some studies. As an example of a possible relationship between malignant lymphoma and PMR on this ground they refer to a case described by us^{6,7} in which malignant lymphoma occurred four years after the diagnosis of PMR was made. Among our 54 patients with PMR we have recently reported another case⁸ in which chronic lymphatic leukaemia developed five years after the onset of typical PMR. In this patient lymphocytic infiltration was detected in renal, liver, and muscle biopsy specimens at the time of diagnosis of PMR, when the number of lymphocytes in the peripheral blood and bone marrow was normal. The significance of the combination of the two diseases in this patient is unclear. It may simply be the coincidental coexistence of two diseases, both relatively common in elderly people. However, the clinical course does point to a more direct relationship. Histocompatibility antigens have been studied in patients with chronic lymphatic leukaemia, but, so far as I know, no increase in any specific HLA haplotype has been shown.

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Renal failure associated with ergot poisoning

SIR,—In their case report on "St Anthony's fire and pseudochronic renal failure" (8 October, p 935) Drs C D Pusey and D J Rainford found no reports of acute renal failure in ergotism. I would like to report a case of acute renal failure in association with ergot poisoning.

A 37-year-old woman was admitted with a history of intermittent claudication associated with a very high intake of ergotamine tartrate tablets for the treatment of migraine. Both legs were cold, with absent foot pulses. The temperature of the left great toe was 23°C. She was treated with anti-coagulants, oral tolazoline, bilateral femoral, sciatic, and tibial nerve blocks, phenolamine and sodium nitroprusside, methylprednisolone, and low-molecular-weight dextran 40. Her systolic blood pressure dropped as a result of this treatment to an average of 60 mm Hg over the next 8 h and then rose to above 100 mm Hg. During this time she was given 20 mg of intravenous frusemide and passed 1 l of urine over the next five hours. The haemoglobin and blood urea were normal on admission. After her initial diuresis her urine output ceased and she went into acute renal failure with the blood urea concentration rising to 43 mmol/l (260 mg/100 ml) on the ninth day after admission, at which point peritoneal dialysis was begun. Renal function returned to normal, as did the skin temperature in both legs. An intravenous urogram and creatinine clearance done later were both normal.

Gabbai *et al*¹ in their description of an outbreak of ergotism reported blood urea concentrations rising to 10–20 mmol/l (60–120 mg/100 ml) and, in the four patients who died, blood urea levels of more than 25 mmol/l (150 mg/100 ml).

Hypotension in association with treatment with low-molecular-weight dextran is a well-recognised cause of acute renal failure.^{2,3} It is reasonable to postulate that this was an unlikely cause for the development of acute renal failure in a patient who was young, with normal kidneys. A combination of the hypotension, dextran infusion, and renal artery narrowing secondary to the ergot poisoning is a more likely cause of the development of acute renal failure. It is difficult to be sure which of the two contributing factors was of more importance, the ergot poisoning or the hypotension and associated dextran treatment. However, the possibility exists that the ergot poisoning was the most important of the contributing factors.

I would like to thank Dr Victor Parsons of King's College Hospital for allowing me to publish details of this case.

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Mobilisation after myocardial infarction

SIR,—Your leading article on this subject (10 September, p 651) does not emphasise the ease with which a rehabilitation programme can be set up in a district general hospital.

We at Lewisham have, over the past 18 months, had 150 patients through our rehabilitation unit, and, although it is quite true that 20% or so usually drop out at some stage during the course, the majority gain considerable psychological benefit. Their increase in physical fitness and morale is testified to by all who come in contact with them, particularly their immediate family. Our unit is run by one of the physiotherapists with a doctor who meets once a week with a member of the medical team to iron out particular problems. It does not require any particular resources and has certainly not put any great strain on the finances of the hospital.

The enthusiasm of many of the participants has been such that they have started, with the help of the Inner London Education Authority, a coronary rehabilitation class at night school, which is well attended, and we hope to extend this aspect of the programme.

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Bilateral injuries in childhood: an alerting sign?

SIR,—You published a letter from Dr A R Buchan and me last year (16 October 1976, p 940) giving a preliminary warning of the possible suspicious nature of bilateral minor injuries in children under 5. At that time we reported the total absence of bilateral injuries in daily inspections of 481 children on the register of the 10 day nurseries in Leicestershire.

This research has now been completed and, although many aspects are not of general interest and are being published elsewhere, the final figures showed that during the 13-week

period from 1 November 1975 to 31 January 1976 20 896 inspections were made and 3709 injuries noted. Of these, only one was bilateral and it was clearly seen to be non-accidental and one of a series of incidents within that family.

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Treatment of depression

SIR,—I feel that your leading article on this subject (29 October, p 1105) left the unfortunate impression that the only treatment of depression is physical. The psychological aspects of depression are wholly ignored. Leading articles like this can only increase the over-prescribing of antidepressants which various recent studies have pointed out. All too frequently medications and physical treatments are used as a quick and short answer to the overwhelming needs of patients whose medical symptoms of depression have their roots in alienation, loneliness, or unhappiness in their lives. Perhaps the article should have been retitled "Physical treatments of depression."

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Propranolol and thyroid surgery

SIR,—We read your recent leading article (22 October, p 1039) with interest and believe your view as regards the use of propranolol as a preoperative measure in thyroidectomy for Graves' disease is ultra-cautious.

Our experience over the past 18 months is, admittedly, limited to some 15 cases. Propranolol was used as the sole preoperative measure in all, with satisfactory results. Technically, the gland is easier to handle at operation. The total time of the "illness" is cut to about ten days, which includes preoperative preparation and hospital stay.

If this drug is used it is important that a dose be given on the morning of operation and that it be continued postoperatively for some 5–7 days.

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Noxythiolin-resistant organisms

SIR,—I was interested to read Dr B Chattopadhyay's article (29 October, p 1121), but his conclusions cannot remain unquestioned.

Sensitivity discs are a test of sensitivity to antibacterial agents; resistance cannot be inferred. Sufficient concentration of noxythiolin may not be achieved by diffusion from discs to inhibit growth of those bacterial strains with a high minimum inhibitory concentration relative to noxythiolin. That such "resistant strains" are killed by relevant concentrations of noxythiolin was elegantly demonstrated by Dr Chattopadhyay. Employing dilutions of noxythiolin in broth culture to "simulate urinary tract infection" he found "resistant" organisms to be totally killed at a concentration of 1.25% noxythiolin. This is half the concentration recommended for treatment of