emergency medicine is indeed a true specialty (Dr Dallos, March 1988 *JRSM*, p. 130).

Incidentally, having had first-hand experience of the fellowship examinations in the specialty in both the United States and Great Britain, the Royal College of Surgeons of Edinburgh should be congratulated on developing a test which is both practical and searching whilst retaining a very traditional format. In my view it demands a broader knowledge base than its American equivalent.

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Managing the dyspeptic patient

Sir, the paper by Lobo *et al.* (April 1988 *JRSM*, p. 212) has well illustrated the advantages of a single-visit dyspepsia clinic for patients with suspected upper gastrointestinal tract pathology. They have however, not highlighted the importance of such a service in the elderly.

It has been shown earlier that upper gastrointestinal endoscopy in elderly patients is safe, gives a high diagnostic yield and helps in changing management[1-3]. A recent study from our centre[4] has also emphasized that initial gastroscopy in the symptomatic elderly (presenting with dyspepsia, dysphagia, haematemesis, malaena, anorexia) effects an early diagnosis (especially of malignancy) and influences overall patient management. This approach bypasses tedious hospital procedures including waiting time for barium studies and is thus cost effective. It would be appropriate to set up such facilities in more centres so that unnecessary delay in diagnosing serious disorders be averted.

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References

1 Belsito AA, Dickinson P. Fibreoptic oesophagogastroscopy. A crucial diagnostic test in the elderly. *Geriatrics* 1972; 27:90

2 Jacobsohn WZ, Levy A. Endoscopy of the upper gastrointestinal tract is feasible and safe in elderly patients. *Geriatrics* 1977;32:80-3

3 Lockhart SP, Schofield PM, Gribble RJN, Bason JH. Upper gastrointestinal endoscopy in the elderly. *Br Med J* 1985;i:456-7

4 Misra SC, Kar P, Mansharamani GG. Upper gastrointestinal endoscopy in elderly patients with upper abdominal symptoms. *J Assoc Phys India* 1988;36:155-6

The authors reply below:

Sir, We would agree that upper gastrointestinal endoscopy in elderly patients is very useful, but this was not the question we were addressing in our paper. The point we were hoping to make was that as 'dyspepsia' may be the presenting complaint in a wide range of conditions, it would ideally be best if the patient was seen by a specialist before endoscopy was performed. We would think this probably of greatest importance in the elderly group referred to by your correspondents because unwarranted complications in this age group can be disastrous.

R J DICKINSON
A J LOBO
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Nephrotic syndrome as the marker for underlying malignancy

Sir, There are a number of flaws in Stevens and Rainford's case report (July 1988 *JRSM*, p 416). They assume an association between a nephritis and a malignancy without presenting immunological evidence and then proceed to draw untenable conclusions.

In a personal series of 784 biopsies of native kidneys over the past 12 years, 72 cases of membranous glomerulonephritis (9.2%) have been diagnosed and only one (0.13%) was malignancy related (cervical carcinoma). Two other tumours occurred in the remaining 712 nephritic patients. If my figures are representative, the chance of a related neoplasm in a patient with a membranous nephropathy is a little over 1%. Should Stevens and Rainford's advice be taken, a large number of renal patients would be needlessly and expensively investigated for malignancies.

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The authors reply below:

Sir, Dr Gabriel appears to have misunderstood the majority of our case report. The search for large bowel malignancy in this woman with nephrotic syndrome was prompted by a prior knowledge of the literature. The assumption of an association between her glomerular nephritis and her underlying malignancy was based on the observation that immediately following removal of her malignancy she went into remission of her nephrotic syndrome. She has now been followed for 3 years and remains free of recurrence of both nephrotic syndrome and large bowel neoplasia.

Dr Gabriel quotes a personal series of 72 cases of membranous nephropathy of which one was malignancy related. He does not report the age of these patients at diagnosis, the incidence of nephrotic syndrome, whether malignancy was actually looked for or for how long the patients have been followed up. He implies that his figures might be representative whilst entirely ignoring the work of Eagen and Lewis* and the published series of Lee *et al.**, Row *et al.** and Zech *et al.** (which quote an incidence of malignancy related to nephrotic syndrome and membranous glomerular nephritis of up to 22%).

We would accept that investigation for malignancy could be restricted to adults with nephrotic syndrome and membranous glomerular nephritis of uncertain aetiology. However, we would contend that any patient who has a treatable malignancy discovered would view the investigation neither as needless nor too expensive.

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*References 1-4 of our original article.

Management of the solitary thyroid nodule

Sir, We read with interest the article by Wheeler (August 1988 *JRSM*, p 437). The author states that 'few investigations have been misapplied more often than thyroid scintigraphy' and that ultrasound scanning will distinguish between cystic and solid lesions with 95% accuracy but contributes very little to management. How then does one investigate the clinically solitary thyroid nodule? There is a recognized error when palpating the neck[1] and about 25% of clinically 'solitary' nodules will be the more easily palpated dominant nodules in a multinodular goitre (MNG).