Succinylcholine Chloride for Casualty Anaesthesia

SIR,—Referring to the use of succinylcholine chloride ("scoline") in casualty practice, my personal technique varies from that of Drs. Terence Vaz and J. M. Bishop (*Journal*, October 17, p. 885). Instead of using gas for induction and then giving succinylcholine chloride, I use the bare minimum of thiopentone and give succinylcholine chloride as much as is needed judging by the age and weight of the patient. By this method I have done over 200 cases of casualty anaesthetics for minor operations. There has not been any ill-effect in this technique. Recovery has been quick, and the patients have looked very fit. Vomiting has not occurred in one single case. Those who have criticized Drs. Vaz and Bishop have not given the matter a thorough trial. If it was dangerous there would have been at least 1 case in 200 which would have shown some ill-effects.

The details of these 200 cases will, I hope, be published soon.—I am, etc.,

Sheffield. RASHBEHARI GHOSE.

Insulin Zinc Suspensions

SIR,—In view of the correspondence regarding the new insulin zinc suspension preparations, the following observations may be of interest. After the investigation into the use of these insulins on 28 patients which were reported by Dr. R. B. Wilson and myself (*Journal*, November 7, p. 1023), a further 42 patients were tried on these insulins in the Victoria Infirmary, Glasgow, prior to their general release on November 16. The majority of cases were similar to those in the original series, many requiring large doses of insulin (from 80 to 140 units in nine cases), but also included were nine new patients who had not previously received insulin. In this supplementary series satisfactory control was obtained with "lente" in 32, with "ultralente" in 2, with a mixture of lente and ultralente in 3, and with lente and "semilente" in 2, while in 3 cases change to the new insulin resulted in much poorer control.

In the combined series, comprising 70 patients, control was effected with a single daily injection of lente in 47 (67%), of ultralente in five (7%), and of mixtures of lente with ultralente or semilente in 10 (14%)—a total of 63 (88.5%). We have found, therefore, that lente is suitable for a majority of patients, but that the proportions of crystalline and amorphous insulins must be altered in an appreciable number of cases. In this regard, however, individual variations appear to be very great. Whereas lente insulin contains 30% amorphous, we found that the proportion of this in the mixtures required to control 10 of our patients were: 12%, 15%, 15%, 16%, 19%, 37%, 47%, 53%, 57%. I would agree with Drs. A. Stuart Mason and D. Verel (*Journal*, November 28, p. 1215) that it would be at least very premature to advocate an alteration in the proportions present in lente. Nevertheless, as very different proportions are required by some patients, the fact that ultralente is not available in the strength 80 units per ml. is a real disadvantage, as Drs. J. D. N. Nabarro and J. M. Stowers (*Journal*, November 7, p. 1027) have already pointed out.

It will be noticed that five of our cases were regarded as failures and it was interesting to find that Drs. A. Stuart Mason and D. Verel had had similar experience. One of these failures has been studied further. She had formerly taken 44 units of protamine zinc insulin, but immediately developed acute symptoms when given 44 units lente. Later it was found she obtained very good control, in fact considerably better than that with the previous protamine zinc, with a dose of 72 units lente. This produced slight hypoglycaemic symptoms in the forenoon and she is now being tried on a mixture with less amorphous insulin.

It seems that there are difficulties in changing some patients on to the newer preparations, and these difficulties require further investigation. It is to be hoped that a solution will be found, since eventually it seems very desirable that, as Dr. W. Oakley has said (*Journal*, November 7, p. 1021), both protamine zinc and globin insulins should be withdrawn. Admittedly no one would wish to change the regime of a diabetic under perfect control and so these older insulins may have to be continued for a considerable time, but I would suggest that they be abandoned forthwith for all new cases.

In our original paper we recorded no local insulin reactions with the new insulins. That such can occur, however, is apparent from the observations of Drs. Stuart Mason and D. Verel. Recently I have encountered two patients who have shown quite troublesome local reactions; both were new patients who had just started to take insulin, and it is not yet known whether this sensitivity will be overcome. Finally, it may be of some interest to record that in two of our patients using lente insulin marked fat atrophy was observed at the site of injection.—I am, etc.,

Glasgow. IAN MURRAY.

Medical Needs in the Gold Coast

SIR,—Having only recently returned from the Gold Coast after two tours of service, I was particularly interested in Mr. Ian Fraser's view (*Journal*, October 31, p. 987) on the shortage of medical officers there. I congratulate him on his keen appreciation of the causes of the present situation, following only a short visit to the colony. From the last paragraph of Dr. K. A. Taylor's letter (*Journal*, November 28, p. 1217) I can only assume that he has not had recent experience of the Gold Coast, and I hasten to assure him that conditions have drastically changed within recent years.

I think that the most important thing necessary to bring about an improvement is a change of heart and attitude in the non-medical administrators, not only in the Colonial Office, but also in the Gold Coast Government (which is now largely African). The present situation is that a European doctor is very unlikely to be offered a pensionable appointment, though he may easily obtain one under contract. From the specialist's point of view this is very important. To take up a post in the colonies is to cut your bridges behind you, for after spending several years outside the United Kingdom it is virtually impossible to be re-employed as a specialist on your return. Drs. G. L. Alexander and H. G. Calwell both make this point (*Journal*, November 28, pp. 1216 and 1217). If the Gold Coast wants specialists it must offer permanent posts. As Mr. Fraser states, "The expatriate specialist is more valuable to the colony the longer he stays."

Arising from this is the present rigid adherence to the "staff list," which lays down that there should be so many surgeons, so many physicians, etc. This adherence is quite absurd. One African surgeon who had his F.R.C.S., and who had been doing specialist work, was kept waiting for three years before being promoted from medical officer to a vacant specialist post. The administrators should realize that it is easier to alter staff lists than to obtain specialists.

Whatever our views are on self-government, it is undeniable that the new administration in the Gold Coast has greatly increased the burden of the ordinary medical officer. This is not made easy to bear by the application of discrimination against expatriates when it comes to study leave. It is now almost impossible for an expatriate to obtain much leave. This causes frustration to the individual and an overall loss of officers to the Service. This should be borne in mind by those who appear to find Africanization more important than their country's needs.

The Gold Coast remains a great challenge to our profession. Disease, curable disease, is there in plenty, and yet there is only one doctor to more than 50,000 inhabitants. But before going to work there we must be assured of our position, and that we will not be asked to practise alongside unqualified persons. Perhaps the B.M.A. can help, but in view of the glib but efficient way they were dealt with by the Colonial Office in the discussion on pay for medical officers in the Colonial Service, only a few years ago, they will have to improve their bargaining power. However, I feel that in Mr. Ian Fraser they have a powerful weapon, equipped as he is with first-hand knowledge and his grasp of the long-overdue improvements.—I am, etc.,

Edinburgh. D. B. SCOTT.