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Sir,

As arrhythmias occur when thrombolytics are administered, it is advised by Rawles (editorial, *April Journal*, p.171) and by Hannaford and colleagues (*April Journal*, p.175) and elsewhere¹ that every doctor carrying thrombolytics outside hospital should also carry a defibrillator. I was not aware of this in 1992 when I considered participating in Hannaford and colleagues' study and it is not yet made clear in published drug advice.² I would ask Hannaford and colleagues how many doctors in their study relied on the ambulance defibrillator rather than their own machine, and if any doctors administered thrombolytics in the absence of a defibrillator.

If reperfusion can precipitate arrhythmias then other drugs that relieve ischaemia might produce arrhythmias during myocardial infarction. I would value further information on this, because drug administration can often be delayed until defibrillation facilities have arrived.

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References

1. Weston C, Penny W, Julian D. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994; **308**: 767-771.
2. British Medical Association and Royal Pharmaceutical Society of Great Britain. *British national formulary* 29. London: BMA and The Pharmaceutical Press, 1995.

Skin biopsies in general practice

Sir,

It is encouraging to learn that Deverell and colleagues found that general practitioners made important errors (malignancy unsuspected or misdiagnosed prior to histology) in only 13 of 722 skin biopsy specimens submitted to a histopathology laboratory (letter, *April Journal*, p.216). I welcome their conclusion that 'skin bi-

opsies can be competently performed by general practitioners'.

However, I would like to take issue with the authors on their choice of gold standard to assess that competence — the accuracy of clinical diagnosis compared with histological diagnosis. I would argue that the case for biopsies by general practitioners is much stronger than they suggest and that they have minimized it with an inappropriate choice of gold standard and subsequent failure to consider the reasons why general practitioners select skin lesions for biopsy.

I wonder if the authors have considered that the skin lesions in question would never have been excised and submitted for histology unless the diagnosis was in doubt. I speculate that their laboratory requisition form contains a section marked 'clinical diagnosis' and suspect that their client general practitioners were simply too well mannered to write 'If I knew that, I would not be sending you this specimen'.

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Effects of anorexia nervosa on bone density

Sir,

As a recovering anorexic I would like to draw general practitioners' attention to the often overlooked effects of amenorrhoea on bone density. After over 10 years of amenorrhoea I was eventually given a bone scan which showed that I had only 47% of the bone density expected for my age in my femur, and 70% of that expected in my spine. As this was discovered before I had reached my peak bone mass I have managed, through calcium supplements, to replace some of that lost and I now have yearly bone scans.

Studies at Kings College Hospital, London show that if amenorrhoea lasts for more than six months there will be some permanent effects on bone density (newsletter for the Eating Disorders Association, 2 August 1991). Likewise, Freeman and Newton report that their studies 'would indicate that it is an extremely serious problem, one which has been markedly under-estimated in the past' and that 'the degree of bone loss is considerably more than that which occurs in post-menopausal women, that it may occur very early in the disorder and may

not be reversible'. They also say that 'the consequence of [this] is that young anorexics, even after recovery, may be at high risk of the type of fractures more commonly a consequence of old age' (newsletter for the Eating Disorders Association, 2 June 1992).

With more awareness of the high risk of osteoporosis in anorexia nervosa it might be possible to reverse, or at least to halt, this dangerous extent of bone loss.

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Useful addresses

The Eating Disorders Association, Sackville Place, 44-48 Magdalen Street, Norwich, Norfolk NR3 1JU.

The National Osteoporosis Society, PO Box 10, Radstock, Bath BA3 3YB.

Postmortems in patients' homes

Sir,

In my article on how John Parkinson performed the postmortem on Sir James Mackenzie I told how Sir James had advocated the value of having a small postmortem set for autopsies in patients' homes.¹ It later happened that his own heart was removed by Parkinson (later Sir John Parkinson) in the bathroom of Sir James' London flat.

I have now become very interested in the question of whether general practitioners did actually undertake postmortem examinations in the homes of their patients. If so, such examinations would probably have been limited to removing one organ such as a kidney or the heart. Information on this subject is difficult to obtain, and I would be most grateful if anyone could tell me of their experience of, or of anything they know about, this subject. My telephone number is 01424 813228, should that prove easier than sending me a letter.

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Reference

1. Hollman A. How John Parkinson did the postmortem on Sir James Mackenzie. *Br Heart J* 1993; **70**: 587-588.