oxidase, for example, accepts many sterols as substrates.^{1,2} It is, of course, unusual for other sterols to occur in major proportions in plasma: one recalls the early studies of triparanol as a drug which led to reduced levels of cholesterol but caused concomitant accumulation of desmosterol.³ Such gross changes are rare, but it cannot be assumed that sterols present in quite low concentrations are devoid of effects. Moreover, some dietary sterols besides cholesterol can be absorbed from the digestive tract, and attention has recently been drawn⁴ to the possibility of deleterious effects resulting from the ingestion of oxygenated sterols present in foods.

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¹ Smith AG, Brooks CJW. *J Steroid Biochem* 1976;7:705-13.

² Smith AG, Brooks CJW. *J Steroid Biochem* 1977;8:111-2.

³ Steinberg D, Avigan J, Feigelson EB. *J Clin Invest* 1961;40:884-93.

⁴ Anonymous. *Lancet* 1980;i:964-5.

Anaesthesia for patients with coronary disease

SIR,—How sad it is that your leading article (26 July, p 341) should fail to give precedence or even credit to work that had appeared in the *BMJ* some years earlier than the first two American papers quoted. I refer, of course, to the work of Chamberlain and Edmonds-Seal.¹ This paper was not mentioned by Tarhan *et al*, whom you quote—a surprising omission especially as a précis of it appeared in the *American Heart Journal* in 1965.

I hope that my letter will go some way to redress the balance and prove that prophets do have some honour in their own country.

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¹ Chamberlain DA, Edmonds-Seal J. *Br Med J* 1964;iii:784-7.

Dorsal column stimulation in multiple sclerosis

SIR,—Your leading article (31 May, p 1287) on dorsal column stimulation in multiple sclerosis is as interesting as it is timely. It is a pity, however, that you seem so unfamiliar with the technique. Electrodes are not "embedded in the subdural extra-arachnoid space" but inserted percutaneously into the epidural space, which means that potential complications such as leak of cerebrospinal fluid (CSF) and serious infections are non-existent; the stimulus parameters are 200 microseconds at 33 Hz (not 200 milliseconds at 150-200 Hz); and voltage and current requirements and safe limits have been defined.¹

You are also apparently unaware of the third international meeting on spinal cord stimulation held recently (and attended by virtually every worker in this field and by neurophysiologists with related interests) and of reports from other British centres involved in this work (including publications six months ago in a journal published by the BMA), and—most extraordinary of all—you have neglected objective physiological changes.²

The latter give some information about how the treatment might work.

Placebo effect obviously must be critically evaluated but should not be overemphasised. Bladder function, the disability which improves most, is not known to be a marked placebo-responder; but if it can be shown that the improvements in 75% of patients reported by ourselves³ and confirmed by others (Hawkes *et al*⁴; Read *et al*, unpublished observations) are due to something other than spinal cord stimulation, then the management of the bladder in multiple sclerosis should become easier and you will need to rewrite the otherwise excellent last paragraph. A discussion of the role of placebo in spinal cord stimulation was included in the recent paper by Illis *et al*³ and clearly placebo cannot explain the findings.

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¹ Jobbling DT, Tallis RC, Sedgwick EM, *et al*. *Med Biol Eng Comput* 1980;18:48-56.

² Sedgwick EM, Illis LS, Tallis RC, *et al*. *J Neurol Neurosurg Psychiatry* 1980;43:15-24.

³ Illis LS, Sedgwick EM, Tallis RC. *J Neurol Neurosurg Psychiatry* 1980;43:1-14.

⁴ Hawkes CH, Wyke M, Desmond A, *et al*. *Br Med J* 1980;280:889-91.

*.*The points raised by Drs Illis and Sedgwick are peripheral to the message given in our leading article. Recently the practice has been to place the electrodes in the epidural space but Cook and Weinstein, who introduced the whole technique, were quoted in the article: electrodes are "placed in the subdural extra-arachnoid space."¹ Apart from Dr Illis's own study,² complications have been found "in 15 of 23 patients and required a total of 21 subsequent operative procedures for correction."³ The electrical stimulus used has varied: the figures quoted were those as given by Cook and Weinstein,¹ but we should in any case remember that excellent results for the technique have been claimed in patients in whom electrode migration was common. Thus an exact stimulus dose does not seem necessary. Illis's own study,² to which he refers, had been read but, as pointed out in the correspondence columns of the *BMJ*,⁴ the results cannot be accepted uncritically. In view of the totally negative results that have also been reported with the same technique,⁵ clinicians would obviously be wise to adhere to the sentiments expressed in the leading article.—ED, *BMJ*.

¹ Cook AW, Weinstein SP. *NY State J Med* 1973;73:2868-72.

² Illis LS, Sedgwick EM, Tallis RC. *J Neurol Neurosurg Psychiatry* 1980;43:1-14.

³ Young RF, Goodman SJ. *Neurosurgery* 1979;5:228.

⁴ Hawkes CH. *Br Med J* 1980;280:1619.

⁵ Rosen JA, Barsoum AH. *Ann Neurol* 1979;6:66-7.

Acute renal failure

SIR,—The article "For Debate" by Dr N Wright and others (12 July, p 117) and the conflicting view presented by your leading article (7 June, p 1333) illustrate the wide range of opinion about whether the investigation and treatment of acute renal failure should be in a specialised renal unit or in the "non-specialised" wards of district general hospitals. I have held the view for some years that it is usually inappropriate in acute renal failure to delay consultation with a unit set up to provide specialised advice and having all the

necessary facilities for the investigation and treatment of renal failure. Many of the reasons for this need for consultation were discussed in your leading article, and the problems and pitfalls in diagnosis and treatment are reflected by the large bibliography which those who regularly treat such patients must attempt to keep in touch with.

My opinion about the need for consultation, and often referral, is based only on the impression that colleagues often lack the detailed knowledge, the skills, or the facilities appropriate to the clinical problem. I lacked these myself before training, experience, and reading made me into a "specialist" and my hospital and local charities provided the facilities and staff I needed. I have, unfortunately, no statistically validated facts to support my opinion, but neither do the authors of the article from Dudley Road Hospital provide any facts to refute it—and I question whether it is appropriate to call their regional poisoning treatment centre a "non-specialist" unit. The medical and nursing skills in such a unit will be similar to those in a renal unit, and the physicians in charge will have had experiences that include caring for many renal problems. In many district general hospitals the experience of the staff will be quite different, and the use of many of the techniques infrequent. To contrast the results of a series of 28 patients with the larger series reported from renal units in Glasgow and Newcastle upon Tyne, both of which are referral hospitals for many district general hospitals, is not useful. Such comparisons should not be attempted without larger numbers, and some attempt should be included to consider whether the groups being contrasted bear some resemblance to each other.¹ They are unlikely to do so from my own experience of observing acute renal failure in district general hospitals² and in hospitals which are established referral centres.

It is possible that Dr Wright and his colleagues have set up a specialist unit appropriate for the treatment of acute renal failure, together with that of severe poisoning, which I presume was his primary objective. I hope that he invites some of his nephrological colleagues to discuss his renal cases, so that they can provide some informal "peer review" and, in particular, consider the deaths in their series.

I hope that medical and surgical teams lacking appropriate experience or facilities will not be encouraged by his conclusions to practise in less specialised facilities beyond the level of their competence. When the consultant staff of Dr Wright's hospital expands, and as the time since he worked in close co-operation with a unit staffed by nephrologists increases, perhaps he will consider whether the service his hospital provides would not be improved by the appointment of a nephrological colleague to share in the responsibility of his unit, which has obviously taken on responsibilities for renal patients in a careful and thoughtful way. Such an appointment might also help in improving the look of the statistics for chronic renal failure in his region, which is known to have almost the lowest treatment rate per million of population for any industrialised society.³ Similar comments can be made about the clinical experience described by Dr A R Luksa (26 July, p 305), who also seems to be describing results in a specialist unit run by a very interested consultant if not a nephrologist, and also working in a region that has very poor statistics for treatment rates in chronic renal failure and has, in my

opinion, too few nephrologists for its population.

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¹ Knapp MS. *Lancet* 1977;iii:1068.

² Dombey S, Sagar D, Knapp MS. *Br Med J* 1975;iii:484.

³ UK Transplant. *Annual report*. Bristol: UK Transplant, 1979.

Integrated dialysis and renal transplantation: small is beautiful

SIR,—We blush with pride to recognise our own renal unit in the article by Dr A J Nicholls and others (21 June, p 1516). We realise now that as well as being small we must also be beautiful.

Exeter serves a population of over one million people in Devon, Cornwall, and Somerset. The geographical remoteness and rural nature of the south-west peninsula necessitated the establishment of a dialysis and transplant facility in this small but central city. Since the service started in 1966, 175 people have been taken on for long-term treatment, mainly home dialysis. Transplantation started two years later and so far 72 kidneys have been grafted. In the last year 26 new patients came forward for treatment and 13 grafts were performed. In agreement with the assessment of Dr Nicholls and his colleagues, we consider that we have now reached 50% of final unit size.

From the beginning of UK Transplant, we have pursued an active policy of donor kidney retrieval from our own and surrounding district general hospitals and up to now we have been net exporters. For the future we are endeavouring to raise £350 000 to build a new unit since our present building is already bursting at the seams. We need to continue medical education to ensure that renal failure is more widely and more quickly recognised, and to increase the donation of kidneys. Only if we are able to transplant the majority of our patients will we be able to continue taking on new patients at our current rate and grow to our optimum size.

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Doctors and the prevention of alcoholism

SIR,—The role of doctors in combating excessive drinking, one of "man's self-destructive activities" (19 July, p 244), is by no means restricted to early diagnosis, treatment, and rehabilitation of the victims. It is also vital in the all-important task of prevention—for example, by educating government, politicians, and the general public. This was well illustrated by the 1980 Annual Representative Meeting's concern with the need for measures to reduce the nation's high alcohol consumption: the ARM appealed to the Government "to take positive steps, including fiscal measures, . . . to make alcohol an expensive luxury . . ."; and doctors were urged to create "public awareness" of the dangers of heavy drinking (p 244).

Last year an article in your columns posed the question whether alcoholism was "a medical or a political problem."¹ It concluded

that it was primarily a political problem, a view that has recently acquired increasing popularity. But surely in this aspect too, as so often in questions concerning problem drinking, it is not a matter of "either or"²—not a matter of "either political or medical" with little intervening ground. Alcoholism is both a political and a sociomedical problem³ and the medical profession, instead of shifting responsibility on to the politicians, should play a leading part also in prevention by educating government and the general public in the nature of the problem, the risks involved, the need for urgent measures, etc. Not so long ago a slogan became quite popular: "Alcoholism comes in people, it does not come in bottles"; nowadays the trend seems to be towards reversing this slogan. But surely both "people" and the "bottle" have to be considered in a comprehensive multidisciplinary team effort; and preventive measures should not be limited (in the main) to reducing availability of the "agent" by fiscal and legal measures—vitaly necessary as they are—but should also and equally be directed at "host" and environment.²

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¹ Kendell RE. *Br Med J* 1979;i:367-72.

² Glatt MM. *Alcoholism—a social disease*. London:

Teach Yourself Books, 1975.

³ Glatt MM. *Br Med J* 1979;i:684.

⁴ Glatt MM. *Lancet* 1980;i:982.

Penile injuries from vacuum cleaners

SIR,—I read with interest the report on penile injuries from vacuum cleaners by Mr N D Citron and Mr P J Wade (5 July, p 26). The condition is not uncommon and was first described by Fox and Barrett in 1960.¹ It represents one of the bizarre methods of masturbation adopted by elderly men.

In a series of 57 penile injuries reported at the annual meeting of the British Association of Urological Surgeons in June 1980, I reported three patients with this condition. Their ages were, typically, 66, 55, and 60 years. They had suffered degloving injuries and two patients required suturing of multiple lacerations and one required split skin grafting. All three patients underwent urethral catheterisation for urinary retention, and were given prophylactic antibiotics.

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¹ Fox M, Barrett EJ. *Br Med J* 1960;ii:1942.

Bone-marrow aspiration and trephine biopsy

SIR,—I was interested to see the two articles on bone marrow aspiration and trephine biopsy in your excellent series "Procedures in Practice" (19 July, p 204 and 26 July, p 280). My experience of patients at this hospital, who have frequently had a marrow examination done previously elsewhere, is that the procedure has a bad name with them owing to excessive pain. This is almost always because an inexperienced operator has not obtained adequate periosteal anaesthesia or has not ensured that the needle enters the bone through the anaesthetised area. If precautions are taken

to ensure this the procedure can be conducted entirely painlessly, except for the actual moment of aspiration.

Another practice which is worthy of record, and which I believe originated in Professor Witt's department at Oxford, is the use of a small piece of waste x-ray film, cut to size, as a spreader of the marrow particles. With experience the slight flexibility of this enables particles to be spread better than with a slide.

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Evolution of colonic polyps

SIR,—I was asked to offer a word of caution over the recommendation that a colectomy and ileorectal anastomosis should be advised in people with multiple polyposis coli (26 July, p 257). I have recently had experience of two young sisters who were so treated where the social circumstances were not ideal for regular follow-up and both within a short period developed invasive carcinoma of the rectum. Certainly in these cases it would have been better to have performed a panproctocolectomy in the first instance as both have adjusted to ileostomy quite satisfactorily.

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Careers for diabetic girls in nursing

SIR,—Like Miss H K E Browning, I have been following the discussion on nurse training with interest. Her letter (26 July, p 307) however, only confirms my impression that most of the prejudice against diabetic girls applying for nurse training comes from the nursing profession itself, and not from doctors in NHS occupational health services, who frequently screen candidates for fitness for such training.

In the school of nursing attached to this area, candidates are accepted or rejected following interview and testing. No health questions are raised by the interviewers, though I suppose that a candidate might volunteer some health information—I would sincerely hope that this would not prejudice any decision. Successful candidates are then screened and medically examined here, and the school of nursing is informed only that a candidate is considered fit or unfit for training. A well-controlled diabetic would be passed as fit. Such a candidate would then be asked for written permission to inform the director of nurse education of the condition, in case any problems arise during training. We also feel that, whenever possible, a diabetic candidate should live initially in one of our larger nurse hostels, where GP access for prescriptions, etc., is somewhat more easily obtained. We have also invoked the help of our dietetic department in adjusting times of insulin dosage and diet during spells of night duty.

Like Dr D G H Sylvester (28 June, p 1616), I feel that there are very few medical conditions which preclude nurse training. Some of these are gross obesity, certain orthopaedic conditions, severe epilepsy, and, arguably, certain skin conditions. There appears to be no bar to the acceptance of prospective students with diabetes in our medical schools, and this training is equally demanding.

It may well be that diabetes does not make a