doctors a way back into British medicine. How difficult will this be? Will we be encouraged to do unusual things by the Royal Colleges and supported on our return, or looked at askance and turned away from the door? To say that a door is present is a beginning; we now need to know how big it will be and how difficult it will be to pass through it. One of my consultants suggested that it would only be suitable for the immortals amongst us.

The prospect of five regulated years of infectious disease training in an English town does not excite me at all. I would prefer to go to the tropics, to perform research in an infectious disease hospital there and receive, in the process, a good training. If I am not allowed to do this, I will probably simply leave the profession. Calmanisation is incompatible with the academic medical career that I would like to follow.

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M EDDLESTON
University of Oxford School of Clinical Medicine

In response

Dr Eddleston expresses legitimate concerns and it is difficult to give him the reassurance he seeks. The NHS Executive left appointment of specialist registrars and conversion to new-style programmes in the medical specialties to the last and there has been insufficient time to see the effects of change. Most discussions about the Calman recommendations relate to clinical training but strenuous efforts have been made to safeguard the training opportunities for those with academic and research inclinations. Specialist Registrars are free to take time out for research for long enough to complete a PhD and have guaranteed right of re-entry. Overseas experience, research or clinical, can count towards training for a CCST provided it is adequately supervised and approved in advance. The Specialist Order makes provision for those whose training has involved specialisation in a narrow clinical field, usually on the basis of particular research interest, to gain direct entry to the Specialist Register without the need for a CCST.

These are a few examples of the flexibility that does exist and it is hoped that full advantage will be taken of the opportunities that the regulations permit. An academic and research medicine supplement to the NHSE *Guide to Specialist Registrar Training* has recently been published, and it clarifies many of the issues about which concern has been expressed. Dr Eddleston's letter is important in revealing that even among medical students there are anxieties about future training opportunities – a stage when we cannot allow academic aspirations to be discouraged. It is to be hoped that it may prompt deans of medical schools to ensure that well-informed advice about future training prospects is readily available to undergraduates.

D A SHAW
Medical Co-ordinator
Joint Committee on Higher Medical Training

The acute uraemic emergency

Editor – Due to the age-related nature of both non-steroidal anti-inflammatory drug (NSAID) usage and congestive cardiac failure (CCF), the latter, although not cited by Dr Tomson (January/February 1997, pages 10–5), also deserves mention as a risk factor for NSAID-related nephrotoxicity[1]. The irony is that, when CCF co-exists with acute gout, itself an acknowledged complication of diuretic treatment of CCF, the symptomatic relief of arthropathy, through the use of NSAIDs, may occur at the penalty of NSAID-related deterioration of renal function, due to the adverse effects of these drugs on the compromised renal haemodynamics of heart failure patients[2].

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O M P JOLOBE
Consultant Geriatrician
Tameside General Hospital

'Brain attack'

Editor – Neil-Dwyer and Lang (January/February 1997, pages 49–52) can be reassured that their recommendations for investigating aneurysmal subarachnoid haemorrhage (SAH) are not the 'narrow and perverted' view of the specialist. In our Accident and Emergency (A&E) Department, we too found that a high proportion of patients (25/43) attending with non-traumatic recent onset headaches were discharged from A&E without further investigation. Two of these patients were re-admitted with SAH within a week. Of 18 patients admitted from A&E, and a further 7 directly from GPs, for investigation of severe headache, 18 (72%) were appropriately investigated: 13 (52%) SAH were identified (9/13 by CT scan and 4/13 by lumbar puncture).

Locally developd regional guidelines for the management of SAH were applied retrospectively to the study group. Eleven (48%) of the 25 patients discharged without investigation fulfilled the criteria for admission, ie sudden onset of severe headache with one other

symptom or sign suggestive of SAH. Ten of the thirteen cases (77%) of SAH fully satisfied those criteria; one had no headache but neurological signs. In two patients the onset of headache was gradual.

In addition, our audit showed that the workload generated by lowering the threshold for admission would have been an extra 11 inpatient episodes over a seven month period and the prevention of two inappropriate discharges.

We agree with Neal-Dwyer's and Lang's recommendations. The only difference we have with the authors, from the A&E point of view, is their assertion that 'Myocardial infarction patients present with an easily recognised clinical picture'. Now that *is* the view from a specialist's anthill!

KATE LAMBERT
Senior Registrar
Sunderland District General Hospital
CYRUS L MUWANGA
Consultant
Sunderland District General Hospital

Dame Mary Page

Editor—Dr Griffin points out that little is known of Mary Page (September/October, page 465). Some further information has come to light, mostly about her husband, Sir Gregory Page, and their children.

Gregory's father was also called Gregory Page and he was descended from a good family in Hampshire. He was a merchant, shipwright and shipowner in London, and had a brew house in Wapping. He was one of the Aldermen nominated by the Crown to the Corporation of London in 1687. He married twice and Gregory was the first son by his second wife, a widow, Elizabeth Burton of Stepney.

Mary was the daughter of Thomas Trotman of London. She was aged 17 or 18 when she married Gregory Page, by licence in view of her age, on 21 January 1690. He was aged 21.

At the time of their wedding in 1690, Gregory described himself as a brewer. Later he made a great fortune as a shipowner trading with China and the East Indies. He was a member of parliament for New Shoreham from 18 December 1708 until 1713. He became a director of the East India Company in 1709 and remained so until his death in 1720. In 1715 he was re-elected as a Whig for Shoreham. Shoreham's chief industry was shipbuilding and Page gave evidence to the Treasury which led eventually to the prohibition of the wearing of stained calico in 1721. Page died on 25 May 1720 leaving an immense fortune to his elder son: this may have amounted to £700,000. Gregory and Mary had two sons and two daughters. The first son was Gregory who succeeded him and died in 1775 aged 90 when the baronetcy expired. The other son was Thomas. Mary was the older daughter and she married Sir Edward Turner in 1728, who became baronet in 1733 and died in 1735; he too became Chairman of the East India Company. Sophia, the younger daughter, died in 1735. The children of Edward and Mary were progenitors of the Page-Turner family. The family was successful with connections with the East India Company and with parliament.

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CHRISTOPHER GARDNER-THORPE
Consultant Neurologist
Royal Devon and Exeter Healthcare NHS Trust