more distress than single-site aspirations so it was routine practice to cover the procedure by intravenous diazepam. I found this to be extremely successful and in subsequent patients who are anxious I have continued with the practice of sedation by this method.

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Urethral catheterisation

SIR,—The article on urethral catheterisation (4 October, p 928) justifies two comments.

Firstly, although the article gave an excellent account of the reasons for catheterisation and the types of catheters to be used and placed a great deal of emphasis on absolute asepsis, it failed to give an adequate description of the actual catheterisation technique. Urethral catheterisation is a very common procedure on medical and surgical wards and this task is usually delegated to the most junior member of a team. It would, therefore, have been more helpful if the steps in the procedure had been demonstrated by a series of diagrams (as is commonly done with urethral dilatation).

Secondly, the authors failed to commit themselves about the amount of sterile water required to inflate a catheter balloon and recommended "an appropriate volume." Most manufacturers recommend a volume in excess of 20 ml, but many practising urologists regard this as an uncomfortable and unnecessary amount and usually use volumes of less than 10 ml.

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Adverse reaction to bupivacaine

SIR,—Dr A M Henderson's case (18 October, p 1043) of an adverse reaction to bupivacaine used for intravenous regional anaesthesia is a timely reminder that bupivacaine is *not* the drug of choice for this technique. He terms it "unexpected" but we have consistently argued against the use of bupivacaine[1 2] for this procedure because of the risk of such a reaction. The potential for systemic toxicity is great when the tourniquet is released as a relatively large dose of local anaesthetic rapidly enters the circulation. Therefore the drug of choice is prilocaine[3] since it is by far the least toxic of the available local anaesthetics. The incidence of systemic toxicity using bupivacaine is low but with prilocaine it is non-existent.

Plasma protein binding does not confer any safety margin to a drug like bupivacaine, which crosses membranes easily and rapidly. Further, the plasma concentrations mentioned by Dr Henderson are peripheral venous in origin. Of more relevance to the occurrence of systemic toxicity immediately following tourniquet release are the arterial concentrations. The situation is equivalent to that following a bolus injection, when transient high arterial concentrations (and therefore brain concentrations) are not reflected in venous measurements.

We would also suggest that systemic reactions to local anaesthetics are far more effectively treated with increments (50 mg) of intravenous thiopentone than with a combination of diazepam and chlorpromazine. The reaction would have been controlled much faster and we doubt very much if the patient would have had to be kept in hospital overnight.

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[1] Brown DT, Scott DHT, Wildsmith JAW. *Hospital Update*, 1978; November: 738.
[2] Wildsmith JAW, Scott DHT, Brown DT. *Anaesthesia* 1979;**34**:919.
[3] Eriksson E, ed. *Illustrated handbook in regional anaesthesia*. Munksgaard: Copenhagen, 1969.

Cancer and the fetus

SIR,—Minerva refers (9 August, p 461) to a review article[1] which pointed out the rarity of cancer occurring during pregnancy and to the amazingly rare transmission of malignant cells to the fetus across the placenta. I personally reviewed the world literature in 1967[2] and at the time I could find only 22 documented cases recording placental or even transplacental metastases, and I reported only the third case involving carcinoma of the bronchus. Most cases were of malignant melanoma and it is these tumours which appear to metastasise more readily to the placenta and fetus.

In my original case cells morphologically identical to those of the primary oat cell carcinoma were found by my colleague Dr R Seal in the maternal blood spaces of the placenta. The fetus was spared and at follow-up two years later the child was quite normal.

It would be interesting to know why the trophoblast appears to resist tumour cell invasion. Surely this must be an important research area in our entire understanding of the biology of carcinoma in humans.

EGRYN M JONES

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[1] Greene M. *JAMA* 1980;**243**:2241.
[2] Jones EM. *Br Med J* 1969;ii:491-2.

Controlled trial of cromoglycate and slow-release aminophylline in childhood asthma

SIR,—The paper by Dr A T Edmunds and others (27 September, p 842) raises some questions of ethics. The authors state that both theophylline and cromoglycate provide effective prophylactic treatment in childhood asthma. Why then was it necessary to include a placebo period? These quite severely affected children were on no regular medication for four weeks, during which time their symptoms increased and on eight occasions hospital admission and attendant loss of schooling resulted. The question of venesection at the end of two treatment periods when they were obviously not taking aminophylline is also open to question.

It has been my experience that asthmatic children who are well controlled on regular therapy are reluctant to enter a study of this type. It is therefore surprising that not one of 30 children dropped out of the study during an exacerbation of symptoms when they knew that there was a possibility that they were taking a placebo only. It would be interesting to know exactly what the parents were told before consent was obtained for their children's participation in this study.

The conclusion of this study supports the work of MacDonald and McWilliam, who found cromoglycate and slow-release aminophylline equally effective.[1] I would like to add that when the price of spinhalers and theophylline assay are included in the costing slow-release aminophylline continues to be the most cost-effective drug, which is preferred by the majority of children.

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[1] MacDonald TH, McWilliam R. *J Int Med Res* 1979;**7**, suppl 1:87-92.

**We sent this letter to Dr Edmunds, who replies below.—ED, *BMJ*.

SIR,—We thank Dr Blumenthal for his comments and interest. It was necessary to include a placebo period to demonstrate that the trial patients required the treatment being studied. All our patients were able to take salbutamol freely throughout the trial. Patients in whom unacceptable symptoms persisted despite regular use of salbutamol, and patients who recorded peak expiratory flow rates less than 25% of the expected normal on all three measurements over a period of 24 hours, were reviewed at the hospital. If necessary they were treated with a short course of prednisolone. If a patient required more than two courses of prednisolone in any treatment period he or she would have moved on to the next treatment; however, the need for this did not arise.

The study was approved by the United Bristol Hospitals ethical committee. All patients and their parents were given full details of the trial before they gave consent. Thus they knew that they would not remain ill for long if they did develop acute asthma. They also knew that venepuncture was required at the end of each period as the trial was double blind, and it was necessary to demonstrate that therapeutic doses of slow-release aminophylline were being taken. The majority of parents at the conclusion of the trial felt that they understood the pattern of their children's asthma better, and that their children were subsequently better controlled when maintained on the best-choice treatment as found in the trial.

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Family planning

SIR,—In his book review on the development of family planning services in Britain (11 October, p 999) Mr Michael Brudenell begs some questions. Firstly, he infers that family planning is about the "unplanned pregnancy problem" and, secondly, that "the consumer is the ultimate arbiter of what is right for him or her."

The first statement puts clinical family planning into a totally negative role, whereas in reality—when almost half of those using the services are nulliparous—the doctor is in an ideal situation to affect the health of early pregnancy for many of these *future* parents. Health advice on rubella vaccination, smoking in pregnancy, nutrition, post-pill contraception for up to six months before conception, etc, is acceptable to women in this situation.

Secondly, if we as doctors are concerned about the physiological health of women using medical methods of contraception, we cannot be merely consumer salesmen (or saleswomen). There are times when we need to refuse a particular method for an individual for medical reasons and at the same time explain the reasons.

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Pseudomonas cross-infection due to contaminated humidifier water

SIR,—Referring to the article on *Pseudomonas fluorescens* cross-infection by Dr Penelope J Redding and Mr Paul W McWalter (26 July, p 275), I report an exactly similar problem with an infected reservoir of humidifier water that caused chest infections and deaths in intensive care patients.

After a series of deaths (including a 31-year-old man) in postoperative surgical patients treated in intensive care (not all on ventilator therapy) we screened bacteriologically all possible sources of bacterial contamination. An 8-litre plastic container containing sterile distilled water standing outside the theatres, utilised to refill the humidifiers used to administer nasal oxygen to postoperative surgical patients, contained *Pseudomonas aeruginosa*, as did the humidifiers.

The hospital subsequently switched to Hospal Aqua-Pak disposable gas nebuliser humidifiers for all purposes for postoperative oxygen for spontaneously breathing patients intubated with a T-tube. These sets have a 500 or 100 ml water canister and a "dial a percentage" oxygen control, driven directly from the oxygen flowmeter, and are exceptionally convenient. Every 24 hours the whole set was changed. Ventilator tubing and humidifiers were changed at least daily. The Bennett cascade humidifiers were either run at 55°C or had 1% aqueous chlorhexidine (non-volatile) added to them.

In my experience this habit of using large-volume canisters is widespread, and many staff are not aware of the fact that it is so dangerous.

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Single-car road deaths—disguised suicides?

SIR,—The observed monthly variations in the recorded total numbers of deaths by suicide may possibly be appreciably affected by the extent to which deaths which are at risk of being mistaken for suicides are recorded as suicides. If there is a tendency for the total numbers of deaths from these two causes (suicide and possible suicide) to be relatively constant, there will be a negative association between changes in the numbers of the two kinds. Mr J Jenkins and Dr P Sainsbury (18 October, p 1041) seem to assume that any important association must be positive. Nevertheless, their table shows that the greatest sum of the ranks for six consecutive months occurs from September to February for single-car single-occupant road deaths and in precisely the other six months for the suicides.

Spearman's rank correlation coefficient, computed from the ranks given in their table, is $r_S = -0{\cdot}64$, for which $p < 0{\cdot}025$ in a two-sided test of the hypothesis that this is a chance deviation from zero. This calculation disregards the variation in the lengths of the months, which might be expected to have a slight tendency to produce a positive association. If the ties are broken by reference to the numbers of days (for example, 44 deaths in February may be regarded as worse than 44 deaths in July), $r_S = -0{\cdot}65$; but if the rankings are done on the average numbers of deaths per day r_S moves towards zero but cannot nullify the question of the relationship between the two series.

Quite possibly the number of weekends or public holidays, or of days of extremes of weather or some other factors, would be better for standardising the months. A satisfactory analysis would require much more information than could have been given in a short paper. It may be noted, however, that, very roughly, a change of 10 deaths by suicide is accompanied by a change in the opposite direction of one death in the tabulated car accidents. One possible explanation, which can perhaps easily be confuted, might be that about one-tenth of the recorded suicides are accidental deaths (perhaps associated with preoccupation, emotional stress, mental confusion, or tiredness) of a general kind, of which some of the single-car single-occupant deaths are an alternative manifestation.

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Listening and talking to patients

SIR,—In interviewing a patient the doctor must guide the topic of conversation towards those subjects which must seem to him most likely to yield a diagnosis. It may be quite natural in these circumstances that a patient may feel frustrated in his desire to enlarge on what may interest him. When a consultant recommends that patients should be given more opportunity to talk at length to the GP it is reasonable to point out that more time given to the history may mean less time available for the examination, and that other consultants recommend that patients should be examined more. It would probably be wisest to allow GPs to decide for themselves how best to apportion their time between history-taking and examination in order to obtain the best results.

B JAMES

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Perinatal practice and compensation for handicap

SIR,—Mr P Mitchell and Mr I G Chalmers's letter (27 September, p 868) on perinatal practice and compensation for handicap is timely and appropriate, as is the subsequent correspondence in the issue of 18 October (p 1067).

I agree it is a disaster that parents of severely handicapped children should be expected to provide evidence that the handicap of the child is a result of some iatrogenic cause because this may be impossible and is irrelevant. Like Professor Illingworth (p 1067), I am particularly concerned about the cases of so-called damage from whooping-cough vaccination. There is no incontrovertible evidence that whooping-cough vaccine itself causes brain damage or convulsions. The legislation now active for compensation for whooping-cough vaccination victims was totally wrong, partly because it implicated the whooping-cough vaccination as potentially harmful and partly because it restricted compensation to a small proportion of severely handicapped children. It takes a very long time to get such compensation and much of the cost may be absorbed, as Mr Mitchell and Mr Chalmers say, by administration. The Act dealing with vaccine-damaged children has reinforced the fear of many and has contributed substantially to the major outbreak of whooping cough in our population. Probably for some 20 years I have hardly seen a case of whooping cough in our wards; we are never without them now.

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DHSS in the witness box

SIR,—You consider it laudable in your leading article (18 October, p 1023) that in a parliamentary democracy government ministers are called to account for their actions, but how much better would it be if on certain important occasions their intentions were also more closely examined. It does not require a Commons select committee to expose the present inefficiency of the NHS. This is self-evident, much of it the predictable outcome of the 1974 reorganisation. Could not the same or some other equally inquisitive and influential parliamentary committee take evidence now from those of us who are deeply concerned about the next phase of reorganisation?

In Wales the Secretary of State has produced a document frivolously entitled *Patients First* declaring in a supplement his misguided intention to retain area health authorities. In this area he will even increase its membership and the authority, in turn, will keep every element of its cumbersome central administration—including, for example, a superfluous and costly planning department with nothing new to plan. And to our dismay extra administrative offices will be built in our clinically deprived hospitals to house the next generation of district officials.

To improve "efficiency," meanwhile, when laboratory workers, medical secretaries, and other lowly but essential members of staff retire or move elsewhere they will not be replaced, regardless of the consequences in terms of service to patients. We have, of course, been involved in the ritual of so-called democratic consultation and in the fullness of time will look forward to another leisurely select committee report deploring the continued disintegration of the NHS.

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Pay of AMOs and RMOs

SIR,—The letter (1 November, p 1218) on the subject of merit awards for area medical officers (AMOs) and regional medical officers (RMOs) deserves some comment. Your readers may not be aware that the generality of AMOs and RMOs receive a supplement