

## Epley's procedure should be used to treat benign positional vertigo

EDITOR,—In response to our review on the treatment of benign positional vertigo<sup>1</sup> Graeme M Weiner advocates Cawthorne-Cooksey exercises as the superior choice for this condition.<sup>2</sup> We are aware that this reflects widespread practice in Britain, but the published evidence justifying it is weak.

Cawthorne-Cooksey exercises were devised to promote central compensation of stable unilateral vestibular deficits, and they serve this purpose well. Only one study, however, has evaluated the efficacy of such exercises for benign positional vertigo; it found that 32% of patients were cured after one week.<sup>3</sup> This compares unfavourably with the 60-80% rate of immediate success after just one application of Epley's procedure as shown in several open studies cited in our review. The efficacy of this technique, which aims to clear the posterior semicircular canal of mobile particles, has been substantiated further by two recent studies.<sup>4,5</sup> Patients appreciate the physician's support through a quick and effective manoeuvre as an alternative to repeated self inflicted attacks of the condition as occur with Cawthorne-Cooksey exercises. The 20% of patients who experience frequent recurrences can be taught an adapted version of Epley's procedure for self treatment at home.

We would invite Weiner to try Epley's manoeuvre himself because it was the grateful response of patients that ultimately defeated our initial scepticism.

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## Correct technique is important in cardioversion of atrial fibrillation

EDITOR,—We are concerned that Gregory Y H Lip and colleagues' article on cardioversion of atrial fibrillation omits important information about the technique of cardioversion.<sup>1</sup> Direct current external cardioversion is the method most widely used to restore sinus rhythm in patients with atrial fibrillation. However, meticulous attention to detail is necessary if the technique is to have optimal results, and we take issue with the authors' guidelines for direct current cardioversion.

It has long been established that optimal results are achieved with an anterior-posterior arrangement of the paddles instead of the more usual anterior-apical approach.<sup>2</sup> The anterior-posterior approach incorporates a greater proportion of atrial tissue in the defibrillation field than the standard approach. Such a position also minimises the distance between electrodes and the quantity of lung tissue between the defibrillating electrodes.<sup>3</sup> It also seems appropriate to start direct current cardioversion with a higher level of energy as delivery of 100 J will result in successful cardioversion in only around

half of patients.<sup>4</sup> Most authorities suggest a single shock of 200 J before one of 360 J, although it is our practice to start with a 360 J shock with the anterior-posterior arrangement of the paddles.

In our institution almost all patients who present with atrial fibrillation of unknown duration are offered direct current cardioversion after an appropriate period of anticoagulation in an attempt to restore sinus rhythm. Should this be unsuccessful then selected patients are offered internal atrial cardioversion<sup>5</sup> before the atrial fibrillation is finally accepted as being chronic. Failure to use the correct technique may unnecessarily condemn patients to chronic or prolonged atrial fibrillation with all the haemodynamic and thromboembolic disadvantages for the patients and the economic consequences for the NHS.

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## Children and sport

### De-emphasise team sport

EDITOR,—The report *Raising the Game*<sup>1</sup> is, as Helen Trippe notes,<sup>2</sup> a start. Unfortunately it is a start down the wrong path. The report places the emphasis firmly on developing competitive team sport at the centre of physical education. In doing so it intensifies the connection between healthy exercise and vigorous sport. The evidence shows that vigorous exercise is neither necessary to provide a health benefit nor suitable for all people in society.

Competitive sport is not liked by a sizeable number of children, particularly girls. As children get older, they tend to stop participating in sports outside school. For boys, participation in soccer outside school drops from 59% in 11 year olds to 42% in 16 year olds, and similar falls are seen in sports such as rugby and cricket. For girls, the participation in netball decreases from 19% to 6% between ages 11 and 16. This fall continues as people age, and *Social Trends* identifies that at 45-59 participation in team sports is 11%.<sup>3</sup>

As has been shown by a number of surveys, such as the Allied Dunbar National Fitness Survey,<sup>4</sup> as a nation we are not taking enough exercise. Though team sport can be a beneficial source of exercise for some individuals, it is a minority interest. It would not be physically possible to increase the use and provision of facilities to allow the nation to get its exercise from team sports. Concentration on team sport at school will also confirm the link between exercise and health with sport and make the message of increasing moderate activity more difficult. It will alienate the substantial number of children who for one reason or another dislike sports and will reduce the time available for wider activities, such as dancing, walking, or cycling.

Policies must be developed that take the range of activities that will provide healthy exercise into account, and action developed to ensure that these occur. In a recent report from the Royal Society of Health we set out several recommendations for action in various settings to encourage an increase in activity.<sup>5</sup> These settings included the family, the community or local authority, schools, the workplace, and health bodies. It is by developing a wide range of measures to encourage and facilitate moderate exercise such as cycling and walking that we will be able to achieve a healthier nation.

Increasing the emphasis on competitive sport ignores those who do not enjoy it or cannot participate and alienates them from all forms of exercise. We should pay attention to the World Health Organisation and the International Federation of Sports Medicine, which noted that "daily physical activity would be accepted as the cornerstone of a healthy lifestyle. Physical activity should be re-integrated into the routine of everyday living. An obvious first step would be the use of the stairs instead of lifts, and walking or cycling for short journeys."<sup>6</sup>

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## Physicians must not be misled by arguments against screening with densitometry

EDITOR,—As the person chiefly responsible for the development of bone densitometry, I wish to reply to the unreasonable arguments of Trevor A Sheldon and colleagues that the reply by David Barlow and colleagues does not address.<sup>1</sup> Critics mistakenly dispute the use of densitometry for assessing risk by questioning its sensitivity in diagnosing fracture. Using densitometry to diagnose a fracture is comparable to diagnostic use of blood pressure for stroke or lipid concentrations for infarction. Bone density indicates the risk, not the presence of a morbid event. The gradient of risk associated with bone density is high compared with that associated with blood pressure or lipid concentrations: a 12% decrease in the density of the femur triples the risk of hip fracture.<sup>2</sup> Bone density, like blood pressure and lipid concentrations, shows overlapping distributions in patients and controls, but the overlap is much less for bone density.

Critics also question the use of densitometry for monitoring treatment because peripheral density increases by only 1% a year, which equals the precision error. Antiresorptive treatments (such as bisphosphonates and oestrogens) and stimulators (such as fluoride) increase spinal density by over 3% annually. Increases in spinal density are significant in 80% of patients after one year, since they are three to five times larger than the precision error. The clinical strategy for monitoring registered treatments, however, is not to prove their efficacy but to assess their failure.<sup>3</sup> The failure to maintain femur density (which occurs in 10-30% of treated patients) after one year is a good indicator of either non-compliance or non-response.

The Advisory Group on Osteoporosis was correct in its opposition to screening for osteoporosis in the absence of symptoms or indications, even