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Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced.

The plague of Athens

With a degree of assurance Dr T Bazas categorically asserts that the plague of Athens was smallpox (December 1994 *JRSM*, p 755).

In fact as already pointed out (April 1993 *JRSM*, p 244) it is very difficult if not impossible to determine the nature of the epidemic disease known only by Thucydides's short description in *The History of the Peloponnesian War*.

As the clinical picture included gangrena of the extremities which occurs also in exanthematic typhus (and not in smallpox) several medical historians have suggested that this disease would have been typhus.

The smallpox hypothesis was already put forward long before Dr Bazas[1].

Furthermore, the latter obviously extrapolates when he writes: 'The disease was transmitted from person to person by droplets and not by insect bites', as no such indication is given in Thucydides's description.

The determination of the exact nature of this epidemic disease will thus ever remain an elusive mystery.

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REFERENCE

1 Béteau JP. *La Peste d'Athènes (430–426 av JC)*. Paris, 1934 mentions several authors from 1815 to 1926 making this hypothesis more recently formulated by Littman RJ, and Littman ML. The Athenian Plague: smallpox. *Trans Proc Am Phil Assoc* 1969;**100**:261–75

Are ethical committees reliable?

I was interested to read the article by Dr Hotopf (January 1995 *JRSM*, pp 31–33). He comments on the problems caused to potential researchers by the multiplicity of Local Research Ethical Committees (LREC), but does not appear to realize the problems caused to those LRECs who are asked to consider proposals formulated in a manner different from that which they have found to suit the requirements of their District Health Authority.

More importantly, he seems to overlook the facts of the present situation, namely that the Department of Health requires each District Health Authority to establish, and receive advice from its own LREC, and makes no provision for accepting advice from any other Committee.

I suggest therefore that he omits the recommendation most likely to lead towards the changes he wishes to see, i.e. that the Department of Health introduces a common application form for use by LRECs.

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Dr Samuel Johnson's illness: idiopathic pulmonary fibrosis not bronchiectasis

Dr Jerome M Reich (December 1994 *JRSM* pp 737–741) in his fulgent discussion of the pulmonary illness of Samuel Johnson hastily dismisses the importance of two key clinical symptoms in bronchiectasis: (1) the presence of copious, purulent sputum; and (2) the occurrence of repeated bouts of respiratory infections in childhood, adolescence, and early adult years. These two features unequivocally missing in Johnson's medical story are *sine qua non* for the diagnosis of diffuse bronchiectasis.

Then, what was the nature of Dr Johnson's distemper? I believe that Matthew Baillie's specimen of Samuel Johnson's lung provides the answer; the learned doctor had idiopathic pulmonary fibrosis (cryptogenic fibrosing alveolitis). Idiopathic pulmonary fibrosis usually affects individuals in the fifth and sixth decades of life; produces severe, uncontrollable bouts of dry cough; causes honeycombing of the lungs with cystic and bullous appearance; and induces, in inexorable cases, corpulmonale.

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Rickets and the crippled child: an historical perspective

I enjoyed greatly Dr Denis Gibbs' interesting and scholarly account of the history of rickets in England (December 1994 *JRSM*, pp 729–732).

Dr Gibbs gives the credit of the first detailed description of rickets to Dr Daniel Whistler whose thesis on the disease was published in Leiden in 1645. However, the *Dictionary of National Biography*[1] clearly shows that the original observations upon which Whistler's thesis was based were Francis Glisson's.

> He (*Glisson*) communicated his notes to other fellows of the College of Physicians, of whom seven added some remarks of their own. Dr George Bate and Dr A Regemorter were appointed to aid Glisson in preparing a treatise on the subject. As the work went on it became clear that he had made nearly all the observations and conclusions, and the other physicians desired him to take as his due the whole honour of the work. After more than five years of this open scientific discussion the book appeared.

The book, entitled *De Rachitide Sive Morbo Puerili qui Vulgo The Rickets dicitur, Tractatus*, was published in London in 1650. About Dr Whistler, the *Dictionary of National Biography* continues.

> In 1645 Dr Whistler, to whom, as a student in London, the knowledge of the investigation at the College of Physicians of this new disease was easily accessible, published at Leiden "Disputatio medica inauguralis de morbo puerili anglorum quem patrio idiomate indigenae vocant The Rickets". An examination of the dissertation shows that Whistler's knowledge was secondhand, obtained from Glisson himself in England and indeed he only lays personal claim to one thing, the proposal of the name Paedosplanchnosteocaces for the disease. Whistler was a young man trying to utilise

an imperfect knowledge of the well known but not yet printed discovery of a great scientific investigator. What little information there is in his thesis is due to Glisson, while Glisson owes nothing to him.

Why the names of Dr Bate and Dr Regemorter were added to the English edition, *A Treatise of Rickets Being a Disease Common to Children* published in 1651, is not clear.

Francis Glisson is, of course, better known for his description of the fibrous capsule of the liver, in his *Anatomia Hepatis* published in 1654. He also described the sphincter of the bile duct in his *Tractatus de Ventriculo et Intestinis* (1677), but Oddi's (1887) name has become attached to this structure[2].

I am grateful to Mrs Carole Smith, Acting Assistant Librarian at Gonville and Caius College, Cambridge, for information and references about Francis Glisson.

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1 Stephen L, ed. *Dictionary of National Biography*, Vol 21. London: Smith, Elder, 1890:437–8

2 Dobson J. *Anatomical Eponyms*, 2nd edn. Edinburgh & London: Livingstone, 1962:79

Swallowing in motor neurone disease

We read with interest the report of Leighton *et al.* (December 1994 *JRSM*, pp 801–805) on the treatment of swallowing problems in motor neurone disease (MND). The relentlessly progressive dysphagia associated with bulbar and pseudobulbar palsy is a most distressing feature of this devastating disease and presents a major issue in the palliative care of patients with MND. The authors discuss the role of cricopharyngeal myotomy and pharyngostomy in the management of this problem. Although the authors note a patient satisfaction rate of 89%, it is stressed that these procedures are only suitable for patients who are fit for general anaesthesia and acknowledged, at least in the case of pharyngostomy, that morbidity was unacceptably high for a palliative procedure.

In recent years percutaneous endoscopic feeding gastrostomy (PEG) has been increasingly used to alleviate symptoms associated with dysphagia in MND. This procedure is now very widely used and it is unfortunate that this technique was not mentioned until the penultimate sentence of the Leighton *et al.* paper. Our experience in approximately 30 MND patients has already shown the PEG has enormous advantages over both cricopharyngeal myotomy and pharyngostomy. It can be used in patients in whom a general anaesthetic would be dangerous and the average length of in-patient stay is much less than the 8 days quoted for the two ENT procedures. Moreover, the insertion of a PEG reliably and predictably reverses the adverse nutritional status in MND patients with bulbar symptoms. Most importantly in palliative terms, PEG relieves the inexorable feeling of hunger to which MND sufferers were previously condemned during the final weeks and months of their lives. We therefore throughly endorse the comments contained in the last two sentences of this paper. PEG has revolutionized palliative care in MND and we foresee an increasing role for PEG in the management of an ever wider range of patients with neurogenic dysphagia.

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Non-attendance in outpatients

King and colleagues have highlighted the problems of non-attendance for outpatient appointments (February 1995 *JRSM*, pp 88–90). As the authors acknowledge non-attendance has important resource implications for the health service. However, their proposed solution—overbooking—is likely to cause patient and clinician dissatisfaction. Clearly, on some days all patients will attend and this will inevitably lead to queues with consequent dissatisfaction amongst patients. Furthermore, clinicians will be required to either work longer hours to clear the queues, when all the patients attend, or to curtail appointment lengths.

A better solution is to change the appointment method. Two randomized trials of appointment methods within the context of an osteoporosis screening programme have shown that non-attendance to appointments can be reduced from 20% to less than 3% by alteration of the method of invitation[1,2]. These appointment methods were very cost effective compared with the standard appointment system. Appointment methods which either ask the patient to make their own appointment or require confirmation of intention to attend the appointment are associated with very low non-attendance rates. Alternatively, an American study has noted that non-attendance can be reduced through a system of reminders shortly before the appointment falls due[3]. Randomized trials of appointment systems within the context of outpatient departments would be justified.

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1 Garton MJ, Torgerson DJ, Donaldson C, Russell IT, Reid DM. Recruitment methods for screening programmes: trial of a new method within a regional osteoporosis study. *BMJ* 1992;**305:**82–4

2 Torgerson DJ, Garton MJ, Donaldson C, Reid DM, Russell IT. Recruitment methods for screening programmes: trial of an improved method within a regional osteoporosis study. *BMJ* 1993;**307:**99

3 Bigby JA, Giblin J, Pappius EM, Goldman L. Appointment reminders to reduce no-show rates. *JAMA* 1983;**250:**1742–5

Acts of commission, omission, and demission or pulling the plug

There was a reference to the judgement in the Airedale NHS Trust v Bland test case in the article by Shaw (January 1995 *JRSM*, pp 18–19). In this and the small number of similar cases, much unnecessary pain to the relatives and staff looking after him could have been saved by a more logical definition of legal death.

A person's individual personality and ability to behave as a human being depends on the survival of his cerebral cortex. Once this has been demonstrably destroyed, he, as an individual with his own personality has, effectively, died.

It is irrelevant that his brain stem may be functioning to maintain some 'signs of life'. It should be possible at this stage to certify the patient dead and to withhold all treatment. No one could then be accused of murder or even euthanasia.

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