or low dietary calcium intake) but routine assessment of vitamin D status in otherwise healthy postmenopausal women is unlikely to be cost-effective.

Finally, the decision about whether or not to screen for myeloma is a difficult one and cannot be based on any one parameter. In general it should be considered in individuals presenting with spinal osteoporosis in whom there are no obvious risk factors or other underlying causes. However, if clinical suspicion exists on any basis (including an elevated ESR) screening should be performed.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Temporary cardiac pacing and the physicians of tomorrow

In district general hospitals (DGHs), temporary pacing is usually provided by general medical firms and it continues to be a core component of general internal medicine (GIM) training. Limited instruction and supervision[1] have contributed to a high complication rate[2–4] and the declining number of temporary pacings[5] plus shorter working hours of doctors in training have further compromised exposure. Are specialist registrars (SpRs) currently in training likely to have gained sufficient experience to provide a pacing service when they become consultants?

All SpRs in one region were identified and those training in cardiology and in specialties unlikely to provide GIM were excluded. A questionnaire was sent to the remainder, of whom 80/102 replied (78%). The median experience at SpR level was 3.3 years and all but two were expecting to provide an acute medical service when they became consultants. In the preceding year the median number of pacings performed was one and 35 (44%) had not paced for over 12 months. Forty-nine (61%) felt that their training had been inadequate and only 24 (30%) felt that upon completion of training they would be competent to pace. Thirty-seven (46%) thought that general physicians in DGHs should pace, 35 (44%) thought that only cardiologists should be involved and 8 (10%) believed that both could be involved, depending on experience.

Forty-nine SpRs were within two years of completing their training and their responses were analysed separately. Two of them had never performed a pacing and both were expecting to provide an acute medical service. Thirty-seven (76%) did not feel capable of providing a pacing service, 51% believed that pacing should be provided purely by cardiologists.

The current practice of temporary cardiac pacing is unacceptable. It should no longer be provided by all general physicians and should not be a core component of GIM training. Those who wish to provide a pacing service require guidance on how many procedures they have to perform to achieve and maintain competence. All units and individuals who pace should audit the practice and complications of their service in conjunction with their cardiac referral service. Solutions will vary according to local facilities and expertise. For units that lack expertise, atropine and external pacing could facilitate rapid transit to more experienced centres.

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Bile acid malabsorption and post-infective diarrhoea

A recent article on bile acid malabsorption and persistent diarrhoea (*JRCPL* September/October 2000, pp448–51) highlights an important cause of diarrhoea. I would like to draw the attention of the authors to our study (JRCPL Januray/February 1997, pp53–6) which was the first to observe an association of bile acid malabsorption and post-infective diarrhoea. This study was also conducted in a district general hospital setting.

We found that a subgroup of patients, 16 out of 29 with idiopathic bile acid malabsorption after excluding the known causes of bile acid malabsorption, dated their diarrhoea back to an episode of infective gastroenteritis. The time period ranged from about 3 months to 18 years. Interestingly the response to cholestyramine was seen in all but one patient. In their study, Bardhan *et al* rightly emphasise the significance of bile acid malabsorption in so-called diarrhoea predominant irritable bowel syndrome. However, they have not looked at the association of gastoenteritis and bile acid malabsorption as we have published before. In our practice now, enquiring about an episode of gastroenteritis just prior to the onset of diarrhoea is an important part of history taking in patients referred for investigation of chronic diarrhoea. This I feel is quite useful as a trial of cholestyramine where ^{75}ScHCAT scan is not available and can be useful both diagnostically as well as therapeutically.

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