Causes of osteoporosis in men with vertebral crush fractures in study by Francis *et al*¹ and at osteoporosis clinic at King's College Hospital (figures are numbers of patients)

Cause of osteoporosis	Francis <i>et al</i> 's study, 1989 ²	Osteoporosis clinic, King's College Hospital, 1989-90
Primary	40	10
Steroid treatment	15	16
Neoplastic	7	1
Gastric surgery	5	1
Hypogonadism	5	1
Anticonvulsant treatment	4	
Osteogenesis imperfecta	4	4
Homocystinuria	2	
Immobility	1	1
Steatorrhoea	1	
Combined (including alcohol plus other risks)	10	
Alcohol (sole risk)		8
Diabetes mellitus		2
Total	94	44

treatable conditions such as hyperthyroidism and multiple myeloma which may present as osteoporosis.

In addition to the tests that Anderson suggests we include a full blood count, erythrocyte sedimentation rate, thyroid function tests, liver function tests, paraprotein studies, and measurement of urinary calcium concentration in our initial investigation of men presenting with osteoporosis. We do not routinely measure the serum prolactin concentration unless initial investigations or the clinical picture suggest hypogonadism, and, although steroid treatment is a common cause of osteoporosis, endogenous hypercortisolism is rare so we do not screen for Cushing's syndrome unless there are other clinical reasons to suspect the diagnosis.

Osteoporosis in men is often neglected. There has been little evaluation of treatments in men, and we hope that recognition of the clinical problem will lead to properly conducted studies.

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1 Anderson DC. Osteoporosis in men. *BMJ* 1992;305:489-90. (29 August.)
2 Francis RM, Peacock M, Marshall DH, Horsman A, Aaron JE. Spinal osteoporosis in men. *Bone Miner* 1989;5:347-57.

Faecal urge incontinence caused by exercise

EDITOR,—E S Kiff does not mention faecal urge incontinence caused by exercise in the article on faecal incontinence.¹ This may reflect underrecognition of the well documented condition "runner's trots," which three of my patients have.

The patients (two women aged 28 and 42 and a man aged 39) all have well controlled distal ulcerative colitis. As Kiff mentions, reduced rectal capacity as a consequence of proctitis is a recognised cause of faecal urge incontinence. My patients, however, do not have any problems until they engage in long distance road running. Each trains on average 40-60 km a week and frequently participates in races of up to marathon distance. Their training schedules are so disrupted by extreme urgency or actual incontinence that they have to plan routes through wooded countryside or past public conveniences. They find that a combination of a low residue diet and antidiarrhoeal drugs, although handicapping, may allow them to compete in races. All patients know apparently healthy club colleagues who suffer similar symptoms.

Oettlé has studied the effect of moderate exercise (50% maximum oxygen consumption) on the gastrointestinal system of healthy subjects.² He found that transit time was dramatically accelerated both by running and by cycling on a bicycle ergometer. Frequency of defecation was not, however, increased. A colon transit study was performed on one of my patients. The patient ingested 10 radio-opaque beads, which were evident in the right colon on abdominal radiography immediately before exercise. After running for eight minutes at 12 km/h on a treadmill the patient had to stop and visit the toilet with considerable urgency. A repeat radiograph immediately afterwards showed one residual bead in the rectum.

Halvorsen *et al* have reported the effects of more strenuous exercise: they found that 20% of a group who ran marathons in their leisure time experienced symptoms that seriously affected their performance.³ Some evidence suggests that this may partly be due to an ischaemic enteropathy.⁴ In summary, exercise such as running may cause faecal urge incontinence, particularly if other factors such as proctitis are present.

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1 Kiff ES. Faecal incontinence. *BMJ* 1992;305:702-4. (19 September.)
2 Oettlé GJ. Effect of moderate exercise on bowel habit. *Gut* 1991;32:941-4.
3 Halvorsen FA, Lyng J, Glomsaker T, Ritland S. Gastrointestinal disturbances in marathon runners. *Br J Sports Med* 1990;24:266-8.
4 Bounous G, McArdle AH. Marathon runners: the intestinal handicap. *Med Hypotheses* 1990;33:261-4.

Iatrogenic injuries in theatre

EDITOR,—T H Taylor mentions nerve damage, diathermy burns, and backache as examples of injury due to incorrect positioning on the operating table.¹ Another example is the ulcer that occurs in diabetic patients whose heels have not been adequately protected during their time on a hard theatre table or in the immediate postoperative period. At the very least such ulcers delay mobilisation—sometimes considerably in those who have had a joint replacement operation or an amputation; at worst they may lead to amputation.

Medical and nursing staff must not attribute these ulcers to misfortune or misadventure. They are due to carelessness and are preventable. Diabetic patients who have neuropathy or absent foot pulses must have their heels protected, either by foam leg troughs or by ample use of cotton wool padding, before they go to theatre and until they regain full consciousness and can move their legs freely. Sheepskin heel muffs are useless.

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1 Taylor TH. Avoiding iatrogenic injuries in theatre. *BMJ* 1992; 305:595-6. (12 September.)

Use of live donors in renal transplantation

EDITOR,—The United Kingdom Transplant Support Service has recently produced its report covering transplant activity for 1991-2.¹ The report highlights the dramatic differences in clinical practice in Britain regarding the use of live related donors in renal transplantation.

Of the 37 transplant centres that reported using cadaveric transplants, only 26 also reported using live donors, which implies that in 11 units patients

receiving dialysis are not being offered this treatment option under any circumstances. The 26 units used 85 renal transplants from live donors compared with 1786 cadaveric transplants in the year, corresponding to a live donor transplant rate of about 5% overall. The use of live donors within these 26 units varied tremendously: in our unit and that at Charing Cross Hospital live donors contributed around 20% of all transplants while in other units they contributed only 1%. If all these 26 units achieved a 20% live donor transplant rate this would be equivalent to about another 270 grafts each year, representing an increase in total renal transplant activity of about 17%. If the 11 transplant units that do not use live donors at all changed their policy the potential increase in transplant activity would be substantially greater.

Extensive clinical experience of live donor renal transplantation, in Britain and the rest of the world and extending over a considerable period, shows it to be a highly satisfactory form of treatment. Even allowing for the continuing efforts to increase retrieval of cadaveric kidneys, this source of organs seems unlikely to be sufficient to keep up with the ever increasing number of patients joining the waiting list for a transplant. Further debate on live donor transplantation should take place so that this effective treatment can be offered to the greatest possible number of patients who are currently being maintained on long term dialysis programmes.

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1 United Kingdom Transplant Support Service Authority. *Annual report 1991-2*. Bristol: UKTSSA, 1992.

Change in drug treatment after discharge from hospital

EDITOR,—In Rachel Ann Cochrane and colleagues' study only five days of medication was provided when patients were discharged, yet the authors are surprised that medication was renewed without the patient necessarily having been reviewed by a doctor.¹ If patients are discharged on a Thursday there is little time in a busy practice for a non-urgent visit to be arranged before the medicine runs out. In addition, other NHS workers spend considerable time providing a renewed prescription and the drugs probably cost more from a community pharmacist than they would from the hospital pharmacy.

Perhaps one of the things that the working party being set up in Sunderland should consider is whether giving one month's worth of drugs on discharge would increase compliance.

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1 Cochrane RA, Mandal AR, Ledger-Scott M, Walker R. Changes in drug treatment after discharge from hospital in geriatric patients. *BMJ* 1992;305:694-6. (19 September.)

EDITOR,—Rachel Ann Cochrane and colleagues investigated changes in elderly patients' drug treatment after discharge from hospital and found discontinuity of drug treatment and changes in both drugs and formulations.¹ We carried out a similar study in the east of Glasgow.² We visited 56 elderly patients on or after the fifth day after discharge from hospital (median day 8) and found that 15 had not had a new prescription issued. Fourteen drugs had been added to the new prescriptions issued and 17 had been omitted, from a possible total of 128 drugs. Inaccurately labelled containers or changed drug names, or both, were