

Lung Biopsy

SIR,—Your leading article on lung biopsy (6 June, p. 555) cannot be allowed to pass without comment. To say that "owing to the indifferent contribution it has made in assisting diagnosis over the years the method has now been virtually abandoned" suggests that your leader writer cannot be familiar with either the paper by Steel and Winstanley¹ or with current practice in a number of hospitals all over the world.

Quite contrary to the view quoted above, I believe that trephine biopsy has made a great contribution to the diagnosis of diffuse lung disease, and the procedure has converted me from being a keen advocate of open lung biopsy to an ardent supporter of the much simpler technique.

To suggest that the procedure is more alarming or more liable to morbidity than a formal thoracotomy under general anaesthesia in an operating theatre seems to me to be pushing the objection of trephine biopsy beyond the limits of reason.—I am, etc.,

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REFERENCE

- ¹ Steel, S. J., and Winstanley, D. P., *Thorax*, 1969, 24, 576.

SIR,—Your leading article "Lung Biopsy" (6 June, p. 555) seems to call for comment. Far from being "virtually abandoned," trephine biopsy with a high-speed air drill is the method of choice at the London Chest Hospital, and is being increasingly used in teaching hospitals and thoracic units in Britain and abroad. In a recent account¹ we reported 119 trephine biopsies, of which

85% were diagnostically significant, and the total has now grown to 182. Complications were not serious. The incidence of pneumothorax was 26%, but only a quarter of these patients needed an intercostal tube. There was no instance of pleural infection. In contrast, Gaensler *et al.*² carried out 106 lung biopsies by open thoracotomy under general anaesthesia. They used an intercostal tube as a routine and their complications, though few, were more serious than those we encountered.

The only feature of trephine biopsy which could be regarded as "alarming" is the whistling noise produced by the air drill, and this should be familiar to anybody who has visited the dentist in recent years. Premedication is unnecessary and local anaesthesia is used. After biopsy patients are fully mobile within half an hour and can usually leave hospital the following day. There is thus a considerable saving in operating theatre time and hospital bed occupancy.

We feel that lung biopsy should not be entirely restricted to patients in whom there is a prospect of finding a treatable condition. In industrial lung disease, for example, diagnosis has more than merely therapeutic value, and in any patient there is always the possibility of finding something totally unexpected.—We are, etc.,

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REFERENCES

- ¹ Steel, S. J., and Winstanley, D. P., *Thorax*, 1969, 24, 576.
² Gaensler, E. A., Moister, M. V. B., and Hamm, J., *New England Journal of Medicine*, 1964, 270, 1319.

Pseudo-obstruction of the Large Bowel

SIR,—In the Current Practice article (6 June, p. 583), Mr. P. K. Caves and Dr. H. A. Crockard refer to pseudo-obstruction of the large bowel. The term pseudo-obstruction of the intestine was used by Naish and his colleagues¹ to describe a syndrome of intermittent intestinal obstruction, often associated with malabsorption without organic cause. Pathologically, these cases show marked hypertrophy of the smooth muscle of the bowel wall and, in the cases in which it has been examined, pathological changes in the myenteric plexus.² The lesion is permanent and does not recover. The treatment is excision of the affected segment, if practicable.

The cases which Mr. Caves and Dr. Crockard describe appear to be those of acute colonic dilatation of varying aetiology, most of which recovered completely. This is manifestly a different condition. The terminology of obstruction without organic cause is already confused, but perhaps it would be less so if the name "pseudo-obstruction" were confined to the condition originally described by Naish, and acute dilatation or some other similar term used for the type which recovers with or without treatment.—I am, etc.,

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REFERENCES

- ¹ Naish, J. M., Camper, W. M., and Brown, N. J., *Gut*, 1960, 1, 62.
² Dyer, N. H., Dawson, A. M., Smith, B. F., and Todd, I. P., *British Medical Journal*, 1969, 1, 686.

Anxiety and Investigations

SIR,—Your leading article entitled "Anxiety and Investigations" (16 May, p. 377) on the use of diazepam omitted to mention one of the common side effects of intravenous administration of sedative doses of this drug, namely amnesia. This has frequently been reported in the literature.¹⁻³

We recently carried out a volunteer trial in the laboratory⁴ and found dense amnesia for at least 10 minutes and mildly impaired learning more than 30 minutes after injection. Considerable care should, therefore, be taken not to release outpatients until their powers of memory return, which is probably at least half an hour after the acute effects of the drug have passed off. Since the effects of the intravenous administration of this drug appear to dissipate variably over a period of some hours, it would also be advisable before undertaking such procedures to warn the patient and his escort of the need to make arrangements to

prevent possible indiscretions during this period.—We are, etc.,

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REFERENCES

- ¹ Brown, S. S., and Dundee, J. W., *British Journal of Anaesthesia*, 1968, 40, 108.
² Fox, G. S., Wynands, J. E., and Bhamhani, M., *Canadian Anaesthetic Journal*, 1968, 15, 281.
³ O'Neil, R., and Verrill, P. J., *British Journal of Oral Surgery*, 1969, 7, 12.
⁴ Clarke, P. R. F., Eccersley, P. S., Frisby, J. P., and Thornton, J. A., *British Journal of Anaesthesia* (in press).

SIR,—Your leading article entitled "Anxiety and Investigations" (16 May, p. 377) omits one useful action of diazepam which contributes to its success in conservative dentistry and possibly in other investigations. When given intravenously in doses in the region of 1 mg./5kg., Keilty and Blackwood¹ found a high incidence of amnesia for an intra-oral injection given two to three minutes later, and this was confirmed by O'Neil *et al.*² using a slightly higher dose of diazepam. This amnesia is very transient, but patients remain quiet and the operation can be continued under local anaesthesia.

As stated in your survey cardiovascular effects of this dosage are minimal. In fact, Brown and Dundee³ found that the intravenous injection of doses of 0.61-0.8 mg./kg. diazepam did not produce a fall in systolic pressure in excess of 20 mm Hg.—I am, etc.,

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REFERENCES

- ¹ Keilty, S. R., and Blackwood, S., *British Journal of Clinical Practice*, 1969, 23, 365.
² O'Neil, R., Aellig, W. H., and Laurence, D. R., *British Dental Journal*, 1970 (in press).
³ Brown, S. S., and Dundee, J. W., *British Journal of Anaesthesia*, 1968, 40, 108.

Phenylketonuria

SIR,—Your leading article on phenylketonuria (6 June, p. 553) ends by stating that in some regions centralization of the biochemical investigations of infants in whom two screening tests have been positive may be necessary, but that subsequent treatment and supervision should be possible locally if adequate facilities are available.

The differential diagnosis of phenylketonuria from other causes of high blood phenylalanine levels can be very difficult, and it is a serious error to treat an infant unnecessarily with a low phenylalanine diet. We, therefore, believe that the diagnosis should in all cases be confirmed in one of a small number of centres specializing in the diagnosis and management of the inborn errors of aminoacid metabolism.¹⁻²

The management of the established case is also difficult, and requires a team of experts including a dietician with paediatric experience and a biochemist with a special interest in these aminoacid disturbances in addition to the paediatrician. A psychologist