Pulmonary Aspiration after Fibre-endoscopy

SIR,—I was very interested in the article by Drs. B. J. Prout and C. Metreweli on this topic (4 November, p. 269). In my previous department, where we performed about five fibre-endoscopic examinations daily, our patients occasionally developed fever and pulmonary infiltration after the examination. We too used diazepam (5-30 mg intravenously), atropine (0·5 mg), and pethidine, and periodically we used local anaesthesia (lignocaine spray). It was our impression that the use of local anaesthesia had no significant effect on the frequency of the pulmonary aspiration.

In my present department we have the help of an anaesthetist, and the patients receive neurolept analgesia (droperidol, fentanyl). For about four years we have never seen pulmonary infiltration after fibre-endoscopic examination.

I think that it is not very important what sort of anaesthesia is used, but that it is most important to have sufficient anaesthetic assistance to ensure that the patient is properly sedated during the examination and is fully awake soon after the examination has finished.—I am, etc.,

N. C. LINDE

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Previous Tuberculosis Infection and Cerebral Glioma

SIR,—It was noted in the fourth report of the Medical Research Council's trial of tuberculosis vaccines[1] that the mortality from all malignant neoplasms during the 15 years following entry to the trial at age 14½-15 years was greater among those who were initially tuberculin-positive (36 deaths among 21,957 subjects) than among those who were initially tuberculin-negative (29 among 32,282 subjects). The probability of obtaining so large a difference by chance is about 1 in 50. The numbers of deaths from cerebral tumours (not given separately in the report) were nine and five respectively, showing a similar disparity to that for deaths from other malignancies. The association between previous tuberculous infection and cerebral glioma reported by Dr. D. W. Ward and others (13 January, p. 83) from a retrospective inquiry may therefore not be restricted to this specific neoplasm, but may be part of a wider phenomenon involving all neoplasms.

It was also noted in the report of the M.R.C. trial that there was no significant excess (or deficiency) in the mortality from all malignant neoplasms in those initially tuberculin-negative subjects who were then given B.C.G. or vole bacillus vaccine by random selection (namely, 17 deaths among 19,415 subjects) as compared with those who remained unvaccinated (12 among 12,867 subjects). The numbers of deaths from cerebral tumours were three and two respectively. This finding, from a controlled comparison, does not suggest that an (artificial) mycobacterial infection has any immunological consequences relevant to subsequent neoplasia. It therefore seems that the higher mortality from neoplasms among those who entered the trial with evidence of a previous (natural) mycobacterial infection is more likely to be related to some aspect of the environment in which that infection occurred than to represent an immunological consequence of that infection. Dr. Ward and his colleagues consider only immunological explanations for their association.—I am, etc.,

IAN SUTHERLAND

M.R.C. Statistical Research and Services Unit,
London W.C.1

1 Medical Research Council, *Bulletin of the World Health Organisation*, 1972, **46**, 371.

Family Planning

SIR,—The recommendations of the General Medical Services Committee on family planning (*Supplement*, 13 January, p. 14) are excellent. The immediate results are likely to be a fall in demands for abortion and an improvement in the doctor/patient relationship, which has deteriorated. The long-term effects are likely to be a curb on population growth reflected in a fall in unemployment and affecting schools, hospitals, housing demands, social services, production of cars for the home market, pollution, and environmental destruction. The social services can take up a great deal of time in a large medical centre with a 10-minute appointment rule. It might be advisable to lower the age to 15—a vulnerable age. It might also be advisable to limit child allowances to the second or third child only. —I am, etc.,

W. D. HOSKINS

Pulborough, Sussex

Side Effects of the Pill

SIR,—Dr. D. A. Varvel (23 December, p. 729) states that "probably 50%" of his patients taking the contraceptive pill have complete loss of libido. In agreeing with this Flt. Lt. D. J. S. Triplett (13 January, p. 111) suggests that the reason may be that the source of the female libido is the urge to reproduce. He also wonders what effect vasectomy has upon the wives.

With regard to the effect of the pill on libido, there have been a handful of published studies, but by far the best is that of Herzberg *et al.*[1] They conducted a detailed prospective study of women in various parts of England. They found that of the women who stopped or changed the pill, 19·8% (8% of all those taking the pill) gave loss of libido as the reason. However, this was not the commonest reason because of those who stopped or changed, 29·1% gave headache and 27·9% gave depression as the reason. Those who did not stop the pill tended to have an increase in libido. The mean libido score for all the women taking the pill showed no significant change. It is interesting that the same study showed that women with the intrauterine device tended to have a substantial increase in libido. Those who stopped or changed the pill because of loss of libido had a depression score (assessed by the Beck Inventory) at their initial assessment which was higher than that of all other women taking the pill. It should therefore be possible to reduce the number of women who get a loss of libido with the pill by trying to avoid prescribing it for those with a predisposition to depression.

With regard to vasectomy, the Simon Population Trust in 1969 reported that 79·4% of the wives of 1,008 vasectomized men found that their sex lives had improved and only 0·5% found that it had worsened. Female sterilization is also more likely to have a good rather than a bad effect. Steptoe,[2] in a follow-up of 350 cases, found that 57% reported improvement in sex life and 14% reported worsening. A similar survey of 216 women recently carried out at Nuneaton showed 50% improved and 9·7% worsened, and 83% of those reporting improvement attributed this to the operation (unpublished data).

All these studies, therefore, seem to suggest that the urge to reproduce is not a significant source of the female libido, though perhaps it is so with a few women. —I am, etc.,

MICHAEL L. COX

George Eliot Hospital,
Nuneaton

1 Herzbeg, B. N., Draper, K. C., Johnson, A. L., and Nicol, G. C., *British Medical Journal*, 1971, 3, 495.
2 Steptoe, P. C., *British Medical Bulletin*, 1970, 26, 60.
3 Simon Population Trust. *Vasectomy: Follow-up of a Thousand Cases*. Cambridge, 1969.

Fenfluramine and Haemolytic Anaemia

SIR,—I refer to the letter from Dr. A. M. Nussey (20 January, p. 177) concerning the occurrence of haemolytic anaemia in a 46-year-old woman who had been prescribed fenfluramine on three occasions during three preceeding years. I am able to reassure Dr. Nussey and your readers that we do not have any record on our adverse reaction files of cases of haemolytic anaemia following treatment with fenfluramine (Ponderax). I believe this is also the case so far as the Committee on Safety of Medicines is concerned.—I am, etc.,

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Ampicillin Dosage in Pneumonia

SIR,—I should like to add a comment to the interesting article by Drs. Valentine U. McHardy and M. E. Schonell on ampicillin and prednisolone in treatment of pneumonia (9 December, p. 569). The authors found a statistically significant difference showing that the proportion of patients who became afebrile within a week was larger with a dose of 1 g of ampicillin daily than with 2 g daily and that the difference was statistically significant.

The explanation could be that ampicillin can cause fever. In 1968 I made a comparison of the effects and side effects of phenoxymethylpenicillin and ampicillin in the treatment of scarlet fever (110 cases in each group). Ampicillin rashes occurred in 10 patients on the eighth to tenth day. However, it was also observed that in no fewer than 11 ampicillin cases (10%) the fever returned after the patient had become afebrile, without any clinical explanation. The rise of temperature occurred on the third to the eighth day (nine on the fourth to the seventh day) and reached a peak of 37·8-39·6°C. In most cases the temperature showed a spontaneous tendency to return to normal and the fever disappeared in all cases as soon as administration of the drug was stopped after the tenth day. In my opinion this reaction must represent some non-

allergic type of drug fever. It is quite possible that this reaction to the drug could explain why the temperature in the cases treated by Drs. McHardy and Schonell with the higher dose became normal later than those treated with the lower.—I am, etc.,

JUSTUS STRÖM

Roslagstulls Hospital,
Stockholm

1 Ström, J., *Acta Paediatrica Scandinavica*, 1968, **57**, 285.

Hazard of Ultrasonic Detection of Deep Vein Thrombosis

SIR,—I was interested in the letter from Drs. J. N. Brown and A. Polak (13 January, p. 108). I have always been dubious about squeezing the calf in such a case in order to determine whether there was a flow, and recently I have been putting the cuff on the foot. This enables detection of flow to be determined either at the popliteal level or the groin without any difficulty and with the least possible danger. Squeezing the foot with the automatic cuff is to my mind a much more logical approach in the detection of deep vein thrombosis.—I am, etc.,

D. W. BRACEY

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Peterborough

Actinomycin D for Wilms's Tumour

SIR,—Although it is widely accepted that actinomycin D should be given in conjunction with surgery and radiotherapy in the initial treatment of Wilms's tumour, a number of reports have cast doubt on its value.[1-3] Stone and Williams[2] found that when it was given at and after nephrectomy seven out of 13 patients remained free of metastases, whereas 12 out of 14 remained free of metastases when it was not given.

In the entire Birmingham Region during the years 1965-9 inclusive a total of 48 cases of Wilms's tumour were registered, all in patients under the age of 15 years. Excluding two cases of stage I tumour found incidentally after accidental death, the three-year survivals free of tumour were as follows:

Patients Receiving Actinomycin D as Part of Their Initial Treatment

Stage I (tumour confined to kidney	4/9
Stage II (spillage at operation)	1/1
Stage III (residual tumour)	1/10
Stages IV and V (metastatic and bilateral ...	0/6
Stage unknown (preoperative irradiation) ...	0/3
Total ...	6/29
(Under the age of 2 years Stage I	1/2)
Stage III	0/3)

Patients Not Receiving Actinomycin D

Stage I	5/6
Stage II	1/2
Stage III	1/6
Stages IV and V	0/1
Stage unknown	0/2
Total ...	7/17
(Under the age of 2 years Stage I	1/2)
Stage III	1/2)

It can be seen that only in stage II were the results better for patients receiving actinomycin D, and the numbers here are so small as to be meaningless. In all other stages the patients receiving actinomycin D fared as badly as or worse than those who did not receive the drug.

I believe that these results, taken in conjunction with those reported by the authors quoted above, warrant a properly controlled trial with random allocation between actinomycin D or no chemotherapy as part of the initial treatment of Wilms's tumour.—I am, etc.,

H. W. C. WARD

Queen Elizabeth Hospital,
Birmingham

1 Ledlie, E. M., Mynors, L. S., Draper, G. J., and Gorbach, P. D., *British Medical Journal*, 1970, **4**, 195.
2 Maier, J. G., and Harshaw, W. G., *Cancer (Philadelphia)* 1967, **20**, 96.
3 Stone, J., and Williams, I. G., *Clinical Radiology*, 1969, **20**, 40.

Anaesthesia by Acupuncture

SIR,—Before you relegate acupuncture anaesthesia (or analgesia) to the position of a lost cause, I wish to point out that in the original letter (5 August, p. 352), signed by four of the 10 British doctors who visited China in April 1972, we were primarily interested in having the extraordinary phenomenon of major operations under anaesthesia (or analgesia) induced by acupuncture *investigated* by a competent team of scientists. Psychiatrists could be included to make sure if only Chinese peasants or Maoists are susceptible, and to measure the level of suggestion or hypnosis.

We came to the conclusion that Chinese doctors are honest, and they freely admitted to using western drugs and tranquillizers as adjuvants when required. Dr. I. Capperauld (28 October, p. 232) describes cases of gastrectomy (which most of us did not see) in which evidently fairly large doses of adjuvants were used. On the other hand, we all saw other major operations on patients of whom some had very small doses of sedatives, but others had no sedatives at all.

There is obviously room for the whole spectrum from complete scepticism to total acceptance. The essential points are that the patients were *fully conscious*, not even drowsy, and that the *phenomenon works* in most cases. The Chinese admit that about 20% of people are unsuitable candidates. However, many patients who could not otherwise undergo major operations are able to have them and with minimal physiological disturbance.—I am, etc.,

SIDNEY HAMILTON

British High Commission Hospital,
New Delhi, India

Dangers of Diazoxide

SIR,—It is not clear from Dr. P. Kuan's letter (13 January, p. 114) whether his patient with malignant hypertension who developed skin eruptions and thrombocytopenia received diazoxide orally or intravenously. As ampoules of diazoxide for intravenous injection contain 300 mg of the drug, the stated daily dose of 500 mg suggests that the oral route may have been employed.

Both rashes and haematological reactions including thrombocytopenia have been recorded during oral diazoxide therapy for hypoglycaemia.[1-3] Although these have not so far been reported with short-term intravenous administration, the possibility of such adverse effects occurring after repeated injections cannot be excluded[4] and investigators are advised to carry out regular haematological checks where courses of diazoxide injections last more than a few days, or where continued oral therapy is used.—I am, etc.,

B. H. BOEREE

Allen and Hanburys Ltd.,
Ware, Herts

1 Drash, A., Kenny, F., Field, J., Blizzard, R., Langs, H., and Wolff, F., *Annals of the New York Academy of Sciences*, 1968, **150**, 337.
2 Wolff, F., Hirsch, E., Wales, J., and Viktora, J., *Annals of the New York Academy of Sciences*, 1968, **150**, 429.
3 Wales, J. K., and Wolff, F., *Lancet*, 1967, **1**, 53.
4 *Drugs*, 1971, **2**, 78.

Availability of Cadaveric Kidneys for Transplantation

SIR,—I was particularly interested in the paper by Mr. David L. Crosby and Dr. W. E. Waters (11 November, p. 346). Recently a survey was carried out among the staff of this hospital with regard to renal transplantation. A total of 196 persons participated in the survey (9 senior medical students, 11 doctors, 20 paramedical staff, and 156 nurses). Details of the questions and answers are published elsewhere[1]

The most interesting findings were as follows: (1) Slightly more than 50% of doctors, nurses, and medical students were willing to donate their own kidneys after death, yet 70% of the same people were not agreeable to the use of the kidneys of someone close to them for transplant purposes. Contrary to popular belief, religion did not appear to play an important part in refusal except in Muslims. The two commonest reasons put forward were fear of causing distress to the next-of-kin and a wish to be "buried in one piece." (2) All except Muslims favoured transplantation as a therapeutic procedure. (3) With the exception of doctors, none of those questioned favoured a change in the law to make it easier to obtain organs from the dead for transplantation.

I believe that this is the first survey of its kind in a developing country with a multiracial and multireligious society and its implications are important. This could possibly explain the slow progress that renal transplantation has made in this part of the world. In the final analysis, it is obvious that for any measure of success to be achieved in a transplant programme, a correct attitude of mind has to be created. This could only come about with better education and dissemination of relevant information through the mass media.—I am, etc.,

P. H. FENG

Thomson Road General Hospital,
Singapore

1 Feng, P. H., Chen, V., and Lee, Y. K., *Asian Journal of Medicine*, 1972, **8**, 395.

Management for Health

SIR,—Mr. R. J. Maxwell's distinguished paper (20 January, p. 160) makes interesting reading but does not provide evidence for his statement that "all these are unmistakable signs that management performance is poor." The N.H.S. has been kept going since 1948 in the face of many difficulties, which must indicate some success in managing. However, the main factors have been the goodwill and traditional loyalties carried forward from the long previous life of that