

down in the patient's notes what has been said.

The subject of patients and their investigations also deserves more attention. Dr M Goldman in the same issue (p 1699) describes the information that he sends to patients about barium meals. He is correct that a barium meal may worry someone far more than a highly complex investigation. I am just analysing the results of interviews with 504 patients concerning a wide range of tests. They are often told less about commonplace investigations such as barium meal because the staff assume that they know all about it already, whereas cardiac catheterisation is fully explained. One must also bear in mind that patients often hear frightening and incorrect tales from others—for example, nowadays drinking a teacupful of barium in a dimmed room is less unpleasant than a pint swallowed in darkness. Even venepuncture and electrocardiograms scare some. Stressing that these are just routine tests often helps.

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Treatment of septicaemia

SIR,—I was surprised to read Dr A M Geddes's recommendation (15 July, p 183) that a combination of gentamicin and cloxacillin should be used for the initial treatment of septicaemia before the causative organism has been isolated. The only valid indication for the use of cloxacillin in such a situation is the suspected presence of a penicillinase-producing *Staphylococcus aureus*, since the susceptibility of all other species to cloxacillin is less than to benzylpenicillin.¹ However, gentamicin has been repeatedly shown to be highly effective against staphylococci, including cloxacillin-resistant strains,² both in vitro³ and in vivo,⁴ and while gentamicin resistance in *Staphylococcus aureus* has been reported,⁵ cloxacillin is not superior in this respect.

May I therefore suggest that benzylpenicillin is a more rational antibiotic to use in combination with gentamicin in this situation? This combination has the additional advantage of synergistic bactericidal action against enterococci.⁶ Metronidazole may be added if there are clinical grounds for believing bacteroides infection to be a possibility.

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¹ Garrod, L P, et al, *Antibiotic and Chemotherapy*, London, Churchill Livingstone, 1973.

² Hoeprich, P D, *Journal of Infectious Diseases*, 1969, **119**, 391.

³ Barber, M, and Waterworth, P M, *British Medical Journal*, 1966, **1**, 203.

⁴ Richards, F, McCall, C, and Cox, C, *Journal of the American Medical Association*, 1971, **215**, 1297.

⁵ Bint, A J, et al, *Journal of Clinical Pathology*, 1977, **30**, 165.

⁶ Watanakunakorn, C, *Journal of Infectious Diseases*, 1971, **124**, 581.

SIR,—Septicaemia (Dr A M Geddes, 15 July, p 181) may result from contaminated infusion fluid—contaminated either before or during use. Although contamination of infusion fluids may be as high as between 3 and 38% in the US,¹ the number of cases giving rise to clinical signs of septicaemia is

very small. However, when it does occur death may result.² Common pathogens such as staphylococci cannot grow in glucose infusion fluids, whereas members of the Enterobacteriaceae may reach 10⁷ organisms/ml.³ Blood cultures of patients infused with contaminated fluids have been negative and treatment with antibiotics unsuccessful.⁴

If septicaemia from infusion fluid is suspected, disconnecting the entire infusion set should promote a quick abatement of symptoms.⁵ Further infusion should be made with a complete new set, at a new site if possible and with an infusion bottle from a different batch. Use of the same cannula and set can result in contamination of a fresh infusion bottle by upward flow of bacteria.¹ These first-aid measures do not preclude antibiotic and other treatment, which, however, will be useless unless the source of endotoxin is removed.

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¹ Maki, D G, *Annals of Internal Medicine*, 1972, **77**, 881.

² Meers, P O, et al, *Lancet*, 1973, **2**, 1189.

³ Maki, D G, in *Microbial Hazards of Infusion Therapy*, ed L Phillips, P D Meers, and P F D'Arcy, p 13. Lancaster, MTP, 1976.

⁴ Maki, D G, et al, *American Journal of Medicine*, 1976, **60**, 471.

⁵ Wyatt, H V, *Scandinavian Journal of Infectious Diseases*, 1978, **10**, 95.

Treatment of hypertensive emergencies with oral labetalol

SIR,—We read with concern the recent report by Dr R R Ghose and others (8 July, p 96) on the treatment of hypertensive emergencies and the subsequent correspondence (12 August, p 501).

Like Dr C S Good we are concerned about the specific indications for treating the majority of these patients as "hypertensive emergencies." Thus of the 11 patients studied only one had hypertensive encephalopathy and only four had grade IV retinopathy. In the remaining six patients the only indication for urgent treatment was a diastolic pressure of 130 mm Hg or above. To define severe hypertension requires much more than an elevated pressure.¹ In our view this finding alone is not an indication for the rapid lowering of blood pressure. It is well known that arterial pressure can fluctuate greatly in patients with apparently mild hypertension; thus using 24-hourly monitoring the Oxford group² showed huge fluctuations of arterial pressures ranging from 140 to 270 mm Hg systolic and from 65 to 170 mm Hg diastolic in individual patients. We suggest that there is no evidence to support the view of Dr Ghose and his colleagues that their patients had "severe" hypertension requiring urgent intervention with antihypertensive drugs.

Our second concern regards the validity of the observations reported. It is well known clinically that admission to hospital alone may result in substantial falls of arterial pressure. Indeed, the early Veterans Administration study³ was strongly criticised because they studied hospital inpatients. In this present study no placebo-treated control group was investigated and we question the contribution made by labetalol to the observed falls in arterial pressure reported.

We suggest that immediate intervention with antihypertensive therapy without a period of observation and bed rest in such

patients is rarely if ever indicated. Furthermore, therapy with agents such as labetalol may render subsequent investigations to exclude phaeochromocytoma, Conn's syndrome, and renal artery stenosis uninterpretable.

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¹ Kincaid-Smith, P, in *Hypertension Manual*, ed J H Laragh, p 787. New York, Yorke Medical Books, 1973.

² Bevan, A T, et al, *Clinical Science*, 1969, **36**, 329.

³ Veterans Administration Cooperative Study Group, *Journal of the American Medical Association*, 1967, **202**, 1028.

Back pain

SIR,—May I add a few words to Dr J K Waterlow's letter (29 July, p 355). He advises "displacing the drearily misleading popular phrase 'slipped disc'." I couldn't agree with him more. I prefer the term "lumbar instability" because this covers the main causes of pain in the back and the lower limb. Spinal compression disorders are only part of the story and probably are the cause of about 40% of back pain. I find that in more than 50% of cases back and limb pain is due to ligamentous strain alone or ligamentous strain plus a subluxation of the sacroiliac joints. Other causes are what the osteopaths call the lateral facet jamming and spondylolisthesis. If one diagnoses and treats all backache on the assumption that the lumbar disc has protruded, then inappropriate treatment is going to be given to more than half the patients.

The conditions that I have mentioned can be diagnosed more readily by history-taking than by radiology. There is not a composite treatment for all the conditions—each needs to be treated individually. A disc needs to be put back into its correct position by the quickest means possible—manipulation, spinal traction, epidural local anaesthesia, or bed rest. A sacroiliac subluxation requires correction by manipulation. Ligaments that are strained require strengthening, not by exercises but by sclerosant therapy. If the reduction of the disc and the correction of the sacroiliac joint are unstable, then sclerosant therapy requires to be given to stabilise these joints. Likewise with an unstable joint due to spondylolisthesis sclerosant therapy stabilises the joint. If these methods are carried out early recovery occurs and certainly most back troubles can be relieved. For those that are intractable surgery is required, but this, I find, is only necessary in about 1% of all cases.

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SIR,—Dr J K Waterlow's support (29 July, p 355) for Mr A G H Murley's plea (8 July, p 125) for positive advice and common sense in back pain will appeal to all clinicians who are dissatisfied with the results of treatment by the standard methods at present in use.

Controlled studies on these methods have proved them to be more or less useless.¹ Dr Waterlow's advice to the patient to move around normally and avoid heavy lifting is an example of masterly inactivity, for recovery from an attack of backache is usually slow but sure if not exacerbated by ill-judged treatment.