a diagnosis of auto-immune connective tissue disease, possibly systemic lupus erythematosus (SLE).

In support of this possibility is Beethoven's facial rash. The excellent life-mask of 1812 and the death-mask of Danhauser (1827) illustrate deep facial scars. Portraits represent Beethoven with flushed maxillae and nasal areas with peri-orbital pallor. Is this the rash of SLE?

Fatigue, fever, malaise, weight-loss and anorexia are common in SLE, as are conjunctivitis, episcleritis and joint problems. The 'black petechiae' of the body at death may represent purpura, seen in around 50% of patients with SLE[5].

As the doctors withdrew from the composer shortly before death Beethoven commented, 'plaudite, amici, commoedia finita est'[6]. He never did think much of doctors - perhaps we should leave him in peace.

I E WILLETTS
Department of Surgery
Kings Mill Hospital, Mansfield Road
Sutton-in-Ashfield, Nottinghamshire NG17 4JL

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Enterostomy feeding

I read with interest the article by Powell-Tuck and van Someren entitled 'Enterostomy feeding for patients with stroke and bulbar palsy' (December 1992 *JRSM*, p 717). The work by Horner *et al.*[1] was not performed on people in the acute phase of stroke. Their patients were studied a mean time of 2.9 months (range 1-24) post stroke. Studies performed in the acute phase of stroke[2,3], without the benefit of videofluoroscopy, found an incidence of dysphagia between 28% and 43%.

The gag reflex is a poor predictor of any difficulties swallowing, and has nothing whatsoever to do with the swallowing reflex[4]. In fact Horner *et al.*[1] found it a poor predictor, suggesting that dysphonia, and a 'wet' voice were better predictors, to this could be added multiple laryngeal movements when attempting to swallow. Recent work by Nathadwarawala *et al.*[5] suggest that the time taken to drink a standard volume of water is a good predictor of swallowing difficulties.

Patients who have difficulty swallowing following acute stroke, often have resolved by 24-48 h and the majority by 8-9 days[5]. Work has suggested that a gastrostomy should be considered at 2 weeks[6]. If it is left longer than this patients will be in a hypercatabolic state making replenishment difficult, possibly worsening the dysphagia[7]. Larsson *et al.* found that 28% of elderly patients[8] are malnourished on admission to hospital, other work on stroke patients has found up to 57% of stroke patients may be malnourished on admission[9].

I would conclude that difficulty swallowing following stroke should be taken seriously and acted upon quickly. The most salient point is that the absence of a gag reflex does not represent a poor swallow, and should not automatically mean a reflex 'nil by mouth' order.

DAVID G SMITHARD
Senior Registrar in Geriatric Medicine
St Thomas' Hospital Elderly Care Unit
Lambeth Palace Road London SE1 7EH, UK

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The authors reply below:

We were interested to see Dr Smithard's letter and certainly do not wish to argue over the 'precise' incidence of swallowing difficulties following stroke. We seem to agree that it is high and probably above 30% at least. Gordon *et al.*[1] found 41 of 100 in the acute stage.

We described the gag reflex as a *clinical correlate* with aspiration and referenced our comment. We made no claims for it being directly related to the swallowing reflex, a controversy of which we were well aware. Clinicians want simple practical guidelines as to patients at risk and there is reason to consider both pyriform pooling and absent gag as such. We accept the comments about dysphonia and timed swallows. It is incidentally becoming increasingly clear that swallowing difficulties commonly occur in unilateral stroke not involving the brainstem[1].

Swallowing difficulties commonly improve with time and this is the reason for delaying the decision to perform gastrostomy to a time when little further improvement is likely. If gastrostomy is inserted too quickly the patient may unnecessarily be put through the slight discomfort and risks of its insertion and resources wasted. There need be no rush in such patients who are generally institutionalized. They are certainly not 'hypercatabolic' as we made plain in the editorial. As to whether the delay before insertion should be 2 or 4 weeks may depend to some extent on individual circumstances, but we generally prefer to wait 4 weeks. This is, in fact, in line with Park *et al.* quoted by Smithard[2].

Our principal message is that swallowing difficulties occur more frequently after stroke than many realize, and that gastrostomy can be very helpful if the difficulties are prolonged. With that Dr Smithard seems (a little reluctantly) to be in agreement.

J POWELL-TUCK
N VAN SOMEREN
The Royal London Hospital Medical College
Turner Street
London E1 1AD, UK

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Charles Dickens: orthopaedics and the handicapped

It was very interesting to read A J Carter's article on Charles Dickens, orthopaedics and the handicapped (January 1993 *JRSM*, p 45). Deaf children also attracted Dickens' attention.

In his American notes (1842) Dickens refers to his visit to Parkins Institute at Boston, where Dickens met Laura Bridgman a blind deaf and dumb girl (a kind of Helen Keller). Dickens devoted several pages to displaying Laura's progress and achievements and describing the way she was taught. Dickens also refers to a blind, deaf and dumb child, Oliver Caswell, who