.

It has been suggested that lithium inhibits the vasopressin-stimulated adenylylase and that the distal renal tubules become relatively insensitive to antidiuretic hormone (ADH).¹ Meinders *et al* suggested that carbamazepine's antidiuretic effect may be related to this drug's ability to increase renal responsiveness to endogenous ADH.² Hence, it is likely that carbamazepine will be beneficial in lithium-induced polyuria. In an initial open study, this drug apparently produced some relief within one week in one 50-year-old man with bipolar manic depression. In view of that a placebo-controlled (double-blind crossover) investigation involving 10 patients with unipolar and bipolar disease was carried out.³ Oral carbamazepine (300-600 mg daily for six weeks) was observed to have no pharmacological effect either in alleviating subjective symptoms or in improving renal responsiveness to subcutaneous Pitressin injection. Half of the patients dropped out during the active phase of the treatment. Most developed various central symptoms like ataxia, dizziness, blackout, agitation, restlessness, confusion, and feelings of unreality during carbamazepine therapy, and these symptoms disappeared with discontinuation of this medication. It appeared that lithium exacerbated carbamazepine-induced central side effects, or vice versa. There was no significant fluctuation in plasma lithium concentrations, but it was not possible to measure

the plasma concentrations of carbamazepine during this investigation because of a methodological problem. It should be emphasised that these patients were all maintained on lithium for 2-12 years: their affective states were fairly well controlled, many of them were holding responsible jobs, and they had satisfactory therapeutic relationships with the clinic.

Prolonged lithium therapy is known to be associated with negative sodium balance and central sodium depletion,⁴ and further unbalance in sodium metabolism (either by reducing sodium or by retaining water) may be fatal in these patients.⁵ Lithium is also known to reduce nervous conduction velocity.⁶ Although the mechanism of increased incidence of various central symptoms in these patients during carbamazepine therapy was not very clear, it could be related to the drugs' mutual effect on sodium metabolism or on nervous conduction velocity. Since, however, the above investigation was carried out in a limited number of patients in an outpatient department, it will be interesting to see the outcome of further controlled trials involving larger number of patients.

KARABI GHOSE

Lingfield Hospital School,
Lingfield, Surrey RH7 6PN

¹ Dousa T, Hechter O. *Life Sci* 1970;9:765-6.

² Meinders AE, Ceika V, Robertson GL. *Clin Sci Mol Med* 1974;47:289-99.

³ Ghose K. *Pharmacopsychiatr Neuropsychopharmacol* 1978;11:241-5.

⁴ Edelfors S. *Acta Pharmacol Toxicol* 1975;37:387-8.

⁵ Ghose K. *Br J Hosp Med* 1977;18:578-80.

⁶ Girke W, Krebs FA, Muller-Oerlinghausen B. *Int Pharmacopsychiatry* 1975;10:24-36.

Epidemiology and clinical practice

SIR,—Since June 1979 we have met on a number of occasions to consider the relationship of epidemiology to clinical practice. We think that the present separation of the two disciplines is to the disadvantage of both. The conclusions from our meetings are: (1) There is a demand for training in epidemiology among doctors at registrar and senior registrar level who wish to develop epidemiological skills and use them in a subsequent career in hospital or general practice. In most specialties the rules for accreditation are too rigid to permit trainees to attend courses such as an MSc in epidemiology. (2) There is a demand for posts which combine clinical practice as a consultant or general practitioner with an opportunity to carry out epidemiological research. (3) There is a demand among men and women seeking a career in epidemiology for a training programme which does not require service experience in medical administration or health service planning. Such a programme could lead to a career within a subspecialty of community medicine.

A meeting to discuss these issues will be held in London in June. Will anyone wishing to attend please write to Professor ED Acheson, MRC Environmental Epidemiology Unit, South Academic Block, Southampton General Hospital, Southampton SO9 4XY.

E D ACHESON	W MCKEE
D J P BARKER	R G MOORE
N J BLACKLOCK	M F OLIVER
R B COLE	G A ROSE
P C ELMES	M SHEPHERD
N S GALBRAITH	M D WARREN
R F HELLER	