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.,

A. B. WEBER

Department of Haematology,
Corbett Hospital,
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

Knightwood 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 Fiberoptic Bronchoscopy

SIR,—Dr. I. W. B. Grant (23 November, p. 464) has not questioned the safety of fiberoptic bronchoscopy but its adequacy in clinical practice. Our experience suggests that it is possible to undertake perfectly adequate examination with the fiberoptic 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 fiberoptic bronchoscope, since the spatial orientation and manoeuvring 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 fiberoptic 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 fiberoptic 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 should 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 fiberoptic bronchoscopy are complementary, but the fiberoptic bronchoscope alone has opened an exciting new field, the possibilities of which should not be underestimated.—We are, etc.,

S. W. CLARKE
R. K. KNIGHT

Brompton Hospital,
London S.W.3

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

sent as soon as possible." This reply is still awaited, three months later.—I am, etc.,

HAROLD CAPLAN

Chairman,
Medical Executive Committee,
Enfield District Hospitals

London N.21

Knocking the B.M.A.

SIR,—As a constant "knocker" of the B.M.A., I hope that you will allow me to reply to Dr. C. D. Campbell's letter (21 December, p. 722).

I am a member of the B.M.A. with an attendance record at divisional and branch council meetings second to none. I have proved to my own satisfaction that it is impossible to influence the Establishment by constitutional means. I am sad about this National Association of Doctors in Practice.

Many moons ago the Establishment, aware of the way things were going, chose to wait for truth to dawn on the grass roots (always too late!) rather than to lead. The cold hard facts are that when shops are reporting a trebling of Christmas spending my family is cutting down and, when compared with last year, there has been a 26% increase in basic wages I have made a loss. The record of the B.M.A. in protecting its members'

because there is little alternative to the B.M.A., though I have hopes for the financial interests in recent years is catastrophic, and two of my G.P. colleagues with at least average lists are making less than well-paid bricklayers.

I am sadly but sincerely driven to the conclusion that resignation from the B.M.A. will do more to bring action from the Establishment than any amount of tub-thumping and, short of a sudden miraculous change, I shall resign in the near future.—I am, etc.,

F. W. B. BREakey

Gateshead

SIR,—Ever since I qualified I have worked full-time for the National Health Service and am not interested in private practice. For more than 20 years I have waited for the B.M.A. to negotiate a decent contract for me and others like me and stop fighting a rearguard action for private practice at my expense. I am not waiting any longer; if the B.M.A. does not learn this time, within five years it will be replaced in serious negotiation by the Association of Scientific, Technical and Managerial Staffs.—I am, etc.,

J. TUDOR HART

Port Talbot, Glamorgan

food prepared with wheat starch. I certainly do not tolerate it, and, like several other coeliacs whom I know personally, have limited myself entirely to rice, maize (corn), potato starch and flour, buckwheat, sago, and tapioca with good results. . . .

Silver Nitrate on Orange Sticks

Mr. N. F. KIRKMAN (Withington Hospital, Manchester) writes: I have found orange sticks tipped with silver nitrate to be most useful in the cauterization of small sinuses in general surgical and especially in proctological work. For some reason these useful adjuncts to a surgical outpatient clinic seem to have disappeared. I write this note in the hope that manufacturers will reconsider introducing them.

Vaccination without Tears

Colonel H. GALL (Richmond upon Thames) writes: As one who has served many years in India I read Dr. C. J. Burns-Cox's Personal View (14 December, p. 651) with special interest. But why frighten ignorant people, or anyone else, by unnecessarily sticking needles into them? I have always performed vaccination with the wooden cherry stick used in cocktails; a match stick, of course, does equally well. The end is dipped into the lymph and then rubbed lightly for 2-3 seconds on each spot chosen to bear a vesicle. In non-immunes three perfect vesicles always develop. . . .

Total Commitment

Mr. P. H. SMITH (Leeds) writes: It seems to me that a total commitment payment is likely to mean just what it says and, as such, is likely to limit the ability of any doctor to receive fees for any service provided. This could have the most important influence not on the part-time consultant's income but on the full-time consultant's income since if my reasoning is correct it may no longer be practicable for full-time consultants to provide medicolegal reports and to appear in court since they will be "totally committed" elsewhere. . . .

V.A.T. and the G.P.

Dr. J. R. CLAYDEN (Holmfirth) writes: Were I a butcher, a baker, or a candlestick maker I should be able to recoup V.A.T. on my petrol, car repairs, and telephone bills. Because I am a mere general practitioner I am not even eligible to register in order to reclaim this. What a sad reflection on our negotiators, who should have foreseen the possibility of swingeing increases in V.A.T. areas affecting the profession and ensured that we were placed in the same category as other tradesmen whose need for both car and telephone could never be a matter of life or death. In the coming year our practice of five doctors will offer the Government the present of £1000 plus in V.A.T. A small percentage of this will eventually find its way back to us in tax relief one year later. In any other kind of business we would recover the whole sum and still gain tax relief on the remainder. . . .

Points from Letters

Is Salmon a Scapegoat?

Dr. G. B. STENHOUSE (Morpeth) writes: Your statement (7 December, p. 550) that "the days of dedicated spinster have gone for ever" is far too sweeping a generalization and can cause unhappiness and offence. From my own experience I know that the "dedicated spinster" is very much a reality. You will find her in any Roman Catholic nursing home and she sets an example of unselfish devotion that could be an example to many.

Endoscopy without Sedation

Dr. W. S. C. CHAO (Prince of Wales's General Hospital, London N.15) writes: Upper gastrointestinal tract endoscopy is an important investigative technique which is usually performed with opiate premedication or intravenous diazepam. This sedation appears to be unnecessary and to have disadvantages. My endoscopy technique was learnt in Japan. The only drug used is a lignocaine throat spray. The patient walks into the clinic, gets on to the table, and his throat is sprayed with lignocaine. Endoscopy is completed. The patient walks from the table and returns to work. No escort is needed and car-driving is not contra-indicated. Over the past four years in England I have performed over 1000 examinations without any complications. . . .

Imipramine Poisoning: Survival of a Child after Prolonged Cardiac Massage

Dr. IAN RAMSAY (North Middlesex Hospital, London) writes: The report by Drs. D. P. Southall and S. M. Kilpatrick (30 November, p. 508) emphasizes that patients who

have a low cardiac output due to tricyclic poisoning should have cardiac massage carried out for long periods before resuscitation is abandoned. I reported¹ the case of a 14-year-old girl who had taken 2500 mg of imipramine. On admission she had ventricular tachycardia. Sinus rhythm was restored with intravenous propranolol but the blood pressure could still not be recorded. External cardiac massage produced a good arterial pulse and a blood pressure of 60/0 mm Hg. Whenever cardiac massage was stopped pulse and blood pressure became unrecordable and the pupils dilated. The external cardiac massage was continued for five hours, after which she was able to support herself with a pulse of 136/minute and a blood pressure of 50/0. She made a full recovery though there was evidence of cellular death in many epithelial tissues.

¹ Ramsay, I. D., *Lancet*, 1967, 2, 1308.

Gluten Content of Wheat Starch

Dr. CECILIA LUTWAK-MANN (Cambridge) writes: May I . . . draw attention to what may not be generally known by either general practitioners or coeliac patients—namely, that the so-called gluten-free wheat starch used in this country as the main flour substitute for baked goods, etc. is not really gluten-free? In fact it contains up to 1% of residual gluten. The manufacturers, on inquiry, told me that to remove all gluten would mean a great deal more work for their chemists and high cost to patients. This is not a valid excuse in view of the cumulative effect that exposure to small amounts of gluten is almost certain to cause, especially in the very sensitive patients who tend to consume rather large amounts of