

overwhelmingly confirming this. In turn the motion was endorsed by the General Medical Services Committee.

Plain enough. But what do we see now but the GMSC actually setting up working parties to help fundholding practices, in other words helping those doctors setting out on a course to harm patients. Is this not hypocrisy of the first order? Since when has the GMSC been empowered to harm patients?

We are informed that it is all in the cause of professional unity. Bunkum! Would the GMSC defend me if I was one of a small group of 300 or so doctors who favoured euthanasia for particular groups of patients (I don't, by the way)? Of course not. The real reason would seem to be the cause of unity of the GMSC itself, some of whose members have declared their positive interest in fundholding.

The same applies to local medical committees; Leicestershire Local Medical Committee passed a motion in September asking doctors to withdraw interest in the scheme. In October when some members intended going ahead despite the recommendation the council refused to second a motion asking such members to resign.

How can the GMSC and local medical committees hope to regain even a shred of their credibility when they recommend one thing to others and do the opposite themselves? Apart from that, if fundholding is bad for patients then the way to stop it is not to encourage it as the GMSC is doing but to allow the fundholders to split (few that there are) and allow the project to wither on the vine. But perhaps that is too simple a solution.

Incidentally, I resigned from Leicestershire medical committee in disgust at their and the GMSC's attitude on this vital matter.

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*The Secretary writes: "The remit of the GMSC's NHS Review working group is to monitor the effects of the NHS and Community Care Act 1990 for the purpose of representing and protecting the interests of patients and general practitioners with particular reference to hospitals, contracts, general practice, fundholding, and self governing hospitals. When appointing this working group the GMSC reiterated its view that fundholding in general practice is detrimental to patients' interests and the NHS and resolved to ensure that all patients have equity of access to NHS services and to continue to represent the interests of all general practitioners."—Ed, *BMJ*.

UCL may charge medical students

SIR,—Dr Fiona Godlee's news article implied that University College London had formulated plans to charge top up tuition fees and that these would be discussed at the Academic Board on 13 November.¹

In fact there were no plans to introduce top up fees and the purpose of the Academic Board meeting was to have a wide debate within the college about the issue of top up fees. Over 200 of the academic staff were present, and the debate was introduced by Professor Ted Honderich (Grote professor of philosophy). The debate was entirely one sided, with all speakers expressing their opposition to the concept of top up fees. At the end of the debate the provost, Dr Derek Roberts, put the motion "The Academic Board of University College London totally rejects the principle of top up fees for undergraduates." This motion was carried with everyone present voting for it with the exception of two abstentions.

It is now clear and a matter of record that there are no plans for top up fees at University College

London for medical, law, or any other students; that the principle of top up fees is objectionable to the provost and the academic staff; and that pressure needs to continue on the government to fund the expansion of higher education that our society clearly needs.

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¹ Godlee F. UCL may charge medical students. *BMJ* 1990;301:1064. (10 November.)

Drug Points

Low back pain associated with streptokinase

Drs M SHAH and R T TAYLOR (Kidderminster General Hospital, Kidderminster) write: We describe three cases of severe acute low back pain associated with streptokinase infusion for acute myocardial infarction.

Case 1—A 54 year old man with longstanding hypertension and asthma was admitted for investigation of chest pain. He was taking nitrazepam 2.5 mg at night, piroxicam 10 mg twice daily, salbutamol inhaler as required, co-proxamol (dextropropoxyphene 32.5 mg and paracetamol 325 mg) two tablets as required, and captopril 25 mg twice daily. While in hospital he developed severe chest pain. An electrocardiogram showed changes indicating acute anterior myocardial infarction. Aspirin by mouth and a streptokinase infusion were started. After receiving 350 000 units he developed severe, throbbing, central low back pain. The infusion was stopped and the pain disappeared within five minutes.

Case 2—A 35 year old diabetic man who was taking human soluble insulin and isophane insulin, both twice daily, was admitted with a two hour history of chest pain. An electrocardiogram showed changes indicating acute anterolateral myocardial infarction. Aspirin by mouth and a streptokinase infusion were started. After receiving 300 000 units he developed a severe, constant, central low back pain, radiating down the backs of both legs. The infusion was stopped and pain relief occurred within five minutes.

Case 3—A 64 year old man with angina, who was taking digoxin 0.25 mg once daily, co-amiloride 5/50 (amiloride 5 mg and hydrochlorothiazide 50 mg) one tablet daily, nifedipine 10 mg twice daily, and aspirin 150 mg once daily developed severe central chest pain while in hospital. Ten days previously he had received alteplase. At that time an infarct was not confirmed by changes in either the electrocardiogram or cardiac enzyme activities. This time a streptokinase infusion was started. After receiving 255 000 units he developed severe central low back pain, which ceased within several minutes of stopping the infusion. He was then given hydrocortisone 100 mg and chlorpheniramine 10 mg intravenously, and the infusion was restarted with no further problem.

In all three cases starting a streptokinase infusion was associated with very severe low back pain, which disappeared within minutes of the infusions being stopped.

We presume that the back pain in these patients was an allergic manifestation, although we are unsure of the mechanism. Because allergic reactions are well recognised, we used to give hydrocortisone and chlorpheniramine before treatment with streptokinase,¹ but since just before joining the ISIS III trial in August 1989 we have not used hydrocortisone and chlorpheniramine before the thrombolytic agent and have seen three cases of back pain in four months. Previously we used streptokinase for over 12 months with no effects of this nature. Neither the Committee on

Safety of Medicines nor the manufacturers have received reports of severe low back pain with streptokinase.

¹ Lipkin D, Reid CJ. Myocardial infarction: the first 24 hours. *BMJ* 1988;296:947.

Respiratory distress secondary to naftidrofuryl

Drs S A KHAN, J E PACE, and M L COX (Watford General Hospital, Watford, Hertfordshire WD1 8HB) write: We report a case of respiratory distress after accidental chewing of naftidrofuryl. A 93 year old man presented with a 30 minute history of severe shortness of breath. He had chewed a capsule of naftidrofuryl accidentally and experienced a burning sensation in his throat, which made him spit out its remains. He took a drink of milk to relieve the discomfort and immediately became short of breath. There was no cough or chest pain. He had no history of difficulty in swallowing.

He had been taking naftidrofuryl for several years for peripheral vascular disease. He had recently finished a course of doxycycline for bronchitis. He was also receiving pilocarpine eye drops for glaucoma and glyceryltrinitrate spray for angina, although he rarely used the spray.

On examination his respiratory rate was 48 breaths a minute, and he was unable to speak. There was loud inspiratory stridor and decreased entry of air bilaterally, with expiratory rhonchus. The rest of the examination was unremarkable.

Analysis of his arterial blood gases while breathing air showed pH 7.36 (normal 7.35-7.45), base excess -4 mmol/l, carbon dioxide pressure 4.7 kPa (normal 4.5-6.1 kPa), oxygen pressure 5.9 kPa (normal 11.5-15.0 kPa), and standard bicarbonate concentration 21 mmol/l (normal 22-26 mmol/l). Chest radiography and 12 lead electrocardiography gave normal results.

He was treated with oxygen, nebulised β adrenoceptor stimulant, and intravenous steroids. His clinical condition improved and the stridor resolved over the next hour. Analysis of arterial blood gases (while breathing 35% oxygen) showed pH 7.38, carbon dioxide pressure 5.5 kPa, standard bicarbonate concentration 25 mmol/l, base excess 0 mmol/l, oxygen pressure 13.1 kPa, and oxygen saturation 97%. A chest examination showed occasional low pitched rhonchus at the lung bases.

Two hours after admission he was completely asymptomatic and was able to give an accurate account of events preceding his admission to hospital. He remained asymptomatic until he was discharged three days later.

Naftidrofuryl is a potent local anaesthetic and is four times more active than lignocaine.¹ Our patient experienced breathlessness after drinking milk to relieve discomfort after chewing a capsule of naftidrofuryl. Although bronchospasm and laryngeal oedema associated with naftidrofuryl have been reported, aspiration secondary to its local anaesthetic effect has not been documented.

We suggest that dispensaries should be advised to use "not to be chewed" warning labels when issuing naftidrofuryl capsules.

¹ Fontaine L, Grand M, Chabert J, Szarvasi E, Bayssat M. General pharmacology of a new vasodilator substance—naftidrofuryl. *Bulletin of Chemical Therapeutics* 1968;3:463-9.

Correction

Consultation rates among middle aged men

An editorial error occurred in this letter by Dr R S Bhopal (10 November, p 1102). The finding of Bhopal and Bhopal that men had substantially lower consultation rates (and shorter consultations) than women was wrongly attributed to Dr Cook and colleagues.