a direct approach—for example, isolation or molecular identification of a potentially infecting organism from thyroid gland and injection into an experimental animal to test for possible induction of autoimmune thyroid diseases.

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Enalapril and β blockers in chronic renal failure

EDITOR,—T Hannedouche and colleagues report a randomised controlled trial of enalapril and β blockers in patients with non-diabetic chronic renal failure.¹ The importance of hypertension and progression of renal insufficiency is well established.^{2,3} The authors' conclusion that enalapril was superior to β blockers in preventing end stage renal failure in patients with chronic renal insufficiency was partly based on the statement that "no differences in blood pressure were seen at any point of the follow up between the two groups." Table III of their paper, however, shows blood pressure only at one year intervals for a study consisting of three year follow up.

Table IV shows that the patients in the conventional group had a significantly lower incidence of adequate control of blood pressure when taking only one drug—namely, the β blocker. As far as we can tell, additional antihypertensive drugs were added at three month intervals. The conventional group may thus have had poorer control of blood pressure for the first six to nine months of follow up. We wonder if the authors can provide comparisons of blood pressure, especially during the first year of follow up, at three month intervals. Without this information one cannot exclude better control of blood pressure in the enalapril group as the explanation for the drug's beneficial effect. This is especially true as the length of follow up is only three years and even a three to six month period of better control may alter the rate of progression of renal disease.

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Computed tomography for single seizures

EDITOR,—Ronald A Schoenenberger and Sabine M Heim suggest that cerebral imaging after a single seizure may be unnecessary if a score of ≥ 3 is elicited with the CAGE questionnaire (a screening questionnaire on alcohol misuse).¹ Their study raises several related issues that merit further comment.

Focal cerebral lesions thought to be responsible for the presenting seizures were found in 34% of cases. In these cases there was presumably a focal onset before generalisation, which was not evident on ictal clinical assessment. It follows, therefore, that the clinically generalised seizure was in fact a partial seizure with secondary generalisation in an appreciable minority of cases. This fact alone should lower thresholds for imaging in this clinical scenario.

While I accept the validity of the CAGE questionnaire, using it after obtaining a detailed alcohol and drug history, as should be the case, may elicit unreliable answers, especially in a period of postictal confusion. False positive and false negative responses must occur. Moreover, if a seizure is precipitated by alcohol withdrawal (and this is not synonymous with a score of ≥ 3 on testing the CAGE questionnaire) there are immediate clinical implications, not the least of which is the possible need for detoxification.

The possibility of behavioural disturbance during this period is high. Given the frequent interrelation among cerebral trauma, disordered haemostasis, and alcohol misuse, the ratio of risk to benefit in this subgroup of patients with a single seizure seems to be strongly in favour of cerebral imaging irrespective of scores obtained with the CAGE questionnaire.

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Seasonal variations in fatal pulmonary embolism

Several mechanisms contribute

EDITOR,—Peter Wilmschurst draws attention to the increased incidence of coronary heart disease and stroke associated with cold weather.¹ This conclusion is drawn largely from epidemiological data from studies that were not based on postmortem examinations. We are surprised that he does not mention another major cause of cardiovascular mortality, pulmonary embolism.

Fatal pulmonary embolism causes over 20 000 deaths annually in Britain and accounts for a tenth of all deaths in hospital.² It also has a seasonal variation, with both postoperative and "spontaneous" emboli being significantly more common in winter.^{3,4} The cause of many deaths due to pulmonary embolism may be registered as myocardial infarction in the absence of routine postmortem examination, and this may contribute to the seasonal increase in deaths registered as due to ischaemic heart disease.

The seasonal increase in fatal pulmonary embolism may partly be explained by the changes in coagulation described in the editorial, but other factors, such as peripheral vasoconstriction and reduced activity resulting in a fall in blood flow in the lower limbs, may also contribute.⁵ We agree with Wilmschurst that cold weather causes an increase in preventable cardiovascular deaths. The

mechanisms of this increased death rate may include an increase in numbers of cerebrovascular, coronary, and thromboembolic episodes. In the absence of a large study based on postmortem findings it is difficult to determine the contribution of each mechanism and the preventive measures required.

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Malignant phase hypertension does not vary by season

EDITOR,—In his editorial on temperature and cardiovascular mortality Peter Wilmschurst comments that the difference in temperature between summer and winter in Britain should result in a difference in blood pressure of 5 mmHg.¹ Malignant phase hypertension represents a syndrome of high blood pressure that is associated with a high mortality if left untreated. We recently reported that we had not noted a decline in the incidence of this condition between 1970 and 1993.²

To investigate whether the presentation of malignant phase hypertension varied by season we reviewed the month of presentation of 315 patients (211 men, 104 women; mean age 49.4 (SD 12.7) years) with the condition who were referred to our hospital between 1965 and 1994. There was no clear relation between the number presenting and season, although the largest number of patients first presented in March (n=35) and the lowest number of patients first presented in August (n=17) (figure). When patients who presented in March were compared with those who presented in August there were no significant differences in mean age (49.6 (13.3) v 46.2 (8.3) years; unpaired *t* test, *P*=0.27), mean duration of known hypertension before presentation (17.5 (43.8) v 6.4 (14.7) months; *P*=0.18), and mean diastolic blood pressure (144.3 (19.8) v 140.0 (30.5) mmHg; *P*=0.61). There was, however, a trend towards a high mean systolic blood pressure (234.2 (28.0) v

Number of patients presenting with malignant phase hypertension by month (n=315)

216.7 (33.1) mmHg; $P=0.07$) in patients who presented in March.

Our findings are in keeping with a seasonal variation in arterial blood pressure as it is known that higher blood pressures are recorded in winter than in summer.^{3,4} There was, however, no seasonal pattern to the incidence of malignant phase hypertension.

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Histopathology and medical laboratory scientific officers

EDITOR,—Some of the reactions to my personal view on the future of histopathology^{1,2} were disappointing, although not entirely unexpected. A few months ago colleagues and I sent a questionnaire to all those, both consultants and registrars, who had worked for us over the last 17 years. All of the 15 replied (nine registrars, of whom five are now consultants, and six consultants). Although their opinions on our practice diverged, none expressed any concern for the quality of our service. When asked their opinion of the Royal College of Pathologists' code of practice—"all selection of tissue blocks for processing and examination must be carried out by a histopathologist"—five of the former registrars agreed with it, two disagreed, and two were unsure about its relevance while two of the consultants agreed and four disagreed. The diversity of opinion among the 15 respondents was perhaps highlighted by the near universal unsolicited view that medical laboratory scientific officers could be trained to undertake more responsible tasks (unspecified).

It has never been my view that every medical laboratory scientific officer should be given the opportunity of being trained to dissect surgical specimens, for I believe that a selection process should operate; neither did I say that medical laboratory scientific officers should be unsupervised. A day does not go by without one or more of us being called to decide on the appropriate approach to some unusual or difficult specimen. As one of our former consultant colleagues commented, however, "the vast majority of surgical specimens are of a highly standardised nature, the dissection of which is well within the capacity of a trained MLSO."

Dennis H Wright and T J Jones miss the point when they invoke the possibility of medicolegal litigation stopping us in our tracks.³ Like all consultants, we take responsibility for the work of our junior staff; in any event, most errors that give rise to liability to damages occur in the microscopist's domain.

Perhaps Wright has been away from the sharp end for too long to see the banal lesions I was referring to, such as fibroepithelial polyps, seborrhoeic keratoses, and intradermal naevi. Proper training can safely point to aspects of the microscopic picture that require more circumspect

examination by a consultant. I have no doubt that in the years ahead selected medical laboratory scientific officers (laboratory practitioners) will be entrusted with defined aspects of microscopic diagnosis.

J Denis Biggart and Derek C Allen of Belfast City Hospital state that ours is not the only establishment to use medical laboratory scientific officers in this more effective way.² Our practice is as theirs, and we follow an agreed protocol (standard operating procedure). It is a sad reflection on Clinical Pathology Accreditation (UK) Ltd that, for the same reason that their laboratory was accredited, ours was not (Richard I Harris's letter).² I look forward to a time when pathologists and medical scientific laboratory officers can work together without the intrusion of arbitrary and rigid lines of demarcation.

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Failure of consultant expansion

EDITOR,—Stephen Brearley is right to bemoan the lack of progress towards a consultant led service but is too pessimistic.¹ It is important to look not just at the years leading to an appointment as a consultant but also at the years after that appointment. Here, continuing medical education has a role.

In the past many people have seen the achievement of the consultant grade as having "made it." This is understandable in view of the numerous hurdles they have had to overcome. It has then been customary to stay in post until retirement. I believe that this is an outdated model. With a shorter period of more intense training, followed by a statutory requirement for continuing medical training, we may well have to change our view of the nature of the consultant grade itself. I realise that this is a heresy, but models exist to guide us.

In public health, consultants work alongside but ultimately under a director of public health without feeling demeaned. Similarly, doctors in Europe often have a system of senior and junior consultants. Is it too much to suggest that, having aped their system of training, we should follow their system of appointing consultants? Such a system would have spin off benefits. In this more mobile world, having a job for life has lost some appeal. Doctors often need to leave one area of Britain to follow their partners to another area. The creation of more grades might help to allow this fluidity, which might encourage more women into consultant positions. Secondly, with continuing training and development, consultants might wish to follow some new interest, and jobs for life would hinder this.

The real difficulty with appointing more consultants, however, is the cost. Perhaps we have to bite the bullet. Should young consultants in their early 30s start on salaries of £40 000, which shoot up quickly after that? We face a clear choice: either we stay as we are with long and frustrating training or we grasp the future of a well trained, developing workforce, whose pay develops as they do. I suggest that we must grasp that future, warts and all.

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Human rights in Iraq

EDITOR,—Human rights in Iraq have been violated for decades. The fact that doctors are forced to participate in violent atrocities adds another dimension to the suffering of the Iraqi people and, especially, our medical colleagues. Recent reports suggest that doctors have died for disobeying orders to perform amputations and other abominations, defending their conscience and integrity. In the past and during the Iraq-Iran war Iraqi doctors were subjected to terror to force them to carry out violations of human rights on innocent people. This resulted in an exodus of doctors from Iraq.

Doctors are also under pressure because they feel helpless towards their patients. The harsh, punitive sanctions imposed by the United Nations since August 1990, which include sanctions against the supply of the *BMJ*; the destructive war in January and February 1991; the suppression of the civilian uprising; and the continuation of the embargo have resulted in hundreds of thousands of unnecessary deaths, especially among children.^{3,4} Today's lack of medicine and food brings the Iraqi people nearer to a predicted "massive starvation and disease" in one of the rich countries in the world.⁵ The assertion that medicine and foodstuff are exempt from the sanctions is meaningless since Iraq has no funds to buy them.

The unprecedented punitive sanctions have affected the whole of the Iraqi people except the original target, Saddam Hussein. The technical condition for lifting the sanctions—that is, that Iraq will not again be able to make weapons of mass destruction—has been whipped away, as the United Nations Security Council was informed by Rolf Ekens, the head of monitoring of Iraqi weapons. The political condition—the removal of Saddam Hussein—still remains. As recent events in Haiti have shown, economic sanctions and blockades cannot be effective against oppressive and inhumane political regimes unless they are combined with other measures. So does the United Nations, and in particular the United States, want to use force against Saddam Hussein again? Or is it time to lift the punitive sanctions and relieve the suffering of the Iraqi people and their doctors?

We urge all medical professionals and bodies, especially the BMA, to put constant pressure on the British government and international bodies to lift the punitive sanctions on Iraqi people. Measures must be taken internationally to stop the export of any weapons to the regime (and other, similar regimes). The unnecessary death of more than 200 babies and children a day must be stopped and the Iraqi people allowed to regain self respect and a humane existence. This would ensure some alleviation of fear and the persecution of doctors in Iraq.

We have collected an extensive bibliography on the impact of the Gulf war and the sanctions on the people of Iraq; this is available on request.

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**We have now been allowed by the British government to send the *BMJ* to Iraq.—EDITOR