that of urban diets, at each level of affluence or deprivation.

Regretfully, most research in this field continues to search for the holy grail rather than examine the more pedestrian reality of how the health of each of us is directly influenced by our daily food intake. Other factors, such as social cohesion and housing, also contribute, though probably to a much lower degree.

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Hyponatraemia after ingestion of "ecstasy"

EDITOR,—In the week that D L Maxwell and colleagues' report on hyponatraemia and stupor after ingestion of 3,4-methylenedioxymethamphetamine ("ecstasy") was published I saw a similar case.

A 23 year old woman had taken half a tablet of 3,4-methylenedioxymethamphetamine at 11 pm, as she had done on previous occasions. She had drunk half a bottle of wine several hours earlier in the evening. Eight hours after taking the drug she vomited and then slept. Eighteen hours later she was found crying and behaving abnormally and did not recognise her friends. She was taken to the local casualty department 24 hours after ingesting the drug. She was noted to be behaving strangely; she was drowsy but when roused seemed to stare without recognising anyone. She was mute and incontinent of urine. She moved all her limbs and reacted to pain but not command. Her pupils were dilated and equal and reacted to light. There were no other physical signs or fever. Investigations showed a serum sodium concentration of 123 mmol/l (normal range 133-146 mmol/l), but other biochemical and haematological tests yielded normal results. She was observed overnight, and the next morning she had recovered fully but remembered nothing of the night before. Her serum sodium concentration was 133 mmol/l.

This adverse reaction to 3,4-methylenedioxymethamphetamine seems to be fairly new. One possible cause is contamination of the tablets with other substances, though not necessarily psychoactive drugs. This might explain the variable effects in the same person.

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Laparoscopic nephrectomy

EDITOR,—In their article on laparoscopic nephrectomy Kurt Kerbl and colleagues rightly comment that for malignant renal disease this operation is presently controversial, one reason being the fear of the release of the malignant tissue into the abdominal cavity during "morcellation and retrieval of the diseased kidney."[1] We feel, however, that they incorrectly conclude that with their technique of entrapment with a sac before retrieval "seeding is no longer an issue."

There is now ample and increasing evidence that, for a variety of reasons as yet incompletely understood, "port site" recurrences of deposits can occur in a number of operations where malignant tissues are manipulated laparoscopically, including the colon and gall bladder,[2-4] whether or not there is any specimen to be removed and almost certainly despite "entrapment," which of course occurs late on in a laparoscopic procedure, in Kerbl *et al*'s case up to six hours after the start of the operation. Also, the possibility of seeding at other unusual and unexpected sites during laparoscopic surgery has recently been raised.[5]

For these reasons we consider that seeding during laparoscopic surgery for malignant disease remains very much an issue and are pleased to note that the Society for Minimally Invasive General Surgery is currently considering this problem.

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Lead shot passed per urethram

Four unlikely explanations...

EDITOR,—David Vicary's short item addresses an interesting question.[1] Assuming that the patient definitely passed the lead shot per urethram and had definitely never been shot, four unlikely possibilities might explain the passage of lead shot per urethram: the presence of an occult enterovesical fistula; a ureteroenteric fistula secondary to ureterolithiasis; the gradual migration of previously ingested lead shot from the intestinal lumen to the urinary system (for example, after transient inflammation of a colonic diverticulum) without a fistula; and passage of shot from the umbilicus into the bladder through a patent urachus. The third possibility is unlikely as lead is encapsulated after impregnation into tissue.[2] The fourth possibility is unlikely as a patent urachus would cause symptoms, and the possibility of such a port of entry is only theoretical.

Finally, the calibre of a weapon cannot be determined by looking at the shot: most game in Britain is shot with size 6 (2·6 mm) or size 7 (2·4 mm) lead shot, which can be fired by any calibre shotgun. The term rifle should be reserved for a weapon that fires a single missile.

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... and an appendix full of lead

EDITOR,—David Vicary reports that a man with renal colic who had been in the habit of eating game birds passed in his urine what seemed to be the shot with which they had been shot.[1] This reminds me of a case which a surgeon in Auckland told me about when I was a medical student in 1938. A man who was a keen duck shooter and ate the ducks he shot consulted the surgeon about haematuria. *x* Ray films showed some lead shot in the region of his appendix, which was lying on his ureter. The appendix was found to contain shot and was removed; the haematuria ceased. If there had been a fistula from his appendix to the ureter or bladder would he have passed the shot per urethram?

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1 Vicary D. Photo finish. *BMJ* 1993;307:1634. (18-25 December.)

Ischaemic preconditioning

EDITOR,—In their editorial on ischaemic preconditioning Michael Marber and colleagues emphasise the value of early reperfusion in suspected acute myocardial infarction.[1] They go on to suggest that a "preconditioning stimulus" could somehow be used to delay the onset of myocardial necrosis and thereby increase the time available for therapeutic thrombolysis in suspected acute myocardial infarction.

It is difficult to imagine how such a stimulus, however it was given, could greatly influence the ischaemic process. To reach jeopardised myocardium the preconditioning stimulus would have to be given before the onset of symptoms since the vessel related to the infarct is occluded in over 80% of instances.[2] Even if a preconditioning agent could be given prophylactically to patients at risk the additional "breathing space" afforded would be only of the order of 90 minutes.[3] If spontaneous or therapeutic thrombolysis was not achieved within that time the necrotic process would resume. As angiographic studies suggest that early spontaneous recanalisation occurs in only a minority of cases the onus would then be on giving thrombolytic treatment early. Most patients presenting with a suspected myocardial infarction, however, have experienced symptoms for well in excess of the 90 minute breathing space afforded by any prophylactic preconditioning.[4]

Thus on current evidence a hypothetical preconditioning agent seems to be of limited value in the management of acute myocardial infarction.

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Screening for HIV in pregnancy

EDITOR,—We agree with the policy of voluntary named testing being offered universally in antenatal clinics, as in the Swedish national screening programme for HIV infection in pregnant women,[1] and would like to report on our experiences in the Riverside Health District in central London.

A system of voluntary named HIV testing has been in operation in the hospital based antenatal services since 1987. We studied this service in 1991, when the uptake rate of the test was 17% (134/788), asking 318 women whether the test should be offered to all women in the clinic[2]: 296 (93%) of the women felt that it should be, but only