

reduced, and the most widely used concentration is 1:200,000 or 5 µg./ml. Infiltration of a wide area of tissue with this solution means that though the total dose is large the risk of more than a trifling amount being injected directly into a vein is small. If 100 ml. of 0.5% lignocaine with 1:200,000 adrenaline was used the total dose of lignocaine would be 500 mg. and of adrenaline 500 µg. Both doses are large, but as they are absorbed into the circulation slowly over two or more hours the pharmacological effect would be quite small. However, infusion of adrenaline or noradrenaline at a dose of about 4 µg. per minute intravenously does have a measurable effect on the normal circulation, and these are maximum doses, which should not be exceeded. It would be wise to avoid these large doses in patients on other drugs that sensitize them to catecholamines.

It is reasonable to conclude that so long as local anaesthetics containing vasoconstrictors are never used in the finger, toe, penis, or ear, are not injected directly into a vein, nor given in excessive doses they are largely free of risk, and the more prolonged anaesthesia produced by the vasoconstrictor greatly extends their usefulness.

## Diet with Ileostomy

Several clinicians have emphasized that patients with an ileostomy can usually eat a normal or nearly normal diet,<sup>1-3</sup> but it is also clear<sup>2</sup> that some foods cause complications from time to time, such as profuse ileostomy flow, flatulence, and odour. Moreover, the problem is also complicated by individual variations. Foodstuffs which upset one patient when consumed in even minute quantities are eaten several times a day by another without apparent ill effect.

In the management of ileostomy, therefore, the patient's viewpoint is specially important. Recently an interesting attempt to present it has been made by T. J. Thomson and colleagues.<sup>4</sup> By means of a questionnaire these authors invited the 5,100 members of the Ileostomy Association of Great Britain and Northern Ireland to record their experiences after the ingestion of 29 named articles of diet. These covered a wide range and included apples, beans, beetroot, sauces, soups, and cereals.

The response was perhaps a little disappointing in that only 18.7% of those circulated replied in satisfactory fashion, though the authors point out that this group showed a close similarity to the total group of 5,100 patients in respect of age, sex, and duration of ileostomy. In any event the collective view of 952 patients represents a substantial body of opinion. Few (13%) of the group experienced any real difficulty in choosing a diet, while almost all of them were maintaining or increasing their weight when questioned. Of the specific foods listed, onions seemed to cause most difficulty in that about two-thirds of the patients experienced one or more complications after eating them. Other items of diet which sometimes led to complications were peas, beans, fried fish, and

rhubarb, but for all foodstuffs there was considerable individual variation in the patient's response.

Though it is perhaps unwise to read too much into this somewhat limited survey, it does, when taken in conjunction with comments by other clinicians,<sup>1-3</sup> enable firm guidance to be offered to the patient with ileostomy. Firstly, he should be reassured that a full mixed diet is compatible with his ileostomy and that the great majority of patients manage very well in this respect. Secondly, possible complications, such as those mentioned above should be pointed out, and it may be wise in the early postoperative period to proscribe items of diet, such as onions and rhubarb, which are relatively likely to cause them. But at the same time the considerable individual variation should be emphasized, so that the patient should be encouraged to discover for himself whether specific foods are acceptable and discouraged from relying on the experience of others. Here it is worth recalling that many of the so-called complications such as watery flow and odour are both temporary and minor if anticipated. Finally, the patient with an ileostomy, like other people, may be subject to such dietary problems as gastroenteritis and obesity. Gastroenteritis is particularly serious to these patients.

Like other patients after a surgical operation those with an ileostomy look forward to living a life as near normal as possible. So far as diet is concerned there seems little reason why the overwhelming majority should not do so.

## Cataract Spectacles

The management of patients with cataract presents considerable problems, for they are usually elderly and are likely to have difficulty in adapting to aphakic vision after removal of the cataract. The troubles that may beset the patient after operation are not always carefully discussed with him beforehand, when both surgeon and patient are apt to consider that the preparations for a disturbing operation are enough to be going on with. Moreover, despite warnings, patients are apt to think that once the cataract has been removed their sight will again be as good as new.

The spectacles that are needed to give clear sight after operation for cataract present the patient at first with an alarming world of sudden movements and topsy-turvy distortions.<sup>1</sup> Even after weeks of effort and practice the patient will still have a substantial limitation of his visual field. The writers of several letters in our correspondence columns have recently drawn attention to the advantages of alternatives to the spectacles commonly prescribed for aphakic eyes. They have included lenticular implants,<sup>2</sup> or, simpler and less traumatic, contact lenses.<sup>3 4</sup> These will restore the full peripheral field, as well as in monocular aphakia allow the eyes to work in unison. Although contact lenses avoid the need for the heavy "pebble" spectacles that constrict the patient's field of vision, only a few patients who try them seem to find them manageable. Old people have considerable trouble inserting

<sup>1</sup> Trevor-Roper, P. D., *British Medical Journal*, 1970, 3, 33.

<sup>2</sup> Choyce, D. P., *British Medical Journal*, 1970, 3, 648.

<sup>3</sup> Ruben, M., *British Medical Journal*, 1970, 3, 221.

<sup>4</sup> Waller, W., *British Medical Journal*, 1970, 3, 164.

<sup>5</sup> Morwood, J. B., *British Medical Journal*, 1966, 1, 1481.

<sup>6</sup> Morwood, J. B., Report of Medical Officer of Health, Banstead Urban District Council for 1969.

<sup>7</sup> Medical Commission on Accident Prevention, *Medical Aspects of Fitness to Drive Vehicles*, ed. L. G. Norman. London, Medical Commission on Accident Prevention, 1968.

<sup>1</sup> Brooke, B. N., *Ulcerative Colitis and its Surgical Treatment*, p. 104. Edinburgh, Livingstone, 1954.

<sup>2</sup> Goligher, J. C., de Dombal, F. T., Watts, J. M., and Watkinson, G., *Ulcerative Colitis*, p. 285. London, Ballière, Tindall, and Cassell, 1968.

<sup>3</sup> Jones, F. A., Gummer, J. W. P., and Lennard-Jones, J. E., *Clinical Gastroenterology*, 2nd edn., p. 661. Oxford, Blackwell, 1968.

<sup>4</sup> Thomson, T. J., Runcie, J., and Khan, A., *Gut*, 1970, 11, 482.