Points from Letters

Aspirin Consumption

Miss GILLIAN COFFEY and Professor C. W. M. WILSON (Trinity College, Dublin) write: In a recent leader (6 July, p. 5) you stated that the mean consumption of aspirin compounds in the population amounts to eight or 10 aspirin tablets per month as estimated in two different surveys. The results from two separate surveys carried out in Liverpool in 1964[1] and in Dublin in 1974 confirm these estimates. . . . After 10 years the results indicate that both males and females are taking aspirin less frequently. . . . The tendency to less frequent consumption appears to be compensated for by the fact that both sexes now tend to take more aspirins on each occasion. . . . Consumption of more aspirin on each occasion would produce higher blood salicylate levels. In consequence a greater incidence of drug-induced side effects and undesirable clinical consequences is appearing. . . .

1 Wilson, C. W. M., in *Pharmacological and Epidemiological Aspects of Adolescent Drug Dependence*, ed. C. W. M. Wilson, p. 141-158. Oxford, Pergamon Press, 1968.

Leucocyte Count in Appendicitis

Mr. R. S. ARNOT (Scarborough Hospital, Yorks) writes: In many teaching hospitals and current medical textbooks it is customary to regard an elevated blood leucocyte count as a normal finding in acute appendicitis. . . . The fallacy in this assumption has been demonstrated in a consecutive series of 51 patients from Hereford and Scarborough hospitals whose presenting signs and symptoms were suggested of acute appendicitis. In 19 of these patients who were found at laparotomy to have normal appendices the mean leucocyte count (±S.E.M.) was $11{\cdot}7 \pm 1{\cdot}31 \times 10^9/l$ ($11\,700 \pm 1311/mm^3$), while in 32 patients with acute appendicitis (including seven cases of general peritonitis) the count ranged from $4{\cdot}5$ to $20{\cdot}9 \times 10^9/l$ (4500 to $20\,900/mm^3$) with a mean of $12{\cdot}7 \pm 0{\cdot}71 \times 10^9/l$ ($12\,700 \pm 710/mm^3$). The difference between these two values was not significant ($P > 0{\cdot}4$). . . .

Postanaesthetic Hepatitis

Dr. J. R. J. BEDDARD (Bradford-on-Avon, Wilts) writes: In 1966 in the west country there were three very serious cases of poisoning due to an excess of impurities contaminating nitrous oxide. The Royal Society of Medicine (Anaesthetic Section) held a discussion on the presence of nitric oxide and nitrogen peroxide in nitrous oxide.[1] It was pointed out that in the manufacture of nitrous oxide from ammonium nitrate the higher oxides of nitrogen were regular contaminants. . . . Surely, in order to exonerate volatile anaesthetics in current use, research should be undertaken to determine whether these oxides cause a dangerous degradation of some volatile anaesthetics and whether in vivo they produce nitrosamines by themselves. Why assume liver sensitivity to halothane when the impurities or even N_2O itself could cause accumulation of nitrosamines and so produce jaundice?[2-4]

1 Austin, A. T., and Kain, M. L., *Proceedings of the Royal Society of Medicine*, 1967, **60**, 1175.
2 Brown, B. R. jun., *Survey of Anesthesiology*, 1974, **18**, 465.
3 Johnson, E. B., *Lancet*, 1972, **2**, 824.
4 Magee, P., *New Scientist*, 1973, **59**, 432.

Lumbar Puncture

Dr. P. SKRABANEK (St. Laurence's Hospital, Dublin) writes: Your recommendation (4 January, p. 3) of Brocker's method[1] of keeping the patient in a prone position after lumbar puncture, which could be taken up as "the word" by enthusiastic residents to be enforced on surgical, obese, or pregnant patients, did not take into account the refutation of Brocker's paper by Tourtellotte *et al.*[2] . . . They showed in a controlled study on 304 patients that the frequency of spinal-tap headaches was not related to the position or the length of time spent in bed after lumbar puncture. Of their 124 patients kept in the prone position, 47 developed headache compared with 59 headaches in 180 supine patients.

1 Brocker, R. J., *Journal of the American Medical Association*, 1958, **168**, 261.
2 Tourtellotte, W. W., *et al.*, *Post-Lumbar Puncture Headaches*. Springfield, Thomas, 1964.

Overstrength Milk Feeds

Dr. R. A. MILLER (Stow, Midlothian) writes: Dr. B. A. M. Smith (28 December, p. 741) did not state whether or not the infants under investigation behaved abnormally as a result of taking overstrength feeds. It seems worth while publishing observations on the infant's behaviour in this series or in any future series he may investigate. The findings might be an aid in the detection of feeding mismanagement before any serious complication arose. In addition, similar observations made on mothers who have inadequate lactation when breast-feeding their infants might be profitable. Under such circumstances the sodium chloride content of the breast milk is raised throughout the day or possibly for only part of the day. Infants taking this type of milk generally misbehave in that they tend to be very restless, cry, and vomit, even if given the necessary complementary feed. . . .

Well-woman Clinics

Dr. H. B. WRIGHT (B.U.P.A. Medical Centre, London N.1) and Dr. JANE B. DAVEY (Royal Marsden Hospital, London S.W.3) write: As, between us, we have screened over 30 000 women for breast cancer over the past four to five years we feel able to comment on Mr. R. T. Burkitt's letter (7 December, p. 588). Of course, there is likely to be some anxiety related to the possibility of breast cancer. . . . Mr. Burkitt may have had five frightened girls in Ashford, but when we took a mobile unit to Cheltenham we found four new and one known cancers and asked for 19 biopsies among 250 women. These were women who had presumably not made use of the relatively unpressurized medical services in the area, but who did come spontaneously to a special unit. Like Shapiro *et al.*[1] in America, we find a steady seven to eight proven cancers per 1000 women screened and have a biopsy rate of 12%. This may be unnecessarily high but as more becomes known about the natural history of benign mammary dysplasia this will be reduced. We are clear that the highest detection rate depends on three processes—expert clinical examination, thermography, and *x*-ray mammography, done with special equipment to reduce radiation dose to a minimum. . . . As breast cancer is four times as common as cervical, we hope that before too long there will be an equivalent well woman screening service covering the country.

1 Shapiro, *et al.*, *Proceedings of the 7th National Cancer Conference, Philadelphia, 1973*, p. 663.

Consultants' Work-to-Contract

Mr. H. R. W. LUNT (Boylestone, Derbyshire) writes: . . . The present "sanction" of working to contract by hospital consultants could hardly be more futile. The State has complacently permitted the outpatient orthopaedic waiting time in a city not far away to run at a level of 20 weeks for years rather than appoint the necessary number of consultants, and the State will feel no compunction if outpatient waiting time rises or theatre list waiting time rises as a result of work-to-rule. . . . If consultants or any other type of doctor are going to negotiate with the State they must be prepared to go on strike. The strike will be of short duration; it should be supported by other members of the profession with the exception of hospital emergency services. The delay will be very readily noticeable but it is unlikely that any patients will really suffer in a delay of short duration.

Sanctions for G.P.s

Dr. M. B. BOTTOMLEY (Ellesmere, Salop) writes: The G.M.S.C. has rather anticipated the proposed action of G.P.s in the event of the Review Body's award being amended by the Government by asking for signed but undated resignations from the N.H.S. . . . An alternative form of sanction . . . would be for G.P.s to work to rule. . . . If they rigidly maintained their hours of consultation as notified to executive councils and conscientiously examined every patient, if they refused to issue repeat prescriptions without seeing the patient at the surgery, and if they insisted on their contractual right to be the sole arbiters as to where and when the patient was seen, then I feel sure that public opinion would very quickly bring pressure to bear on the Government to satisfy our demands. . . .

Interim Pay Review

Dr. J. M. LONDON (Redditch) writes: It was indeed sad to see Dr. John Fry (25 January, p. 214), who has done so much good for general practice in the academic field, entering the political arena and urging family doctors to act against the recommendations and advice of their democratically elected leaders. We may not all entirely agree with what our leaders do or do not do but it surely behoves us all to give them our maximum support. . . . If Dr. Fry feels unable to support the leaders of the family doctors, then I would respectfully suggest that he "shut up."