Femoral vein thrombosis and total hip replacement

SIR,—I was interested to read of the high incidence of deep vein thrombosis (DVT) following total hip replacement described by Mr J D Stamatakis and his colleagues (23 July, p 223). This alarming incidence, coupled with the known serious embolic complications, gives much food for thought and obviously should influence us in the management of patients undergoing the operation.

However, I would like to ask two questions. Firstly, what were the diagnoses of the patients, and, secondly, what were the prior drug therapies? Presumably some of the patients suffered from rheumatoid arthritis and some may well have been taking aspirin. It is my clinical impression that DVT is rare in rheumatoid disease and aspirin is well known to influence the clotting mechanism. Although drug action may be difficult to assess by the methods used in the study, the influence of the underlying disease process could easily be judged and I think it is important that that information should be made available.

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*We sent a copy of this letter to Mr Stamatakis and his colleagues, whose reply is printed below.—ED, *BMJ*.

SIR,—We have read with interest the comments of Dr Clarke. The high incidence of thrombosis following total hip replacement (THR) reported by us is similar to that of other studies which have used objective methods for diagnosis.¹⁻⁴ Though we have not yet analysed our data in terms of the initial pathology prior to THR, the vast majority of our patients suffered from osteoarthritis. Those with rheumatoid arthritis are generally from a younger age group, who are known to suffer less from thromboembolism following this operation.²

The use of aspirin to prevent venous thromboembolism following THR is controversial.^{2,5,6} In a venographically controlled study we have failed to observe any benefit from this drug in this group of patients.⁷

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¹ Evarts, C M, and Feil, E J, *Journal of Bone and Joint Surgery*, 1971, **53A**, 1271.

² Harris, W H, et al, *Journal of Bone and Joint Surgery*, 1974, **56A**, 1552.

³ Morris, G K, et al, *Lancet*, 1974, **2**, 797.

⁴ Hampson, W G J, et al, *Lancet*, 1974, **2**, 795.

⁵ Dechevance, M, et al, *Haemostasis*, 1975, **4**, 94.

⁶ Schondorf, T H, and Hey, D, *Haemostasis*, 1976, **5**, 250.

⁷ Stamatakis, J D, et al. Submitted for publication.

Treatment costs in the USA

SIR,—Your reviewer of a book on the treatment of children with cancer at Stanford Children's Hospital (29 October, p 1137) complains of the text's inadequacy and asks, "What is the cost, both emotional and financial, especially in a country where treatment has to be paid for by the parents?" I cannot speak of emotional costs, which are obviously high, but it is depressing that a journal of such

stature as yours betrays the ignorance implicit in the question. In the United States the overwhelming majority of persons, including children, are covered by hospital insurance, either private or governmental. As a result even long hospital stays and quite complex modes of treatment may cost the patient and his family little or nothing out of pocket. Surely that elementary fact of American medical economics should be known to those who write for and edit the official journal of the British Medical Association.

HARRY SCHWARTZ

Scarsdale, New York

SIR,—I have just syringed the ears of one of my patients who became deaf on a business trip to the States. The price he had been quoted 12 hours previously in New York for this manoeuvre was 30 dollars for one ear, or the cut price of 56 dollars if both ears were syringed. I feel sure that there must be a moral to be learnt from this story by both patients and doctors on both sides of the Atlantic.

H T N SEARS

Holmes Chapel, Cheshire

Cockles of the heart

SIR,—In his delightful annotation on the heart (Words, 12 November, p 1271) your contributor asks, "Where . . . are the cockles of the heart, and why does the application of warmth thereto give satisfaction?" I had unthinkingly accepted cockles to be the vernacular for auricles, as their sound when spoken suggests to me; but now I turn to my bookshelves to check up.

The large *Oxford English Dictionary* says of "cockles" that some have sought its origin in the Latin *corculum*, diminutive of *cor* (heart). It goes on to report another conjecture, that the most probable explanation lies in the zoological name for cockleshell (*cardum*, from the Greek for heart). Partridge (*Origins*) suggests cockle as an Anglicising of cochlea, itself akin to conch (or shell). Not very consistent, though some connection between hearts and shells seems to be accepted.

Then how and why are the cockles warmed? In the *Dictionary of Phrase and Fable* Brewer remarks that the phrase is used for anything that gives a gratifying sensation, as does drinking a glass of port. But, alas, he goes on to derive cockles not from the auricles but from the ventricles of the heart. In the chilling confusion your contributor might care to try a glass of port and I would gladly join him.

JOHN APLEY

Bath, Avon

Pleuropericardial lesion in Q fever

SIR,—I was very interested in Dr J E Caughey's report of cases of Q fever with pericardial and pleuropulmonary involvement (4 June, p 1447). However, I would like to call your attention to the fact that, contrary to his statement, the pericardial lesion in Q fever was reported as long ago as 1949.¹ In this original description of Q fever in Portugal reference is made to two cases with pleural and pericardial effusions. And in 1976 when describing the

first Portuguese case of Q fever hepatitis without pulmonary involvement² we made a review of the literature, in which are recorded eight other cases of pericarditis, some with a chronic recurrent course.³

The same paper stresses the marked clinical pleomorphism of Q fever and confirms the efficacy, previously described by Freeman *et al*,¹ of co-trimoxazole, especially in the chronic forms of the disease. In the excellent review of chronic Q fever endocarditis by Turck *et al*,⁴ the use of co-trimoxazole is not mentioned. I think that the superiority of a bactericidal over a bacteriostatic agent in a condition such as Q fever endocarditis should not be ignored but further tested and, I hope, confirmed.

JOSÉ REIMÃO PINTO

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¹ Fonseca, F, et al, *Clinica Contemporânea*, 1949, **3**, 1218.

² Pinto, J R, et al, *Jornal da Sociedade das Ciências Médicas de Lisboa*, 1976, **140**, 375.

³ Stephan, E, et al, *Archives des Maladies du Cœur et des Vaisseaux*, 1963, **56**, 1161.

⁴ Freeman, R, et al, *British Medical Journal*, 1972, **1**, 419.

⁵ Turck, W P G, et al, *Quarterly Journal of Medicine*, 1976, **45**, 193.

Seat belt legislation

SIR,—Events of the past week or two have suddenly made surgeons in Northern Ireland realise their special responsibility in persuading the community to accept legislation introducing the compulsory wearing of seat belts. The measure is particularly urgent here because the mortality per vehicle from road accidents in Northern Ireland is about double that in Great Britain, and we have killed more people in the past eight years with our cars than with bombs and bullets.

Mr Ray Carter, Parliamentary Under Secretary to the Department of the Environment for Northern Ireland, set up a committee here a year ago to consider road accidents—a committee which had no medical members. Among its recommendations was one urging compulsory seat belt legislation. After Mr Carter announced that he would introduce such a measure opposition began to appear. Firstly, there were many ill-informed letters in the press. Then Northern Ireland MPs began to voice objections, particularly about the means of introduction—through an Order in Parliament.

At this point I approached a neurosurgeon, an eye surgeon, a plastic surgeon, and an orthopaedic surgeon to see how strongly they and their colleagues felt on the issue. When we discovered virtually unanimous support for compulsory seat belts among our subspecialties the five of us drafted a letter on the subject and sent it to our colleagues. Of 82 surgeons approached, four did not reply, five indicated their unwillingness to become involved with an issue which had become political, and 73 signed a strong letter, which we forwarded to all Northern Ireland MPs. Surgeons in Northern Ireland have backed this measure because they are convinced of the reduction in mortality and morbidity caused by wearing seat belts. They have backed compulsion because voluntary campaigns have rarely persuaded more than 30% of drivers to wear belts, whereas compulsion raises the level to 75-80%.

A private member's Bill at Westminster to bring in compulsory seat belt wearing in Great Britain failed at the committee stage, when there was an insufficient quorum in the