arm into the shoulder but not the praecordium and was accompanied by an episode of vomiting. It was relieved only by diamorphine. Physical examination was normal but later the patient became mildly pyrexial, and serial electrocardiograms and cardiac enzyme assays confirmed an inferior myocardial infarct. The patient made an uncomplicated recovery but has subsequently developed classical symptoms of angina.

This patient presented in a busy accident and emergency department and was admitted only because of the severity of her pain. This case emphasises the difficulty of diagnosing atypical cardiac pain.

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Vomiting as a diagnostic aid—or diagnostic pitfall

SIR,—I was most concerned that the article (6 September, p 636) by Dr D A Ingram and others on vomiting in association with cardiac pain failed to mention other possible causes of vomiting in such patients, in particular strangulated diaphragmatic hernia. This condition is often misdiagnosed as myocardial infarction because the chest pain and vomiting are accompanied by electrocardiographic changes that may be typical of posterior infarction. Erect and supine radiographs of the chest which would probably lead to a correct diagnosis may not be considered justified because of the patient's general condition, and portable films may be positively misleading.

The correct diagnosis usually becomes clear if a nasogastric tube is passed, because in the case of the more usual paraoesophageal type of hernia radiography will show it to have curled up from the region of the diaphragm into the left chest and introduction of a small amount of barium confirms the diagnosis. Sadly, however, it is often too late for surgery to save the patient and not infrequently it is the pathologist who makes the diagnosis. The cause of the cardiographic changes is uncertain—they may occur in patients with entirely healthy coronary arteries, and in one patient, saved by operation, the cardiographic changes entirely disappeared after operation.

To judge by my own experience through the years in district hospitals, it seems that more than 100 patients each year die in this country because of misdiagnosis of this condition. I suggest that strangulated diaphragmatic hernia should always be considered and excluded as a possible cause of vomiting in patients with suspected myocardial infarction.

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Women in hospital medicine

SIR,—I am sorry that Ms Shirley M Dobson (4 October, p 946) so dislikes the current movement towards easing the path of women wishing to work part time in medicine because of family commitments. As a part-time GP trainee in a forward-looking practice which employs a part-time lady partner and has two part-time lady trainees, I would like to refute her implication that working medical

mothers are a pampered group of career women who neglect their children. This is simply not the case.

Every medical woman is caught in a "Catch 22" situation: have your family early, and you are trained for nothing, despite your degree; gain your qualifications, find a post, and you are almost too old to have children. There is no easy answer. Part-time posts at all levels are the best compromise, but by no means a soft option. Family and clinical responsibilities often overlap; but with organisation, hard work, and a sense of humour these can be reconciled.

Medicine is not the sort of career you can lay aside to resume at a later date. Even a break of a few months lessens your confidence; after a year you begin to forget the terminology. The only answer is to keep working—and though it is by no means easy to find part-time posts the position is improving all the time. With the present medical school intake of 50% of female students, this is only sensible.

Child care facilities, extra study leave—these would be marvellous icing on the cake, but the availability of posts is the important thing. We will not neglect our work, and we will not neglect our children.

ANNE C MACLEOD

Inverness

Restore the medical superintendent?

SIR,—It is being suggested in *Patients First* (a misnomer if ever there was one) that "managers" should be appointed to hospitals. It is clear that this is to be a lay administrator with even more power (and less responsibility) than the present hospital secretary.

Since we have lived to rue the day when we agreed to banish the medical superintendent, is not this the time to make a stand for his restoration, particularly one with a clinical commitment of some degree? This is the only way we can be truly involved in the running of a hospital and also bridge the increasing gap between medical and administrative staff. He will of course make mistakes (show me the committee which does not), but at least he will understand and appreciate what the medical staff are talking about. Furthermore, he will be able to deal with a large amount of trivial administration which now occupies so much committee time.

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Excluded from practice

SIR,—After two decades of general medical service overseas I returned to the land of my birth, where I had had the good fortune to be trained at a well-known university. This training has stood me in good stead over the years and has been supplemented by wide and varied clinical experience. I soon discovered that the GP members of our noble profession operate an unofficial closed-shop policy, barring over-50s like myself from entry to the GP establishment even though there is no official retiring age.

Within the next few years a significant number of British doctors are likely to be displaced from both the developed and the developing countries. It seems ludicrous, when one reads of underdoctored areas here, that

these skilled workers, with an average expectation of 15-20 years of productive working life, should be denied the opportunity of practising on equal terms with their peers, many of whom are indeed older than they are.

In my own experience, it was always the senior partners who operated the veto even when the younger ones were sympathetic. It is significant that family practitioner committees, with single-handed jobs to dole out, also upheld the ban.

Having been a paid-up member of the BMA ever since graduation, one wonders whether the powers that be at Tavistock Square are aware of the plight of this group of its members. When the axe falls on 15 February 1981, when mandatory vocational training will become a prerequisite for entry to general practice, will we be completely excluded from taking part in what should normally be part of our birthright?

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Two lessons about rabies

SIR,—I hope that this letter will revive caution about rabies.

Crete is a lovely island with generous people. Its dogs are neither lovely nor generous and on a recent holiday my companion was bitten unprovoked by a mongrel while walking in the Samaria gorge. The dog ran off immediately and I was more concerned by the bite than the fate of the dog. We were aware of the risk of rabies and visited a local doctor, who said that it was "very much of a problem." Although the bite had scarcely penetrated the skin there remained a small but incalculable risk of rabies.

The next eight days of our holiday were spent almost exclusively in searching for the dog and trying to obtain safe rabies vaccine. Our long journey back to the place where the bite occurred was in vain, which left the possibility that the dog had died from rabies or had returned to the surrounding mountains.

We did not succeed in obtaining vaccine from local doctors or hospitals so I called the international medical service in London which was connected with our holiday insurance. This helped by seeking the best possible advice about safe, effective rabies vaccine. The Merieux inactivated rabies vaccine from human diploid cells does not carry the risk of severe reactions that used to occur with the vaccines used formerly. This vaccine was flown out to us, but it was five days before I could get customs clearance to import the vaccine. Language problems bedevilled us at every stage; at one point it was suspected that I was importing a vaccine against *babies*, but I assured them that I was not as yet able to do this.

This experience has taught me two lessons about rabies. Firstly, try to locate the dog *at the time of the bite* so that it can be caught and observed for the development of rabies. Secondly, find the safe human diploid cell vaccine as soon as possible; if it is not available locally there may well be a case for repatriating the patient immediately for a full course of vaccination.

Fortunately we are spared these problems in our rabies-free country.

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