Return to work after coronary artery surgery for angina

SIR,—The proportion of patients returning successfully to work after coronary artery bypass grafting by the Scottish team (16 December, p 1680) is so astonishingly different from the American findings[1] as to make one ask wherein lies the secret of their success. Is it possible that their patients were a group who had "given up" or had "been given up" and therefore were open to motivation by any reasonably energetic group of therapists? Is it possible that Wallwork and his colleagues employed the placebo effect described so well by Preston[2]? Without comparison of surgery with another form of rehabilitation no conclusion can be drawn about its specific effects.

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[1] Barnes, G K, *et al*, *Journal of the American Medical Association*, 1977, **238**, 1259.
[2] Preston, T, *Coronary Artery Surgery: A Critical Review*. New York, Raven Press, 1977.

Gonococcal arthritis

SIR,—Dr Dermot Murray (6 January, p 22) does well to emphasise that his patient was genitally asymptomatic and he states that this is a feature of men with the gonococcal-arthritis syndrome. I would like to emphasise, however, that in our series of 16 patients,[1] 13 of whom were women, only three were initially seen in the department of venereology; others presented to general physicians, rheumatologists, or dermatologists. Although the ESR is almost invariably raised in these patients, the physician must be reminded that it is commonly so in patients with an inflammatory non-arthropathy of this type, be it due to Reiter's disease or gout; and it would be foolhardy to make this the basis of the diagnosis of the gonococcal arthritis syndrome.

It must be emphasised once again that specimens of synovial fluid should always be cultured anaerobically in patients with unexplained arthropathies, although the yield of positive results is seldom more than 25% in the most capable hands. Another source of positive culture results not mentioned by Dr Murray is the rectum.

May I repeat that it is mandatory to exercise a high index of suspicion in all patients presenting with an unexplained arthropathy of this type?

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[1] Seifert, M H, *et al*, *Annals of the Rheumatic Diseases*, 1974, **22**, 140.

SIR,—There has lately been revived interest in the natural history of gonorrhoea with pyrexia and skin and joint lesions—disseminated gonococcal infection or benign gonococcaemia.[1 2] Despite this, it would appear that the diagnosis is still frequently hard to come by in Britain. The case of the patient described by Lieutenant-Colonel Dermot Murray (6 January, p 22) took six weeks to clarify.

I can personally recall two cases in six years, one of which was undiagnosed and in retrospect may well have been disseminated gonococcal infection; in the other case the diagnosis came to light only after prolonged and intensive investigations. Our differential diagnosis included meningococcaemia, typhoid fever, staphylococcal septicaemia, and miliary tuberculosis. It should be realised that, in addition to appropriate culture specimens taken from the frequently asymptomatic urogenital tract, pharynx, and rectum,[3] other bacteriological specimens should be taken according to the clinical state of the disease. Holmes and colleagues[3] show clearly that there are two stages to be considered—an early "septicaemic" one, when cultures of blood often give positive and those of the joint negative results, and a later "septic joint" stage when aspirates of joint fluid may well harbour gonococci.

One wonders whether cases of disseminated gonococcal infection which present to differing specialties would be diagnosed more rapidly and more often if we regularly used the expertise of the consultant in infectious diseases. His counterpart in North America is apparently called on after the first unexplained spike on the temperature chart (S Russell, personal communication).

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[1] Knapp, J S, and Holmes, K K, *Journal of Infectious Diseases*, 1975, **132**, 204.
[2] Ingwer, L, Petersen, B H, and Brooks, G, *Journal of Laboratory and Clinical Medicine*, 1978, **92**, 211.
[3] Holmes, K K, Counts, G W, Beaty, H N, *Annals of Internal Medicine*, 1971, **74**, 979.

Hepatotoxic effects of repeated anaesthetics

SIR,—Dr William H W Inman and Dr William W Mushin (25 November, p 1455) have again drawn attention to the potential hepatotoxic effects of repeat administrations of halothane, particularly within a short period of time. Enflurane may offer advantages in this respect. Over the past two and a half years we have organised a large-scale study of liver enzymes following repeated anaesthetics. A preliminary analysis of the findings shows a 37% (25/68) incidence of abnormal enzymes following repeat halothane, compared with 14% (8/59) after repeat enflurane in a similar patient population.

Details of this study will be reported in full.

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Seat belts and the safe car

SIR,—Mr J A E Primrose is, of course, completely correct in drawing the attention of your readers (13 January, p 122) to the sorry situation in this country with regard to laminated glass in vehicle windows and the failure, on grounds of cost, to ensure its compulsory use in all new vehicles. There is no doubt that all ophthalmologists would strongly support him in the efforts to eliminate the continuing danger arising from the failure of successive administrations to make appropriate regulations.

Regrettably, one has to dissent from a suggestion that the universal use of laminated glass would be a satisfactory *alternative* to the universal use of car safety belts. Not all injury, and certainly not all ocular injury, is caused merely by flying glass or projection through windscreens. The inertial forces of a human body faced with total stop at even 16 kph (10 mph) requires something more than simply being surrounded by unsplinterable glass.

It should not be necessary to point out that this is not of course a situation of alternatives and that there is every reason in the world why both these measures could be made universal practice, and that speedily: windscreens by straightforward government regulation, and belts through the most widespread dissemination among the public at large of knowledge of the appalling extent and nature of the largely avoidable injury arising out of their failure to use these devices—as Mr W H Rutherford urges: the same issue.

The bizarre and irrelevant replies, including accusations of everything from fascism to being a "flat-earther," following the publication of letters in the public media, illustrate how widespread still is the failure of understanding in the public at large.

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Bicycle accidents

SIR,—Cycling in London at least (6 January, p 39) could be made a great deal safer by one simple measure, and that is to ensure that the nearside metre of road surface is kept free from holes and projections—that is, smooth. Our capital is appalling in this respect. Brixton Hill is a good example. There are two narrow and busy traffic lanes, and frequent deep holes and raised obstacles near the kerb. A cyclist, possibly travelling at some speed, has two choices: either to swing out suddenly without warning or to continue (possibly unaware) and risk buckling his front wheel and going over the handlebars or buckling his anatomy, or both.

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Ergotamine tartrate overdosage

SIR,—For many years ergotamine tartrate has been used in the treatment of migraine, and in some patients the response to this drug is dramatic. However, recent experience has shown that the dose of this drug must be carefully adjusted because too much ergotamine in itself may give rise to side effects, including nausea, malaise, aching legs, irritable bowel action, and headache.

Ergotamine tartrate may be prescribed by mouth, by suppository, by inhalation, or by injection. If given by mouth, it should be in a form that is readily absorbed; and not more than 1 mg or 2 mg should be given for each attack. Absorption of ergotamine tartrate is probably improved by giving a tablet of 10 mg of metaclopramide (Maxolon) ten minutes beforehand. The apparent need for the patient to take more ergotamine in an attack is probably due to poor absorption. If the drug is given in the form of a suppository, the dose should be 1 mg or 2 mg; if it is inhaled, two or three puffs (0·72 mg or 1·08 mg) are recommended; and, if it is