3 Silver, J., Neale, G., and Thompson, G. R., *Clinical Science and Molecular Medicine*, 1974, **46**, 433.
4 Kuntzman, R., *Annual Review of Pharmacology*, 1969, **9**, 21.
5 Hunter, J., *et al.*, *Lancet*, 1971, **1**, 572.
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7 Padgham, C., and Richens, A., *British Journal of Clinical Pharmacology*, 1974, **1**, 352P.

The HBAg Carrier

SIR,—Your leading article (23 November, p. 427) failed to consider the troublesome problem of the nurse who is a persistent carrier of hepatitis B antigen. At present routine tests for HBAg are done only for nurses in renal or blood transfusion units. At this stage they are well advanced in their careers and the knowledge that they are carriers of HBAg may subsequently limit the scope of their professional work.

I suggest that it might be worth while to screen every nurse for HBAg carriage on entry to the nursing profession. At this time blood specimens are often collected from nurses for assessment of immunity to rubella; such specimens would also serve for HBAg tests. Any entrant found to be a carrier of HBAg might then be advised to discontinue nursing as a career.—I am, etc.,

CONSTANCE A. C. ROSS

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Poisoned Children

SIR,—We would like to echo the concern expressed by Dr. J. R. Sibert (26 October, p. 231) regarding the letter from Mr. M. Calnan (28 September, p. 802) in which he criticizes the current concern over the high rate of poisoning in children as being alarmist and implies that many of the admissions to hospital for this cause are unnecessary. He states that over 65% of the alleged incidents were in fact "poisoning scares"—that is, no symptoms developed or the substance was relatively innocuous. He implies that parents should be educated to discern whether or not the child has taken a significant amount of a poisonous substance and hence reduce the numbers of children coming to casualty departments, and that once they arrive there the casualty officer should be much more ready to send them home without even emptying the stomach if he thinks that it is only a poisoning scare. He surely is not being realistic. It is only in retrospect that one knows that no symptoms have developed and that the poisoning scare was in fact unfounded.

In the confusion and stress of a domestic poisoning scare a parent can hardly be expected to make rational judgements, and surely any parent worried that his child may have taken a poisonous substance should be encouraged to seek medical advice. Indeed, Dr. Sibert has pointed out that there is often considerable stress in the household before the poisoning episode and this makes clear thinking even less likely. Similarly, even experienced doctors find it impossible to tell which child may develop symptoms, and those providing primary care in the accident and emergency department are perhaps the least experienced. Surely it is better to err on the side of safety and treat all cases of suspected poisoning in children as potentially serious. The attitude expressed by Mr. Calnan can surely lead only to an increase in the number of children dying each year in England and Wales.

We believe the current debate on this problem is not alarmist but fully justified and are pleased to note that after years of pressure official action is being taken to prevent some of the poisoning by tablets—that is, if the Medicines Commission's proposals[1] ever come into effect.—We are, etc.,

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Children's Department,
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1 Medicines Commission (Working Group), *Report on the Presentation of Medicines in Relation to Child Safety*. D.H.S.S., 1974.

More Abortions?

SIR,—Your headline "More Abortions" (30 November, p. 541) and your opening sentence about the "record number" of abortions notified in 1973 might give the uninitiated the impression that there has been a significant increase in British abortions during the past two years. This is not the case. The number of abortions carried out on British residents has remained virtually unchanged since 1972 as shown below.

Year	England and Wales	Scotland
1972[1]	108 500	7500
1973[2]	110 500	7500
1974*	111 500[3]	7000[4]

* Estimated from figures for first nine months

The increases recorded since 1972 have been very largely confined to patients coming to England and Wales from countries in Europe where the abortion law has not yet been reformed. Recently abortion law reform bills have been passed in both Germany and France, which sent us 46 000 abortion patients in 1973. These figures will certainly decline sharply next year.

Women are coming here in increasing numbers from the Republic of Ireland. A recent parliamentary reply[5] suggests that 17% more arrived here in 1974 than 1973. In addition, many more Irish women having abortions in London give local English accommodation addresses. The Irish Hierarchy is so concerned about this that a subcommittee of its council for social welfare has been asked to prepare a report on this problem. Thus it is possible that the very small increase in "resident" abortions since 1972 is in fact caused by "non-residents."

Mr. James White, M.P., in an interview in *The Scotsman* on 28 November, said he intended to obtain an amendment to the Abortion Act to keep out patients from overseas. It will be interesting to see whether he can devise a method of keeping out patients from Eire and the Common Market countries and, if so, whether the new Common Market legislation permits this.—I am, etc.,

MADELEINE SIMMS
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Eugenics Society

London S.W.1

1 *Registrar General's Statistical Review for 1972, Supplement on Abortion*. London, H.M.S.O., 1974.
2 *Registrar General's Statistical Review for 1973, Supplement on Abortion*. London, H.M.S.O., 1974.
3 *Registrar General's Weekly Returns for England and Wales*. London, H.M.S.O., 1974.
4 *Hansard*, House of Commons, 22 November 1974. Written Answers, col. 556.
5 *Hansard*, House of Commons, 25 November 1974. Written Answers, col. 83.

"Negative Pressure": a Dangerous Myth

SIR,—A commonly advocated method for the limitation of "negative pressure" in suction circuits is to interpose a bottle containing a quantity of water between patient and suction course, the inlet and outlet tubes opening above the water-level. A third tube, open to the atmosphere, is inserted through the bottle stopper and dips "H" cm below the water. It is a surprisingly common belief that the suction is now limited to "H" cm H_2O if air is bubbling through the water from the bottom of the tube. I feel this belief to be a potential source of danger to patients, particularly as I have seen the method used postoperatively in neonatal chest cases.—I am, etc.,

D. WAKELY

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near Pontypridd

"Locked-in" Syndrome

SIR,—While we feel that Dr. C. H. Hawkes (16 November, p. 379) has performed a valuable service in focusing more attention on the entity of the "locked-in" syndrome, we would like to make two further points.

(1) The motor response which permits communication in these patients is eyelid opening rather than vertical eye movement; indeed, the diagnosis is often first suggested by eye opening to verbal command.

(2) We doubt that Jennett and Plum[1] ever intended the term "locked-in" syndrome to be replaced by "persistent vegetative state." They emphasized that "locked-in" patients are "entirely awake, responsive, and sentient" in contrast to persistent vegetative patients, who are "capable of growth and development but devoid of sensation and thought."—We are, etc.,

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N. E. F. CARTLIDGE

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Royal Victoria Infirmary,
Newcastle upon Tyne

1 Jennett, B., and Plum, F., *Lancet*, 1972, **1**, 734.

Antiemetics for High-dose Cyclophosphamide

SIR,—Vomiting is a distressing and often intractable side effect of cytoxic chemotherapy. It is particularly undesirable in high-dose cyclophosphamide regimens during which a high urinary output is necessary to prevent haemorrhagic cystitis.

In children with solid tumours cyclophosphamide 1200-2000 mg/m^2 is given here over one to five days as part of cyclical combination chemotherapy protocols. During this intensive therapy promethazine hydrochloride 75 mg m^{-2} 24 hr^{-1} given intravenously 6-8 hourly has been substituted for other antiemetics in seven cases. As a result vomiting is no longer a problem and has been abolished in most of the patients. A urinary output of over 1500 ml m^{-2} 24 hr^{-1} is easily achieved and protein calorie intake, previously negligible on cyclophosphamide, is now very satisfactory.

It is not well recognized that promethazine can be given intravenously—for example, it is listed only for the oral and intramuscular routes in Wood's *Paediatric Vade-Mecum*.[1] Promethazine needs to be diluted in water and is given here over a period of an hour by further diluting it with dextrose saline. Drowsiness is a common side effect, but despite this many of the children are able to leave hospital during the day. Repeated injections are avoided by using heparin locks —after the giving set has been disconnected heparin 100 U/ml is injected into a Butterfly intermittent infusion set or, even more satisfactory, into a male adapter plug connected to a short Teflon catheter.

Advances in the style of treatment may not affect the long-term outlook, but at least the burden is made less onerous for the children and their parents.—I am, etc.,

P. J. KEARNEY

Department of Child Health,
Royal Hospital for Sick Children,
Bristol

1 Wood, B., *A Paediatric Vade-Mecum*, 8th edn. London, Lloyd-Luke, 1974.

Treatment of D.I.C. Complicating Diabetic Coma

SIR,—I share the puzzlement of Drs. G. Nicholson and G. H. Tomkin (23 November, p. 450) concerning the few occasions when diabetes mellitus is complicated by disseminated intravascular coagulopathy (D.I.C.). Furthermore, it seems to me quite possible that even in their particular case the D.I.C. had actually nothing to do with the diabetes but was the complication of "thrombotic thrombocytopenic purpura" (T.T.P.).

What I am proposing is that their patient was "incubating" T.T.P., which put a mild diabetes out of control. Therefore at presentation it was the "out of control diabetes" which dominated the clinical picture. T.T.P. is a most unfortunate choice of name, since it refers to the complication of a disease instead of the disease itself. However, by this name I mean an especially fierce haemolytic process which is characterized by a degree of red cell fragmentation which, in my experience, is rarely seen when D.I.C. complicates other diseases.

Be that as it may, Drs. Tomkin and Nicholson have done a great service by emphasizing the value of high doses of heparin in the management of D.I.C. Three years ago I witnessed the death of a 19-year-old boy who developed D.I.C. following thrombosis of the spermatic vein. He was kept on low doses of heparin in spite of advice to the contrary.—I am, etc.,

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Stourbridge, Worcs

Pneumothorax Associated with Acupuncture

SIR,—Acupuncture is occasionally used in the treatment of intractable pain in the neck, shoulder, and arm.[1] I wish to report an unexpected complication of its use in the shoulder region.

A slim 52-year-old woman developed a frozen left shoulder. As this did not respond to indomethacin or local analgesics she attended a health clinic where treatment by acupuncture was carried out. Fine solid needles (standard wire gauge 26, shaft 2 cm) were inserted in a line along the posterior aspect of the shoulder extending from the cervical spine to the acromion. On insertion of one needle she felt a severe generalized left-sided chest pain made worse by deep breathing. Four hours later she noticed that she became dyspnoeic on mild exertion. During the next two days her dyspnoea and chest pain gradually decreased, though there was no change in her shoulder pain. At the end of this time she attended this clinic and was found to have a generalized left pneumothorax which occupied one quarter of the area of the hemithorax on a postero-anterior radiograph.

It seems likely that the needle punctured the apical visceral pleura, producing a small hole which allowed the slow escape of air over a few hours.[2] This hazard of needle insertion in the supraclavicular region is well recognized by anaesthetists who perform stellate ganglion or brachial plexus block by the posterior route.[2,3] Dissections have shown that the lung apex in a thin subject may be less than 2 cm from the surface (C. S. Cairns, personal communication).

Doctors performing acupuncture in the shoulder region are warned to avoid inserting their needles to a depth of more than 0·5 cm.—I am, etc.,

B. H. R. STACK

Knightswood Chest Clinic,
Glasgow

1 Mann, F., *et al.*, *Lancet*, 1973, **2**, 57.
2 Macintosh, R., and Mushin, W. W., *Local Analgesia: Brachial Plexus*, p. 58. Edinburgh, Livingstone, 1967.
3 Macintosh, R., and Ostlere, M., *Local Analgesia: Head and Neck*, p. 132. Edinburgh, Livingstone, 1967.

Safety and Fibreoptic Bronchoscopy

SIR,—Dr. I. W. B. Grant (23 November, p. 464) has not questioned the safety of fibreoptic bronchoscopy but its adequacy in clinical practice. Our experience suggests that it is possible to undertake perfectly adequate examination with the fibreoptic bronchoscope under the same circumstances as with the rigid bronchoscope, provided one knows how to use it. Superficially this appears easy, but it is not, and as much experience is required as with the rigid bronchoscope. Furthermore, it is a dangerous assumption that an expert with the rigid bronchoscope will be equally expert with the fibreoptic bronchoscope, since the spatial orientation and maneouvring are totally different. We think there are few bronchoscopists who, because of inability to use the rigid bronchoscope, turn to the flexible bronchoscope as a soft option. If so, they are doomed to the disappointment, suggested in Dr. Grant's letter, of an inadequate examination.

With experience of nearly 200 fibreoptic bronchoscopies we find no difficulty in coping with bronchial secretions or bleeding, the small lens is perfectly easy to clean (by wiping, washing, and suction), and angulation of the tip impairs suction not at all (why should it?). In no patient has the procedure been unsuccessful because of these possible hazards. Furthermore, though the biopsy specimens are small, the positive yield with carcinoma of the bronchus has been high and the numbers missed through inadequate biopsy low and recognized.

In our hands we believe transnasal fibreoptic bronchoscopy under local anaesthesia to be relatively free from discomfort, and this view is based not only on experience with patients but also on experience with the technique on ourselves and in other centres. The simplicity of the technique, which is the key, has broadened the scope for what we term medical bronchoscopy—that is, for conditions where subsequent surgery is unlikely. It has seemed unnecessarily complicated to use general anaesthesia in all but occasional patients. We have had no complications or complaints and several patients have undergone several bronchoscopies.

We believe it is misleading to label this procedure barbarous (though barbaric it may be in inexperienced hands). We think also that it goes without saying that no procedure shuld be undertaken by amateurs, however enthusiastic, and all should be undertaken by trained personnel. It is equally important that personnel are trained by those fully conversant with the techniques of handling these new instruments, and at the moment in Britain there appears to be a dearth of those suitably qualified. The techniques of rigid and fibreoptic bronchoscopy are complementary, but the fibreoptic bronchoscope alone has opened an exciting new field, the possibilities of which should not be underestimated.—We are, etc.,

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Advertising Consultant Posts

SIR,—The Medical Executive Committee of the Enfield District Hospitals wish to express their grave concern on one aspect of the Appointment of Consultant Regulations 1974, notified to us in Department of Health and Social Security Circular HSC(IS)24.

From this circular it appears that the Secretary of State is able to dispense with the requirement to advertise consultant posts. This is a retrograde step of the very first order. It has been one of the strengths of the hospital service, before and since 1948, that senior medical staff have a voice in the appointment of their colleagues. This results in ready acceptance of new colleagues and makes for smooth working within the hospital service. The system appears to have worked well and the reason for the change is not apparent.

In correspondence with the B.M.A. secretariat we learn that the B.M.A. has had a meeting with the Department and has told them that in only very exceptional circumstances would there be agreement to appointments being filled without advertisement, and in any event there should be consultation with the profession before such action is taken. The object of this letter is to alert the profession to yet another restriction on our professional freedom, creeping in almost unnoticed in the small print of the massive piles of paper with which we are continually bombarded by the D.H.S.S.

Incidentally, a letter of protest to the Department, sent by me on 19 September, was acknowledged on 24 September and I was promised that "a further reply will be