

tome might suggest). The key symptom headings – the single episode of prolonged vertigo, recurrent vertigo and dizziness, positional vertigo, chronic dizziness, and dizziness and imbalance in the elderly – encompass a surprisingly broad sweep of neurological and general medical practice in succinct and practical form. A brief general section on treatment concludes the book. The authors manage to keep the harassed clinician firmly in view throughout, and successfully resist the temptation to stray into esoterica (no mean feat considering their formidable accumulated erudition and experience). The text is supplemented by useful tables and the illustrations are on the whole clear and occasionally surprising (who could have expected to encounter a medieval exorcism in the middle of a down-to-earth discussion of psychogenic dizziness?). Each chapter concludes with a section, 'What to do if you don't have a clue' which seems set to salvage many an ill-fated outpatient appointment. The enclosed CD is a particular strength of the book; it really does amplify the text and stands alone as a teaching aid in what remains a richly clinical enclave of internal medicine.

Perhaps the single most refreshing thing about this book is the unpretentious and accessible style with which it is written. Bronstein and Lempert make their subject engaging and humane. If not exactly Shakespearean, their book is nonetheless a worthy addition to the canon on this often baffling and too often mysterious symptom. Hippocrates would be proud to own it.

JASON WARREN
Dementia Research Centre
Institute of Neurology
Queen Square, London

letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Response to personal viewpoint on revalidation

Editor – Goddard and Cunliffe liken their experience of assessment for certification in colonoscopy to procedures which may be used in revalidation (*Clin Med* June 2007 pp 304–5). They end their letter with the comment that, 'Revalidation will not be good news for everyone, but everyone should be better for it'. Really?

Firstly, nobody yet knows for certain what revalidation will involve – indeed, doubts have already been cast on its legality in respect of doctors now on the specialist register. Secondly, if revalidation is to mean anything, it presumably could mean, potentially, the loss of a doctor's livelihood. I suggest that this risk would be considerably more stressful than failing colonoscopy certification, notwithstanding the blow to the authors' pride, and the delay in establishing their trust's screening programme that would result. Thirdly, how many of us, or our patients, would genuinely benefit from our (effectively) re-sitting our Royal College diploma on a five yearly basis for the rest of our working lives, particularly as we grow older, and more experienced/specialised?

There are many unanswered questions in relation to revalidation, but above all, I should like to see some hard evidence as to its real value. Or is it just another management concept that does not need testing before its wholesale imposition?

I accept that some form of periodical reassessment of medical staff *may* be

desirable, but I consider Goddard and Cunliffe's largely uncritical welcome of revalidation both premature and naive.

IAN FLETCHER
Consultant Anaesthetist
Newcastle upon Tyne Hospitals
NHS Foundation Trust

The future of coronary heart disease prevention

Editor – Though the recent article by David Wald (*Clin Med* August 2007 pp 392–6) starts well it seems to drift into an advert for the Polypill. The claim that a Polypill will reduce cardiovascular disease by over 80% in both primary and secondary cardiovascular prevention is impressive. This is made in the absence of clinical trial data, or even a product. From a public health perspective, prevention of heart disease is simple. The up-most risk factor is smoking, with a dose linear relationship. The chances of myocardial infarction are about 12-fold greater with 40 cigarettes/day when compared to non-smokers.¹

Hypertension sets the threshold at which cholesterol becomes important. Hypertension and age-related increases in blood pressure are unknown in societies with a salt intake <3 g/day; the UK average is 10 g/day.²

Lipid-lowering agents should only be used as part of the overall management of risk factors for cardiovascular disease and it is important not to over interpret the data.^{3,4} Stopping smoking, increasing exercise, and increasing fruit and vegetable intake should be recommended, as these factors are responsible for 80% of heart disease.¹ The restriction of dietary salt to <3 g/day should also be added to this list as a public health measure.

JOHN WARREN
Medical Assessor
Medicines and Healthcare products
Regulatory Agency (MHRA)

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- 2 Adrogué HJ, Madias NE. Sodium and potassium in the pathogenesis of hypertension. *N Engl J Med* 2007;356: 1966–78.