effect is small and less than that of oxytocin, sex of the baby, epidural anaesthesia, and gestational age.

LOUISE FRIEDMAN
P J LEWIS

Institute of Obstetrics and Gynaecology,
Queen Charlotte's Hospital,
London W6

PAMELA CLIFTON
C J BULPITT

London School of Hygiene and Tropical Medicine,
London WC1

Non-epileptic television syncope

SIR,—Dr J B P Stephenson (17 June, p 1622) points out that not all seizures occurring in front of the television set are due to epilepsy. However, I would question whether the attacks he describes were associated with TV viewing. As he himself has demonstrated, these "anoxic" spells are not rare, and many of our patients spend a substantial portion of their waking hours in front of the TV. The occasional coincidence of any form of seizure while watching TV is therefore inevitable.

Nevertheless, there could conceivably be a connection between TV and these non-epileptic seizures. It might be of interest to inquire what programme was being broadcast. Recently I saw a child with a history of vasovagal episodes whose father had been diagnosed as having television epilepsy. In fact he was an artistic, introspective, and very fastidious man who suffered faintness, dizziness, nausea, and overbreathing while under emotional stress. Each of his TV "seizures" was precipitated by a frightening or distasteful episode in the programme he was watching—for example, a horror film in which a very lifeless leg hung over the edge of the bath while the taps kept running and the water overflowed.

DAVID M HALL

Department of Paediatrics,
Charing Cross Hospital,
London W6

Lymphatic fistula: a complication of arterial surgery

SIR,—Many reconstructive operations designed to restore circulation to the leg involve a dissection in the groin which may divide major lymph trunks and produce a lymphatic fistula. This is probably quite a common problem but, surprisingly, it does not seem to have been recorded. We have recently encountered two such cases, and report them so as to invite discussion of the correct management.

A patient with severe rest pain in the left leg received a femorofemoral cross-over Dacron implant. Five days after the operation a lymphatic fistula developed in the groin which drained 100-350 ml a day for 30 days. The fistula closed without treatment on the 36th day.

Following arterial catheterisation for investigation of myocardial ischaemia our second patient developed a large right common femoral aneurysm, which required resection. Two days after the operation lymph began to drain from a fistula at a rate of 150-250 ml a day. In spite of strict bed rest the fistula continued to drain and after 27 days the area was irradiated for five days (total dose 1500 rads). One day after completion of the radiotherapy the fistula closed.

In an attempt to forestall this complication by demonstrating the inguinal lymphatic channels at operation four patients undergoing arterial reconstructive surgery in the groin were given an injection of French Patent Blue (2 ml Patent Blue with 4 ml 1% lignocaine in four divided doses) into the web spaces of the first and third toes of each foot one hour before operation. Whether because of faults in dosage, injection site, or timing the lymphatics were not satisfactorily shown up. I would be interested to hear of any experience with similar cases and whether visual lymphography can help in the prevention of this postoperative complication.

RODNEY J CROFT

Middlesex Hospital,
London W1

Windows in operating theatres

SIR,—I was interested to read Mr G A D Lavey's letter (13 May, p 1285) expressing his concern at the lack of windows in their new twin operating theatre unit.

Here in Gwynedd in Wales we are in the process of building a new district general hospital which is due to be commissioned in the summer of 1980 and which was also to have windowless theatres. However, at a very late stage a united stand has, I think, led to a change of heart by those in authority and windows may now be provided in the interval between the completion of the basic contract and before the opening of the hospital.

There has for some time been a general feeling of unease at the thought of windowless theatres among the staff here, which was crystallised by an excellent article by Dr Philip Keep entitled "Stimulus deprivation in windowless rooms."[1] He stated that a year's experience of working in a windowless theatre and intensive therapy unit in Norwich had convinced the users that such a unit is unacceptable and that no further windowless units should be built. We then decided to make every effort to get our own theatres changed and this effort has probably been successful. It took many months and several important lessons were learnt on the way.

It is vitally important that the operating theatre users be united on the issue. There are some who are obviously indifferent or prefer a windowless theatre. These can be accommodated in an operating room with blinds. It still allows the free choice of natural light to those who hate the conditions of a submarine.

It must not be forgotten that the nursing and ancillary staff can be great allies. Unlike the medical staff they spend their whole working life in such an unpleasant environment and they have strong and powerful unions to support their case.

It is almost impossible to effect change during the main contract as the penalty clauses inflicted by the contractors are prohibitive. The obvious time is during the project stage of a new hospital; otherwise it has to wait until the main contract has finished.

When the situation is brought to notice it is surprising the degree of support it generates from all over the country. I spoke recently at an Association of Anaesthetists meeting at the Royal Society of Medicine on the subject and, although there was a degree of indifference from the officers on the platform, there was outstanding support from the floor. As the medical representative on the commissioning team of our new district general hospital I have visited many new hospitals in various parts of the country. Those who have windowless operating units invariably regret them but feel powerless to change. There seems to be no organised medical public opinion to back their protest. I feel that we should endeavour to make the windowless operating threate as unpleasant a piece of social history as the high-level block of flats has already become.

KEN HARDY

Gwynedd Health Authority,
Bangor, Gwynedd

[1] *Anaesthesia*, 1977, **32**, 598.

Myelography and epidural double-catheter venography

SIR,—I was interested to read the report by Dr J B Eastwood and others of bilateral central fracture dislocation of the hips following radiculography with meglumine iocarmate (Dimer-X) (18 March, p 692) and the remarks of Dr A K Clarke and others (29 April, p 1143) concerning the diagnostic possibilities of ascending lumbar venography in diagnosing lumbar disc herniation.

I agree with Dr Clarke that epidural venography may be regarded as a very reliable technique. In my opinion the method can be used as an alternative to—or even as a substitute for—lumbar myelography. In this department we have performed epidural venography by means of two catheters (introduced from each groin) and simultaneous contrast injection on 217 patients suspected of lumbar disc herniation.[1] In our operated patients the diagnostic accuracy was 93·7%. The double-catheter method provides the possibility of obtaining homogeneous filling and excellent opacification of the epidural veins at any lumbar level. The catheters are introduced into the lateral sacral veins (heterolateral catheterisation) or into the internal iliac veins (homolateral catheterisation). Also a combination of catheter positions with one catheter in one of these veins and the other one in the ascending lumbar vein provides excellent diagnostic results. The double-catheter method offers the investigator a choice of over 20 catheter position combinations to obtain good quality venograms. The diagnostic quality has proved to be definitely superior to the single catheter method. In my opinion single injection, especially in the ascending lumbar vein, does not provide optimal results. As a rule one or two anteroposterior series are sufficient to establish the diagnosis. I consider double-catheter epidural venography to be a simple and extremely reliable technique. The complication rate is very low and the procedure can easily be performed on outpatients.

I do not agree with Dr R G Grainger (3 June, p 1488) that epidural venography provides significantly less detail in diagnosing lumbar disc herniations than lumbar myelography. The double-catheter method provides more detailed evidence, especially in cases of lateral disc herniation.

Disc herniation is an extradural disease, the operation is performed extradurally, and epidural double-catheter venography is an extremely reliable extradural diagnostic method, so why not stay extradural as a first option in our diagnostic approach? In this way we can avoid unnecessary admission to hospital and prevent the complications of myelography. Headache, occurring after myelography in 25-30% of the cases, is also avoided. It is my firm belief that epidural

Br Med J: first published as 10.1136/bmj.2.6131.205 on 15 July 1978. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.