

increased intracranial pressure is invariably present in acute meningial inflammation<sup>1</sup> and lumbar puncture should always be undertaken with caution. Theoretically, the risk of precipitating sudden intracranial pressure loss may be reduced by minimal physical restraint and avoiding neck flexion; use of a small bore needle; obtaining a minimal volume of cerebrospinal fluid (less than 1 ml); and retracting skin from the puncture site before removing the needle and thereafter generously applying collodion to prevent leakage of cerebrospinal fluid after puncture.

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- 1 Rennick G, Shann F, de Campo J. Cerebral herniation during bacterial meningitis in children. *BMJ* 1993;306:953-5. (10 April.)
- 2 Rosenberg DI, McCrory JH, Abhoudon MK, Murante AA, Downs CE. Neurointensive care for cerebral herniation in childhood meningitis. In: Hoft JT, Betz AL, eds. *Intracranial pressure VII*. Berlin: Springer, 1989:770-2. (Proceedings of the seventh international symposium on intracranial pressure.)
- 3 Lebel MH, Bishara FJ, Syrogiannopoulos GA, et al. Dexamethasone therapy for bacterial meningitis. *N Engl J Med* 1988;319:964-71.
- 4 Fenichel GM. *Clinical pediatric neurology: a signs and symptoms approach*. Philadelphia: Saunders, 1988.

## Where credit is due

EDITOR,—The obituary of R G Macbeth<sup>1</sup> makes no mention of his having introduced sclerotherapy for oesophageal varices into Britain. The credit for this has often been given to me. It would be a matter of great satisfaction to me for some mention to be made that the real pioneer was my friend Ronald Macbeth.

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- 1 Colman BH. R G Macbeth. *BMJ* 1993;306:1193. (1 May.)

## Keeping up to date

EDITOR,—The data given by David N S Kerr and colleagues in their article on continuing medical education are useful, and the discussion is helpful for those, like me, who have budgetary responsibility for consultants' study leave.<sup>1</sup>

Continuing education—keeping up to date—is a professional obligation; it would be reactionary for employing authorities to require this of consultants without helping by providing time and finance, but at present the use of this varies, as the authors' table I shows. The authors' concepts of auditing the use of leave and basing it on a personal plan for continuing medical education are desirable and would diminish the random element in today's use of study leave.

The cost to employers is considerable when lost sessions are added to fees and the cost of travel and subsistence; one royal college recently circulated a document to its fellows suggesting that the annual cost to each consultant of attending meetings to meet its requirements for continuing medical education might be £2000. Employing authorities will increasingly expect to have value for money shown. This is not easy when meetings—ostensibly comparable, such as annual meetings of national societies or colleges—cost widely differing sums. In my short experience daily registration fees for meetings have varied from £35 to £250. Education may not be the sole motive of all consultants taking study leave, but nor is it the entire purpose of the organisations providing it as profit may be vital for them. Employers cannot be expected willingly to subsidise societies in this way.

The concept of a costed personal plan for

continuing medical education for each consultant needs early trial.

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- 1 Kerr DNS, Jones SAM, Easmon CSF. Continuing medical education: experience and opinions of consultants. *BMJ* 1993;306:1398-402. (22 May.)

## Provision of acute beds in inner London

### Are all Thames regions the same?

EDITOR,—Brian Jarman notes "that of the four Thames regions, North West Thames has the lowest supply of acute plus geriatric beds and North East Thames the highest."<sup>1</sup> He also notes that the supply of acute beds in North West Thames is 20% below that for England and the lowest in the country. Tomlinson was asked to report on acute beds in inner London.<sup>2</sup> I am interested to know whether Jarman has data for the four Thames regions broken down for inner London compared with the rest of the regions and whether they confirm the prevailing view that there are excessive acute beds in inner London and, if so, whether this applies to all of the four Thames regions equally.

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- 1 Jarman B. Is London overbedded? *BMJ* 1993;306:979-82. (10 April.)
- 2 Tomlinson B. *Report of the enquiry into London's health service, medical education and research*. London: HMSO, 1992.

### Author's reply

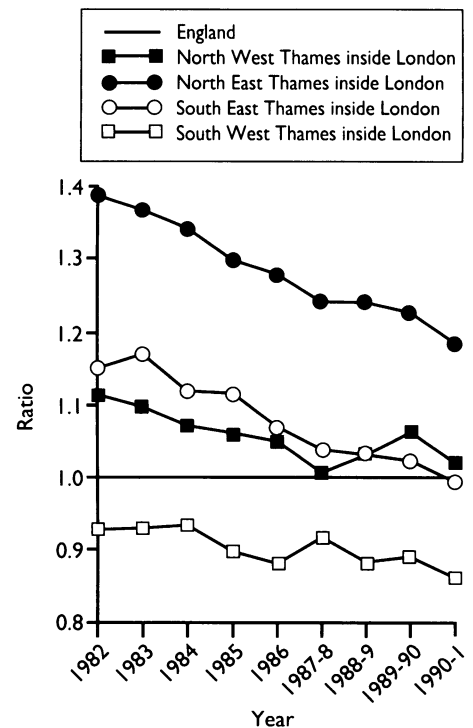
EDITOR,—The figure shows the information that R M Greenhalgh requests. It is clear that by 1991 the supply of acute plus geriatric beds per head of population in the London parts of the regions was about the national average for North West and South East Thames regions and below the average for South West Thames.

N Mays draws attention to the relative over-provision of acute hospital beds in inner London and in deprived areas in other inner cities.<sup>1</sup> My paper drew attention to the fact that, despite this, the use of acute plus geriatric hospital services in London differs little from the national use. In addition, for at least the past 10 years acute hospital beds in London have been closed at a much faster rate than the national average—164 acute beds per million population per year in London for the five years ending 31 March 1991 (257 per million in inner London and 112 per million in outer London), compared with 79 per million population per year in England. The number of acute plus geriatric beds per resident in London in 1990-1 was only 4% higher than the national average. Even allowing for special health authority beds, I believe that it is difficult to conclude that either the use or supply of acute and geriatric beds in London gives a good argument for bed closures faster (as Tomlinson suggests) than the national rate.

I believe that Chaand Nagpaul is correct that there is no conclusive evidence that improvements in primary care lead to lower demands for secondary care.<sup>2</sup>

Christina Victor is correct to emphasise the importance of the relatively lower provision of places in residential homes for elderly people in London.<sup>3</sup> In unpublished analyses of hospital use at the level of electoral wards colleagues and I have shown that the number of places in residential homes per person aged 65 or over is almost as powerful as the supply of hospital beds in

explaining the variation in hospital use among wards. This factor, however, acts in the opposite direction to the supply of beds: where there are relatively fewer residential homes per person (as in inner London) use of hospital beds is greater (as opposed to the lower use of hospital beds where



Ratio of number of acute plus geriatric beds in London (parts of Thames regions in London) per 1000 population to rate in England

supply of hospital beds is lower).

I am grateful to Tony Jewell for pointing out that similar considerations are likely to apply to nursing homes for elderly people (of which there is also a lower supply in the inner London districts).<sup>4</sup> It is important to note that the transfer of income support payments for residential and nursing homes to social services budgets from April will be greater in the areas with greater historical provision, thus again reducing the relative resources for institutional care (hospitals and homes) for people living in inner London.

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- 1 Mays N. Health care in London: other cities also overbedded. *BMJ* 1993;306:1474. (29 May.)
- 2 Nagpaul C. Health care in London: BMA slow to condemn Tomlinson. *BMJ* 1993;306:1474. (29 May.)
- 3 Victor C. Health care in London: inadequate provision for long term care. *BMJ* 1993;306:1474 (29 May.)
- 4 Jewell T. Health care in London: London low on residential and nursing homes. *BMJ* 1993;306:1474-5. (29 May.)

## Correction

### Simple treatment for night terrors

An editorial error occurred in this letter by Sean Maskey (29 May, p 1477). The wording of the title and third paragraph imply wrongly that the treatment described is for both night terrors and nightmares. This treatment is useful only in nightmares.

### Antenatal screening for Down's syndrome

An editorial error occurred in this letter by K Spencer and others (12 June, p 1616). The figures in the second line of the table are the total with Down's syndrome in the population, not the number born with Down's syndrome as shown.