which *Y enterocolitica* was inoculated. The table shows the organisms involved, the age of the components at the time of transfusion, and the outcome of the reaction. The most common contaminants were pseudomonads (nine cases) and yersinia (five). The mortality was considerable. Since its discovery in 1982¹ as a potential hazard in transfusion practice, fewer than 50 transfusion reactions due to yersinia have been reported worldwide.

The survey also highlighted the probability that transfusions are underinvestigated bacteriologically and underreported in Britain, as in other countries. Only four centres routinely investigated bacteriologically all adverse reactions notified. Most centres devolved this responsibility to local hospital blood banks or bacteriology laboratories.

The Advisory Committee on Transfusion Transmitted Diseases is producing guidelines on investigating and reporting such adverse reactions.

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Complementary medicine needs critical evaluation

EDITOR,—Patrick C Pietroni's article on the relation between general practice and complementary medicine omits any evidence justifying the use of alternative treatments.¹ In appealing to interest among general practitioners and popularity among patients to justify complementary treatments he implies that the rationale for using such treatments is fashion rather than objective evidence. At a time when conventional treatments are evaluated with ever increasing scrutiny it seems ironic that alternative medicine—for which the evidence is more elusive—can be accepted uncritically. Surely the economic limitations imposed on general practitioners and their primary health care team require managers to prefer treatments that work rather than appeal to irrational sensibilities.

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Wernicke's encephalopathy and hyperemesis gravidarum

EDITOR,—The case of Wernicke's encephalopathy in hyperemesis gravidarum reported by P S Bergin and P Harvey¹ outlines an important but forgotten lesson from the past. Indeed, Sheehan indicated a mortality of 35% in his report in 1939.² I report another case that included optic papillitis.

A 31 year old, previously well woman with two successful previous pregnancies presented at 13 weeks with a six week history of worsening hyperemesis. Despite intravenous fluids and rectal emetics she continued with intractable vomiting for a further three weeks. Her α fetoprotein

concentration was raised at 16 weeks; fetal death was confirmed by ultrasonography. She underwent a prostaglandin induced abortion.

Two days later she woke with poor central vision (light only in the left and 6/18 in the right eye) and ataxia. Clinical examination showed bilateral sustained ankle clonus with extensor plantars, horizontal nystagmus, and swelling and haemorrhages in both optic discs. She received intravenous Parentovite and improved dramatically over the following five days with resolution of her visual impairment and ataxia. By six weeks she had no abnormal clinical findings.

Optic papillitis is rarely associated with Wernicke's encephalopathy, having an incidence of less than 5%.³ The usual fundal signs are retinal haemorrhages. Indeed, this poorly known feature has previously delayed the diagnosis.⁴ This sign should not obscure or delay the diagnosis.

I agree that oral thiamine supplements are urgently required by any patient with hyperemesis gravidarum, but in all 10 cases of Wernicke's encephalopathy reported in English in the past decade the vomiting had continued for one month and usually occurred after instigation of intravenous fluids. It is also important to remember that Wernicke's encephalopathy can occur whenever there is poor nutrition, including in anorexia nervosa⁵ and hunger strikes.⁶

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Value of Dundee coronary risk-disk

EDITOR,—Correspondence on the value of the Dundee coronary risk disk has been more concerned with theoretical validity than with usefulness,^{1,2} but, as I wrote a year ago, "validity is a matter for argument, but the acid test is whether the Dundee coronary risk-disk is found useful."³ It is, and over 4000 disks have been dispatched since then. The disk is used not only to motivate patients in general practice and occupational medicine but to audit the performance of cardiovascular risk factor clinics and to meet the local targets concerning risk factors and coronary prevention in the *Health of the Nation* initiative.⁴ At the time of my earlier response⁵ to the Oxford critique of the disk,⁶ results of our survey of users were incomplete; we are now past the two thirds response rate. The answer to the claim that the Dundee score is preferable to the Dundee (bus queue) rank is that users of the rank, or the rank and score together, outnumber users of the score alone, are the heavier users, are more likely to show the result to their patients, are more positive about the motivational value of the disk, and recommend the disk more strongly to other users.

Limiting the disk to three modifiable risk factors was a deliberate compromise that has been justified by the comments we have received. Most of the users were satisfied; of those who were not, some thought that not enough factors were included and others that a scoring system based on three factors was too complicated.

Mortality from coronary heart disease by sex in England and Wales 1990

Allan St J Dixon says that the system is flawed⁷ because it does not include the menopause as a risk factor, and he attacks comments attributed to me at a conference.⁸ Deaths from coronary heart disease multiply with age in both sexes; a constant multiple would produce a straight line on a logarithmic plot. The natural menopause occurs close to age 50, and few women stop menstruating more than a few years either side of this. If the menopause was associated with the withdrawal of a protective factor, as is widely claimed, death rates in women should rebound upwards, showing a concave plot inflecting upwards around 50. In fact, the plot is smooth and convex (figure); it is the curve in men that bends over more with age, or, as I stated in my talk, "it's the men wot wobble, not the women." Similar curves apply to other years and other countries, and it is not just national statistics that challenge the myth regarding the menopause. The nurses' health study, of 121 700 American women, showed no evidence of increased risk with a natural menopause.⁹ The deterioration in some coronary risk factors at the menopause, which is alleged to drive the presumptive acceleration in coronary risk, must therefore be compensated by improvements in others, and many prevailing assumptions are too simplistic.¹⁰

None of this is to deny a potential benefit from hormone replacement therapy, but again the situation is not as simple as Dixon suggests. If his verdict of unequivocal benefit represented the consensus the National Institutes of Health in the United States would not be mounting the women's health initiative clinical trial/observational study (costing \$50 million a year for 14 years), one arm of which is a comparison of oestrogen, oestrogen plus progestogen, and placebo in postmenopausal women.

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