

identified. This pathogenic organism was initially identified in the cyst form in the faeces of an 18-year-old woman; she had had on occasions diarrhoea, vomiting, and nausea, rarely lasting more than two to three days, during a five-month period of travel through numerous parts of India. On her travels she ate local food and drank a great deal of local water. She presented in the UK, 22 days after returning from India, with frequent bouts of diarrhoea and some rectal bleeding on defecation. *Shigella flexneri* was isolated from her faeces. If the bacterium had been accepted as the sole cause of her condition and microscopic examination of her faeces omitted, she may well have advanced to a serious pathological consequence, and spread the pathogen to others. This case demonstrates that, while the incidence of pathogenic *Entamoeba histolytica* in Britain is extremely low, importation of this dangerous pathogen does occur. For this reason it is important that patients presenting with dysenteric symptoms are carefully screened for parasitic as well as bacterial pathogens.

P G SARGEAUNT

Department of Medical Protozoology,
London School of Hygiene and
Tropical Medicine,
London WC1E 7HT

I A PORTER
G P SINTON

Regional Laboratory,
City Hospital,
Aberdeen AB9 8AU

¹ Price ME. *Br Med J* 1981;283:1175.

² Sargeaunt PG, Williams JE, Kumate J, Jimenez E. *Trans R Soc Trop Med Hyg* 1980;74:653-6.

³ Sargeaunt PG, Williams JE, Bhojnani R, Campos JE, Gomez A. *Trans R Soc Trop Med Hyg* (in press).

⁴ Meyer EA. *Microorganisms and human disease*. New York: Appleton Century, Crofts, 1974.

Gastrointestinal haemorrhage and benoxaprofen

SIR,—We were interested to read the report of Dr I C Stewart (16 January, p 163) on gastrointestinal haemorrhage associated with benoxaprofen in three patients over 70 years old. We are currently reviewing our experience with benoxaprofen over the past 19 months and hope to publish our results later.

The accompanying table shows the incidence of gastric side effects in 257 patients associated with benoxaprofen 600 mg daily. The overall incidence of gastric side effects (nausea, vomiting, heartburn, and epigastric pain) was 12.8%. However, the percentage rose to 31.9% in patients over 70 years old and was only 8.1% in patients under 70. In patients over 70 the incidence of gastric side effects in patients with osteoarthritis was 70% and only 24.2% in patients with rheumatoid arthritis. Benoxaprofen was withdrawn in all but one of the patients with gastric side effects. There were no cases of major gastrointestinal haemorrhage. A 72-year-old woman with a seven-year history of rheumatoid arthritis who had been taking 10 mg prednisolone daily for six years developed an acute duodenal ulcer after taking benoxaprofen 600 mg daily for five months. Four years previously she had undergone surgery for a perforated duodenal ulcer at another hospital.

Side effects associated with benoxaprofen 600 mg daily

Diagnosis	Age (y)	No of patients	No (%) of patients with side effects	No (%) of patients withdrawn owing to side effects
Rheumatoid arthritis	<70	199	16 (8)	16 (8)
	>70	37	9 (24.2)	8 (21.6)
Osteoarthritis	<70	11	1 (9)	1 (9)
	>70	10	7 (70)	7 (70)
Total		257	33 (12.8)	32 (12.5)

Our finding of an overall incidence of gastric side effects of 12.8% associated with benoxaprofen 600 mg daily is similar to a previous report¹ and comparable with the incidence associated with ibuprofen.¹ The reason why gastric side effects were more common in elderly patients with osteoarthritis than in those with rheumatoid arthritis is unclear. Tyson² has reported that benoxaprofen caused more gastric side effects in patients with osteoarthritis over 60 years old than did ibuprofen, whereas in patients under 60 years old the reverse was true. We agree that more studies are needed to evaluate the gastric side effects profile of benoxaprofen in the elderly. Our results suggest that the manufacturers' recommended dose of 600 mg benoxaprofen daily is associated with an unacceptable incidence of gastric side effects in the elderly.

J P HALSEY
N CARDOE

Rheumatology Department,
Norfolk and Norwich Hospital,
Norwich NR1 3SR

¹ Mikulaschek WM. *J Rheumatol* 1980;7,suppl 6:100-7.
² Tyson VCH, Glynne A. *J Rheumatol* 1980;7,suppl 6:132-8.

Will breast self-examination save lives?

SIR,—The leading article by Professor Michael Baum on breast self-examination (16 January, p 142) sums up the present evidence for the effectiveness of this practice very well. He mentions the DHSS-funded trials set up to assess the effectiveness of breast screening practice and ends by suggesting that the instruction of women who attend breast clinics in the practice of breast self-examination would be helpful.

While we would not argue with this statement, we question whether it is enough and also point out that it still leaves the majority of women untaught. Moreover, for some of these women it will be too late. If we are to achieve any meaningful reduction in overall mortality of breast cancer by breast self-examination it must be practised at regular intervals and extend over a long period of time. However, while the logic of such an approach seems obvious the evidence available is not conclusive.

In Huddersfield, where one arm of the DHSS's trial is being conducted, we are following organised educational meetings with a system of monitoring to assess the compliance of women in carrying out self-examination practice on a regular and continuing basis. We are also assessing the way in which these women carry out the examination to make sure that our teaching methods are effective, and also studying their attitudes to this practice. Further, we are constantly reinforcing the training by keeping in touch with them through personal letters and monitoring their progress.

It is vital that any woman who finds a lump or breast abnormality can quickly obtain expert advice. In Huddersfield this is provided at "walk-in" clinics available in various parts

of the health district on specific days. From this programme we expect to show whether women are prepared to take up breast self-examination on a regular basis in sufficient numbers to confirm an eventual reduction in mortality.

W GRAHAM HARRIS
C A F JOSLIN
J PHILIP

University Department of Radiotherapy,
Regional Radiotherapy Centre,
Cookridge Hospital,
Leeds LS16 6QB

Frozen shoulder: adhesive capsulitis

SIR,—I was interested to read your leading article "Frozen shoulder: adhesive capsulitis" (17 October, p 1005) and would like to concur with the letter from Dr S Roy (9 January, p 117).

As a general physician I see a number of patients who are suffering from this condition. In the past two years I have treated over 40 patients with intra-articular triamcinolone acetate. In every case there has been a rapid response with complete clearance of pain, usually in two to three weeks and rarely over six weeks. Many have responded with two injections, a few needing more than this. Stiffness remains initially, but a full range of movement gradually returns and in the absence of pain this delay is not significant. In my experience manipulation is rarely if ever necessary, nor is injection of the subacromial bursa unless there is an associated bursitis, which should easily be diagnosed by accurate shoulder examination.¹ I have seen only three cases in the last three years.

If the effectiveness of this method of treatment were more widely recognised a considerable amount of unnecessary suffering would be avoided. These patients do not need to wait to see an orthopaedic surgeon and are able to return to an active occupation much sooner than they would if untreated.

D J MABERLY

Airedale General Hospital,
Keighley, W Yorks BD20 6TD

¹ Cyriax J. *Textbook of orthopaedic medicine*. 7th ed. London: Ballière Tindall, 1978.

Fractures during ice and snow

SIR,—We should be grateful for an opportunity to report some new information relevant to the correspondence on fractures during ice and snow (23 January, p 271).

The number of injuries caused by slips and falls is not generally appreciated because there are no national statistics on non-fatal accidents in the United Kingdom. Some idea of the magnitude of the problem can be obtained from statistics generated by the United States Health Survey. In 1972 there were 13.6 million injuries caused by falls.¹ Some Swedish research suggests that for every injury caused by a fall two are caused by slipping.² We have no doubt that "underfoot" accidents are the most important cause of injury in the developed countries. However, no information on slip-resistances of footwear is available to the consumer. Our research programme (not yet published) has revealed marked differences in slip resistance and some materials are specially liable to cause slips and falls. Tread patterns of soles and heels are probably important but no work has so far been published. On snow and ice a wide gap in the tread may be dangerous, as it causes a build-up of snow and ice under the shoe. A narrow slit-like gap may give better protection but this is a hypothesis.

The recent prolonged spell of severe weather

provided an opportunity to test the slip resistance of a number of shoe materials. Seven types of footwear were used, one with leather soles and heels and the remainder rubber or plastic of unknown composition. All except one were smooth with no tread pattern. All seven types were worn and tested by one of us. The slip resistance was rated subjectively and the footwear listed in order of increasing slip resistance. The hardness of each sample was then obtained by using a Shore A durometer. Finally, the angle of slip on an oily, polished steel plate was determined. With the exception of the leather, which is known to have properties different from the rubber and plastic compounds, the slip resistance on dry ice was inversely related to hardness, the hardest material being the most dangerous and the softest material giving the best slip resistance. By far the best subjective slip resistance on dry ice was obtained with the Dunlop "Snowmobile," which gave the lowest durometer reading and also had an intricate tread pattern. It is no longer in production. There was general agreement between slip resistance on ice and on an oily steel plate. It is hoped that this small-scale test will promote greater interest in the slip resistance of shoe materials.

Clearing pavements of snow and ice is not the only practical measure which can help to prevent slipping accidents. A great many injuries could be prevented by suitable footwear.

The first International Conference on Slipping, Tripping, and Falling Accidents is to be held at the University of Surrey on 2 April. It is a joint venture planned by the Medical Commission on Accident Prevention and the Robens Institute of Industrial and Environmental Health and Safety.

D P MANNING
C JONES
M BRUCE

Occupational Health Department,
Ford Motor Company,
Halewood, Liverpool L24 9LE

¹ US Department of Health, Education and Welfare. *Persons injured and disability days by detailed type and class of accident, United States 1971-72*. Washington DC: Office of Information, National Centre for Health Statistics, Public Health Service, Health Services and Mental Health Administration, 1973.

² Strandberg L. *The mechanics of slipping accidents*. Investigation Report 29E. Stockholm: National Board of Occupational Safety and Health, 1980.

Medical stereotypes

SIR,—The paper "Medical stereotypes" by Dr C M Harris (19-26 December, p 1676) ends with the statement "No comment seems to be necessary." Despite his long preamble he does not show how the students acquired their initial concepts of various types of doctor. One presumes that, at that stage, lay views came from television, the popular press, and similar sources. After several years of training in scientific, critical observation they apparently have not changed their ideas significantly. If one overlooks the fact that some, such as surgeons and psychiatrists, might resent their views and others, such as general practitioners like Dr Harris, might feel flattered, what does the paper show? We were all students once. Does the paper show that at this time we chose an ideal and sought to join that group? Does it mean that only certain personality types are accepted into individual groups? Or does it show that despite several years of supposed training in scientific reasoning medical students retain, just as inflexibly, the same prejudices as the rest of the population? Or, finally, is this the type of research result to which the Nobel

Prize winner Richard Feynman referred in his recent BBC *Horizon* programme? Comment would appear very necessary indeed.

G T WATTS

General Hospital,
Birmingham B4 6NH

Outlook for hip replacement

SIR,—A leading article on total hip replacement (16 January, p 139) should concentrate on current concepts in materials and methods, and should not rely on data from implants which were developed in the early 1960s.

The early metal-on-metal implants with an equatorial bearing and a relatively high frictional coefficient were undoubtedly prone to loosen, but to use the material provided by McKee and myself in 1973 to damn the all-metal implant is to ignore the improvements in design and manufacture which have occurred since then and have been fully reported at a later date. The rate of revisional surgery in my own department for uncemented metal-on-metal implants has remained stationary at less than 0.5% per annum for many years; and, while any further surgery is for the patient a major disappointment, Jones² has shown that successful revision of an uncemented implant can be expected in 80% of patients but is probably well under 50% in those replacements in which bone cement has been used as a part of a primary procedure.

It is clear that revisional surgery of total hip replacements is becoming an increasing part of any orthopaedic surgeon's work load and, while some of this may well be due to faulty technique in the primary procedure, loosening at the cement-bone interface, fatigue fracture of the implant, and occasionally late-onset infection all contribute to the risk of failure.

Any patient undergoing total replacement of the hip joint should expect that the risk of infection would be much lower than the 2% which was quoted, and that the procedure used would result in a suitable joint for the rest of his active life. Should it fail, for either mechanical or biological reasons, revisional surgery must be safe and successful and the risk of ending with a pseudarthrosis negligible.

The development of uncemented metal-on-plastic prostheses, with or without porous coating, makes this possible; and the work of Judet, Lord, and Luncford in this respect deserves much greater attention in an editorial on the outlook for total hip replacement than the mention which has been given to the ill-fated double-cup experiments. We are all indebted to Sir John Charnley for the introduction of high-density polyethylene and for the development of a superb technique of total hip replacement; but, just as the metal-on-metal joint has now been supplanted by the metal-on-plastic one, so the use of bone cement must in the long run be supplanted by a safer method of implantation of a prosthesis—which should be expected to function for the rest of the patient's natural life, but can if necessary be changed with ease and safety.

P A RING

Redhill, Surrey

¹ Ring PA. *Clin Orthop* 1978;137:87-95.

² Jones JM. *J Bone Joint Surg (Br)* 1979;61A:1029-34.

SIR,—Like Mr A J Harrold (leading article 16 January, p 139), we have been increasingly concerned with the problem of osteoarthritis

of the hip in younger patients. If over 50% of total hip replacements in the under-30-year-olds can be expected to fail before five years,¹ it is a fair assumption that the majority of this group will require further surgery. The greater success of upper femoral osteotomy reported in Continental Europe,^{2,3} and the poor results from revision of total hip replacement even where infection is unproved,⁴ prompted us to review the results of osteotomy conversion to total hip replacement. In 105 conversions that we followed up after an average of 4.7 years we found that 82% of the patients had little or no pain and 3.8% had deep infection.

We feel that there is a stronger indication to perform osteotomy in suitable patients of this age group, knowing that in the event of failure there is a good chance of success from conversion to total hip replacement when the patient is older.

A S BAKER
G J BENKE

Hartshill Orthopaedic Hospital,
Stoke-on-Trent ST4 7NZ

¹ Chandler HP, Reineck FT, Wixson RL. *Orthopaedic Transactions* 1979;3:303.

² Langlais F, Roure J-L, Maquet P. *J Bone Joint Surg* 1979;61B:424-31.

³ Endler F, Endler M. *Orthop Belg* 1978;44:219-47.

⁴ Hunter GA, Welsh RP, Cameron HU, Bailey WH. *J Bone Joint Surg* 1979;61B:419-21.

Child health in the Third World

SIR,—Dr P C Kennerley's compassionate letter (20 January, p 344) deplores the death of 17 million children during 1981 and points out the comparative cheapness of immunisation. But death is not all.

When a child dies the parents are stricken, and the blow seems just as hard where there are many children in a family as where there are only one or two, although probably recovery from the tragedy may be easier in societies with large families, low life expectancy, and pervasive religion. Many Third World countries have too many people for available food or prosperous employment, so that up to a point infantile death can be seen as eugenic. (Someone said of a Catholic ward sister in a Vietnamese children's hospital that she looks on death as a form of family planning.)

What help we can give should aim at promoting vigour rather than merely saving life. What better use of money could there be, as Dr Kennerley suggests, than to employ it in giving vitamin A to prevent 500 children daily from going blind? But needs vary; banana communities have plenty of vitamin A, rice people do not. Likewise immunisation should be selective, with limited funds laid out to the best advantage. Poliomyelitis and tuberculosis cause lifelong disability, and so may "tropical measles," pertussis, and fetal rubella. Some other infections—diphtheria, tetanus, enteric fevers, cholera, yellow fever, plague, varicella, and mumps—hardly ever produce invalidism although some are great killers. Of course, a country can be depopulated, as England was after the Black Death, but this is not a current danger. Dr Kennerley does well to remind us of the value of quick-acting prophylactics although in the long run contraception and hygiene will be more important.

PHILIP EVANS

London NW8 9AX