CORRESPONDENCE

Correspondents are asked to be brief

Distress of Dying

SIR,—It is becoming generally recognized that the current management of terminal illness is often very inadequate as regards the provision of relief from mental and physical suffering, and the article by Dr. W. Dewi Rees (8 July, p. 105) is timely. The management of death and dying is an inescapably important part of medical practice, but it is rare indeed for it to be given a formal place in the crowded medical curriculum, although several useful programmes have been developed in the U.S.A. In my experience in Britain, teaching medical students, nurses, and social workers in training, the students are often very aware of the lack of useful guidance in this subject, and eager to learn about it. As the work of such pioneers as Elizabeth Kubler Ross[1] and Cicely Saunders has shown, dying need not necessarily be a harrowing, uncreative, or unrelieved experience, and thoughtful and imaginative management can relieve so much of the suffering. I was struck by the recent comment of the friends of a great man who died at their home: "We wanted him to die in peace, rather than in hospital." These don't need to be alternatives.

But while Dr. Rees's study is interesting, it is not at all clear how one can interpret his findings. In the area he studied 74% of deaths occurred in hospital and 26% at home. This is in accord with the general pattern of an increasing proportion of deaths occurring in hospitals and similar institutions shown in the United States, for instance, where in 1949 49·5% of deaths took place in hospital, and in 1958-60 the proportion was 60·9%.[2] But when he shows that patients dying at home were more likely to be alert shortly before death, and less likely to suffer from vomiting, incontinence, bedsores, or unrelieved physical distress the significance is obscure. Are not those patients with incontinence, bedsores, persistent vomiting, or unremitting pain just those who are most likely to be admitted to hospital for terminal care, and much less likely to be discharged from hospital? Those classified as "dying at home" are also likely to include a higher proportion of those dying shortly after the onset of the illness, and, other studies suggest, likely to show a different pattern of illness, with a higher proportion of deaths from suicide, homicide, and accidents, as well as heart disease. The differences Dr. Rees has noted may indeed represent some differences in terminal care, but are more likely to be owing to the study of different patient populations. The data for duration of terminal illness is not comparable with other work in this area, as it was based on "the decision of the nurse that the patient was dying"—a subjective decision that tells as much about the nurse as about the patient.

Dr. Rees could add greatly to our knowledge by studying the factors that determine where the terminal patient is treated; and why, even in good and compassionate hands, 14% suffered from severe anxiety, 12% from such severe depression that at times they wanted to die, 34% suffered incomplete relief of their pains, and 28% were at times "never free from their distress throughout the day." When we know that, perhaps patients can die in peace and in hospital.—I am, etc.,

MICHAEL A. SIMPSON

Guy's Hospital,
London S.E.1

1 Kubler Ross, Elizabeth, *On Death and Dying*, Tavistock Publications, 1970.
2 *The Dying Patient*, ed. O. G. Brim, H. E. Freeman, S. Levine, and N. A. Scotch. p. 24. New York, Russell Sage Foundation, 1970.

SIR,—Dr. W. Dewi Rees's investigations into dying (8 July, p. 105) show that 28% of his patients at Llanidloes were fully alert 24 hours before death and 12% wanted to die. Only 26% were devoid of physical distress. Here indeed is concrete evidence of the need to break through the wall of prejudice with which we surround the dying. When death is inevitable, to deny its fulfilment to a person who desires it is little removed from being an accomplice to torture. Once again the urgent need to introduce voluntary euthanasia is clear, as it has been to many—both laymen and doctors—who have attended the dying over the years.—I am, etc.,

S. L. HENDERSON SMITH

Huddersfield, Yorks

Pulmonary Oedema of Mountains

SIR,—Your leading article "Pulmonary Oedema of Mountains" (8 July, p. 65), although an appropriate and timely warning to the increasing number of people going to high altitude, contains some misconceptions.

Women mountaineers do indeed suffer from this illness. In the Himalayas I have experience of four women suffering from acute mountain sickness; three were manifest as high altitude pulmonary oedema and one as cerebral oedema. One of the patients,[1 2] who is a nurse and an experienced mountaineer, gave a clear story of having severe premenstrual tension before she developed pulmonary oedema. Evidence suggests that women who have an exaggerated periodic physiological water retention (antidiuresis[3]) with migrainous headaches, irritability, rapid weight gain, and peripheral oedema may be more susceptible to acute mountain sickness.

I suggest that women going to altitude should take a mild diuretic prophylactically during the premenstrual period. A specific improvement has been claimed for the prevention of acute mountain sickness by acetazolamide (Diamox).[4 5]

Diuretic therapy, using frusemide (Lasix), has proved to be lifesaving if given early enough, but its danger must also be appreciated. During acclimatization the plasma volume diminishes hand in hand with a

physiological increase in red blood cell production. The resulting increased viscosity of the blood is liable to be enhanced by dehydration from enforced diuresis. Vascular thrombosis, a well-recorded complication of altitude, is also more likely to occur. In this context it is questionable whether women mountaineers should be taking the contraceptive pill while at altitude.

Although rapid ascent to altitude seems to precipitate acute mountain sickness, it is by no means the definitive cause. Of the four women patients quoted two were thoroughly fit and acclimatized, having walked for three weeks and crossed several passes between 4 and 15,000 ft (1-4,500 m).

The only specific treatment for acute mountain sickness is descent to a lower altitude—and staying there. People feel dramatically better within hours of going down to the valleys. Because of ignorance of the serious implications of this illness several tragedies have occurred by patients returning to the mountain that has cost them dear to reach, after a short period of convalescence when their symptoms disappeared.

I endorse your suggestion that written warnings should be available to people at risk.

Parties of mountaineers going above 15,000 ft (4,500 m) would be wise to carry oxygen with them for the emergency treatment of acute mountain sickness with pulmonary oedema. Intermittent positive pressure respiration is not practical on a mountain; it might, however, be useful in a comatose patient suffering from cerebral oedema after evacuation to a lower level hospital.—I am, etc.,

PETER R. STEELE

Medical Officer to 1971 International Mount Everest Expedition

Frenchay Hospital,
Bristol

1 Steele, P., *Lancet*, 1971, **2**, 32.
2 Steele, P., *Doctor on Everest*. Hodder and Stoughton, London, 1972.
3 Singh, I, *et al.*, *New England Journal of Medicine*, 1969, **280**, 175.
4 Forwand, S. A., Landowne, M., Follansbee, J. N., and Hansen, J. E., *New England Journal of Medicine*, 1968, **279**, 839.
5 Gray, G. W., *et al.*, *Aerospace Medicine*, 1971, **42**, 81.

SIR,—I was interested to read in your leading article (8 July, p. 65) on acute pulmonary oedema of mountains that no fatality had yet been reported in a woman. I should like to report such a case in Nepal in 1969.

The patient was taking part in a trek and was aged 50. She had been passed fit for this in the United Kingdom, and during the march-in of 100 miles (160 km) she had appeared to be one of the fittest members of the party. When she reached a height of 17,000 ft (5,000 m) she became very tired and found climbing the last 1,000 ft (303 m) to the highest point of the trip more of an effort than other members of the group. She managed to get down to 16,000 ft 4,700 m), where we camped, but the next day she was unable to walk and had to be carried down 13,000 ft (3,994 m).

That night she had little in the way of respiratory symptoms or signs, but at 3 a.m. her breathing was noted to be abnormal, and when I saw her she was dying and appeared to have acute pulmonary oedema, being unconscious with blood-stained froth issuing from her mouth. She died within two or three minutes, and although there was no postmortem there seems little doubt that she was a victim of acute pulmonary oedema of mountains.—I am, etc.,

J. C. FOSTER

Henley on Thames

SIR,—In your interesting leading article (8 July, p. 65) you state that women have not so far been recorded as victims of the disease. Unfortunately this is now not so. When climbing recently in the Kulu area of the Central Himalayas, I was concerned in the attempted rescue of a Japanese woman climber. She had attempted to climb a 19,600-ft. (5,800 m) mountain but collapsed, became stuporose, then comatose. Unfortunately she died before we were able to reach her. She had attempted to climb the mountain within a week of arrival in the Himalayas and it seems certain that she died from pulmonary oedema. Her companion, who was obviously in pulmonary oedema, was rescued by helicopter and survived.—I am, etc.,

A. PINES

Ware Park Hospital,
Ware, Herts

Free Mass Screening in Austria

SIR,—Examination of the healthy population, which is to be without any charge to those requesting it, is to be started on 1 November 1972 in Austria. A pilot scheme will begin in Vienna and the province of Carinthia for one year. After that it is proposed to extend the scheme to the rest of the country.

At first only women over 35 years of age and men over 45 years will be eligible, and taking the population as a whole it is estimated that when the scheme is fully operative 10% of those living in the town and 5% of country dwellers will take advantage of the scheme and request screening.

The cost to the Government of Austria will be just under £6 per person; this will be paid to the doctor carrying out the examination, who will have to fill in a form in order to claim his fee, similar to the practice existing in Britain where claims for payment are sent to the executive council for maternity fees, vaccinations, etc. The Austrian Ministry of Health is well prepared for the screenings to start, and 45-60 million Austrian schillings have already been set aside for this purpose.

The examinations are to take place on a purely voluntary basis for both doctor and patient. Tests will include blood and urine analysis as a routine, gynaecological examinations for women, and examinations aimed at detecting early symptoms of common ailments of men, such as prostatic conditions.

It is interesting to note that the first reactions to these announcements are not entirely favourable. There is criticism of the one-year test period and the arbitrary choice of Vienna and Carinthia for pilot schemes while the remainder of the country will have to wait a further year for screening, although technically there are no reasons why the health examinations should not get underway this autumn throughout the whole country. There is also some dissent about the scheme extending only to those in early middle age, and the Minister is being urged to consider offering it to a younger age group as well. The point is also put forward that it might make more sense to have more thorough examinations during school days and in the army. (Austria has a period of compulsory military service for men.) It seems probable that while it is testing consumer reaction to the scheme, as well as seeing how the extra work will be accepted by doctors, that the Austrian Government is playing safe before making the scheme nationally available.

Whatever the reasons being put forward by the sceptics of the scheme, and clearly there are going to be difficulties before the scheme can be made fully operative and acceptable, the overall value of it to the population can hardly be disputed. Many people who already have periodic check-ups privately as well as the majority of the population are very much in favour of a scheme offering the prospect of free health examinations.—I am, etc.,

FRANCIS P. DURAS

London Colney,
Herts

People with Epilepsy (1972)

SIR,—The Reid Committee has reason to congratulate itself on the success of its report, *People with Epilepsy*,[1] the public interest it has aroused, and the promise of ministerial action on its recommendations. There is unfortunately a danger in the very success of the document. Its recommendations which pertain to the situation as it stood in 1969 are liable to be regarded as gospel and its on-going recommendations dismissed as superfluous. Much of the purpose of the Reid report will be lost if desire "that arrangements should be made to assess results over a period of years, to watch developments and reexamine the evolution of services for people with epilepsy from time to time" is not fulfilled. In deciding the future shape of the committee or its successor, thought should be given to the case for a different balance within the committee, which reflects both the weaknesses of the report and the social changes which have already taken place since the report was drafted.

The social changes since 1969 relate particularly to the epileptic person with a severe handicap. The operation of the Disabled Persons Act has brought new insight into every aspect of community care. The assumption made by the Reid Committee that the risk of institutionalization outweighs loneliness, isolation, hostility, and difficulties in supervision in homes and flats in the community cannot go unchallenged. And in practical terms the size of the task confronting local authorities in resettling mentally retarded, psychiatric, and geriatric patients into the community will mean that only a modest reduction in the number of residents in the epileptic colonies can be anticipated in the near future. Social change has not left the colonies untouched. Many of the recommendations made on epileptic centres or colonies relate to a much earlier study by Jones and Tillotson,[2] before the colonies had established a joint consultative committee or developed a liaison with neighbouring neurological and neurosurgical units. Since 1969 improvements have occurred in social attitudes within the colonies; and, par-