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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Careers for diabetic girls in nursing

SIR,—My attention was drawn to the difficulty a teenage diabetic girl had experienced in gaining acceptance by schools of nursing. She was told that, although her examination grades were satisfactory, being diabetic made her an unsuitable candidate for nursing. In the belief that nursing was a particularly suitable career for a girl with diabetes, I made a survey of schools of nursing asking about their attitude towards admitting girls with diabetes. The result of this survey is set out below.

I wrote to all the health authorities in England and all replied. The hospitals varied in size and types; some were independent and some were specialised. The addresses I obtained from the *Directory of Schools of Nursing*. It was found that 111 hospitals were willing to accept pupils with the necessary academic qualifications provided that their diabetes was controlled. One hospital went so far as to write that my inquiry implied a shocking indictment of selection for nursing and, provided that the diabetes was well stabilised and no major complications existed, diabetics were not only welcomed to that particular school of nursing but during periods of mandatory night duty were assured of medical surveillance, in case of the sometimes inevitable physiological adjustment which must take place. The letter continues, "The nursing profession is supposed to be one of the caring professions, and if we cannot offer our resident expertise to help persons with such well-understood conditions as diabetes to gain satisfaction in a career of their choice then it is time to overhaul our ideas." Thirty-four other hospitals had strong reservations, suggesting that students try other jobs first. They pointed out the heavy physical demands, the longer working day, and the difficulty of adjustment to night duty. It was stated that pupils could be trained if the hospital was near their home or if they lived at home. However, they were willing to consider applications.

There was no correlation between the rejections and the size, type, or area of the hospital. They seemed quite unconnected in any way, with the exception of two which were specialised hospitals. Twelve hospitals stated that they would automatically reject all applications from diabetics; most of them gave no explanation, just straight refusals. Two, however, gave the reasons that the student nurses were too busy and often under considerable

pressure. One hospital went on to say that, although on the whole candidates with diabetes mellitus would not be accepted, they had accepted student nurses with diabetes insipidus—usually after a head injury—and that they had been able to cope well.

Many of the letters showed a keen interest in the survey and pointed out how they had successfully trained pupils with diabetes. One hospital had trained a young man with severe diabetes who was now training to be a registered mental nurse at a psychiatric training school. It was made clear, however, by some hospitals that they had tried unsuccessfully to train pupils to become nurses—the pressure had been too great for them.

It seems extraordinary that there should be such a wide difference of opinion on this question. May I, through the courtesy of your journal, ask those concerned with the welfare of diabetic patients to support my plea that girls with diabetes, provided that they are suitably qualified and provided that they do not have particularly unstable diabetes, are allowed to train as nurses.

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Spring hypoglycaemia in diabetic children

SIR,—We have recently experienced an outbreak of serious hypoglycaemia among the children attending the Oxford paediatric diabetic clinic. It is generally recognised that with the longer hours of daylight diabetic children may require less insulin or more food in the spring, possibly related to more outdoor exercise. In our experience this usually occurs in April or May and the children and their families adapt their diabetic management without undue difficulty. This March, following a mild but dull winter, and before the weather had improved enough to encourage increased outdoor activities, we appear to have experienced the worst outbreak of hypo-

glycaemia since the clinic was established in 1973.

It is difficult to quantify the extent of this "epidemic" as mild-to-moderate hypoglycaemic episodes are managed without medical consultation. However, in the two-week period 9-23 March 13 of the 140 diabetic children who attend the clinic experienced hypoglycaemic episodes that caused them to telephone the clinic staff for aid. Four of these children, all under the age of 10 years, were admitted to the ward having suffered hypoglycaemic fits. In the opinion of the parents these episodes occurred following periods of relatively stable control and were of unusual severity.

There has been no recent change in our policy of clinical management or in the types of insulin used. There are, however, many possible alternative explanations for this apparent epidemic. We wonder, through the courtesy of your columns, whether other clinics have experienced a similar outbreak of premature "springtime hypoglycaemia"?

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Retroperitoneal fibrosis associated with atenolol

SIR,—The letter "Retroperitoneal fibrosis associated with atenolol" by Mr J N Johnson and Mr J B McFarland (22 March, p 864) may be misleading.

The patient had a second infarct in 1974. The authors say, "After the second he became hypertensive and was treated with atenolol 100 mg daily." This implies that the patient may have been taking atenolol for a period of five years (1974-9) before he developed retroperitoneal fibrosis. This is not so. He was hypertensive in September 1978 with a blood pressure of 170/110

mm Hg on three occasions and atenolol therapy was started on 11 September (general practitioner's records). He presented with abdominal pain in April 1979 and was referred to hospital. Therefore he took atenolol for seven and a half months before the onset of symptoms that were found to be due to retroperitoneal fibrosis at operation in July 1979. The authors state that the "patient had taken no other drugs in the six months prior to his presentation with abdominal pain." This is not so. According to the general practitioner the patient had been on clofibrate for a long time and prescriptions were still being issued at appropriate intervals.

In November 1975 the erythrocyte sedimentation rate (ESR) was raised to 24 mm in one hour (general practitioner's records). Before operation, on 11 July 1979, the ESR was found to be raised on two occasions, 91 mm in one hour in May and 106 mm just before operation (information from surgeons). The letter by Mr Johnson and Mr McFarland does not state that hypertension and raised ESR are known to be associated with idiopathic retroperitoneal fibrosis.¹ Two expert pathologists have examined the histological appearances of the tissue removed at operation and both state plainly that they are those of idiopathic retroperitoneal fibrosis. The histological appearances of practolol peritonitis are different and distinguishable. The surgeons recorded post-operative blood pressure (no antihypertensive therapy) of 120/80 mm Hg on 17 July 1979, 110/70 on 18 July 1979, and 160/100 on 6 September 1979. This last reading was taken in outpatients after the patient had made a long journey to the hospital. The blood pressure was normal again a month later when he was seen by the general practitioner, who recorded a reading of 120/80 mm Hg.

It is reasonable to conclude that the abdominal symptoms and hypertension were caused by idiopathic retroperitoneal fibrosis and that both were cured by surgery.

In the concluding paragraph there is an implication that retroperitoneal fibrosis associated with atenolol may bear a similar causal relationship to the sclerosing visceral peritonitis brought about by practolol. There is no evidence that the peculiar and unique fibrotic reactions caused by practolol have ever been shown to arise in connection with the use of any other beta-blocker. In view of the widespread use of this class of medicines it is scarcely surprising that, from time to time, a chance association with the idiopathic form of retroperitoneal fibrosis should be reported. It would be unfortunate if physicians who regularly use beta-blockers should be given a wrong impression.

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¹ Hawk WA, Hazard JB. *Am J Clin Pathol* 1959;32:321.

ECT: balancing risks and benefits

SIR,—It is difficult to counter the unpromising denunciation of unmodified electric convulsion therapy (ECT) by Dr P E Bebbington and others (15 March, p 792) by reasoned argument, since their letter contains so little. They declare that unmodified ECT "should be removed from consideration as a treatment approach in any circumstances" (my italics). It is not clear why this should be a sacred principle.

They appeal to the Royal College of Psychiatrists' guidelines. But guidelines are guidelines, not laws carved in stone; and these guidelines do not make any such unpromising declaration. Dr Bebbington and others express concern for the peace of mind of their patients and their relatives. I do not know about the patients and the relatives of the patients of Dr Bebbington and his nine colleagues; but mine are inclined to demand explanations. I try to promote their peace of mind by explaining the purposes and risks of a proposed treatment on the basis of up-to-date medical knowledge and balanced clinical judgment, not on the basis of an ideology recited in unison. Dr Bebbington and his colleagues are jealous of the good name and reputation of British psychiatry, and so they should be: British psychiatry has a reputation for common sense, clinical and scientific objectivity, and freedom from dogma. These things are valued also by some of the lesser breeds beyond the law.

Professor D A Pond (9 February, p 403) presents a moderate, balanced, reasoned point of view which makes good clinical sense. He reminds us that the reason for modifying ECT is prosaic and practical: to reduce the risk of fracture. He wishes to point out merely that, on occasion, a general anaesthetic may be contraindicated or not available, although there remains a strong indication for ECT. Once in a while the balance of risks may be in favour of unmodified ECT.

There is an adage in medicine: "Never say always; never say never." When, at rare moments in medical history, we do have to say "never," when treatment that has until that moment been a part of clinical practice is to be totally banned without room for clinical judgment, the evidence must be strong and the reasoning conclusive. Dr Bebbington and his colleagues have presented no evidence and little reasoning.

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Compliance and epilepsy

SIR,—In reply to Dr P T White and Dr E G Buckley (22 March, p 864) we would draw their attention to the fact that there have been several studies of drug compliance with epileptic patients.¹⁻⁵ All suggest that poor compliance is a major problem. Our own observations (16 February, p 484), which are based on low or falling blood drug concentrations in association with a recurrence of seizures, are merely in line with previous experience, albeit in a different patient population—new hospital referrals. All the published studies, however, have been in hospital-based populations, and we therefore await with interest the details of their seemingly encouraging and desirable results in a practice-based study.

We cannot agree that we have shown that "the responsibility for failure in the treatment of epilepsy usually lies neither with the disease itself nor with the patient, but with the doctor." In our experience all three make their contribution in varying degrees. A long history of untreated or poorly treated attacks, or seizures associated with brain lesions (both static and, especially, progressive ones) detectable on computed tomography are

frequently associated with failure of optimum therapy with one or more drugs. Certainly, many doctors could do much more to improve the results of treatment especially in the early stages by applying modern knowledge of the clinical pharmacology of the drugs, or by explaining more carefully to patients the implications of starting therapy, the need for good compliance and regular supervision, and the pitfalls to be avoided (both with respect to drug therapy and to other factors which may provoke seizures). Part of the problem is that epilepsy is usually a very long term, often lifetime, disorder. Indeed, in hospital practice it is remarkable how patients accumulate even more doctors than drugs, especially as they are often seen by a succession of registrars. We agree there is a need for much more education in this matter.

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¹ Lund M, Jorgensen RS, Kuhl V. *Epilepsia* 1964; 5:51-8.

² Gibberd F, Dunne J, Hadley A, Hazleman B. *Br Med J* 1970;i:147-9.

³ Lund M. *Acta Neurol Scand* 1973;49:295-306.

⁴ Wilson JT, Wilkinson GR. *Neurology* 1974;24: 614-23.

⁵ Eisler J, Mattson RH. *Epilepsia* 1975;16:203.

Topical corticosteroids on the face

SIR,—Dr M Whitefield's letter (29 March, p 941) regarding the possible link between perioral dermatitis and topical corticosteroids lacking a free 17-OH group ignores two points.

Firstly, hydrocortisone 17-butyrate is readily converted to 21-butyrate outside the liver, even to the extent of conversion in standard vehicles if the pH is not carefully controlled (pH 3.5-4.2). Secondly, Wilkinson cites two cases of perioral dermatitis occurring after hydrocortisone itself.¹ It would therefore be more logical to suppose that perioral dermatitis is a manifestation of topical corticosteroid therapy in general. Dr Whitefield's argument that hydrocortisone does not form a reservoir in the epidermis may partly explain why it is relatively inactive in the treatment of steroid-responsive dermatoses.

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¹ Wilkinson D. *Br J Dermatol* 1979;101:245-57.

Sulphasalazine in rheumatoid arthritis

SIR,—The letters of Professor H L F Currey and his co-workers at the London Hospital (22 March, p 861) are of considerable interest. I am sure there is general sympathy with the expressed view that before a new drug is generally accepted as a useful drug it should be subjected to rigorously controlled studies.

I am less in sympathy with the implied suggestions that editorial policies should not allow uncontrolled studies to be published in reputable medical journals. Without access to studies such as that of Dr B McConkey and others (16 February, p 427), no statistician would be able to predict the number of patients required for a rigorously controlled