safety in dentistry. As an additional safety factor may I make the plea for adequate oxygenation from the outset monitored as described? I feel certain that virtually all anaesthetic deaths would then be avoidable. I should add that I have acted as operator anaesthetist for many years, after 1500 cases originally carried out with a consultant anaesthetist (1961-3). Any prolonged or difficult case assessed as being out of my scope as an operator-anaesthetist has always been referred for a consultant's help.—I am, etc.,

DAVID FORMAN

Hove, Sussex

Epanutin and Isoniazid Interaction

SIR,—The hazards of interactions between different groups of drugs are becoming increasingly recognized.¹ Interaction between antiepileptic drugs and antituberculosis drugs, particularly isoniazid, has been well documented in the American literature² but does not seem to be widely recognized in this country. A recent death associated with this interaction reported in the press prompts me to report the following case where the interaction was fortunately recognized.

A 30-year-old chronic epileptic woman had been treated with epanutin 100 mg three times a day and phenobarbitone 60 mg three times a day for 12 years. She had episodic postictal confusional states and had been admitted to a psychiatric hospital on five occasions. During the last admission she was found to have apical tuberculosis. Isoniazid 300 mg, rifampicin 600 mg, and ethambutol 1200 mg were given daily in addition to antiepileptic drugs. After three days her consciousness became clouded, she was unable to stand, and she exhibited bizarre postural and semi-purposive movements of her limbs. Over the next seven days her level of consciousness deteriorated further and she became hypertensive, hyperglycaemic, and showed evidence of hepatotoxicity. All medication was stopped as the patient was thought to be suffering from rifampicin toxicity. She then began to improve, the level of consciousness lightened, she was able to walk, and liver function tests returned to normal. Antituberculous drugs were again given, substituting streptomycin for rifampicin. The E.E.G. by this time showed continuous "spike and wave" activity and in view of the possibility of status epilepticus anticonvulsants were restarted. After three days consciousness again became clouded, the patient became ataxic with slurred speech, and was unable to stand. (serum epanutin 4.9 mg/100 ml). The possibility of an epanutin toxic encephalopathy due to interaction between epanutin and isoniazid was now recognized. Antituberculous drugs were stopped and the anticonvulsant regimen changed to carbamazepine 200 mg daily and ethosuximide 250 mg three times a day. The E.E.G. became normal and serum epanutin levels fell to zero over the next 12 days, paralleling her continuous improvement. Since then she has been admitted to a tuberculosis hospital where antituberculous drugs have been restarted with no complications.

The development of epanutin toxic encephalopathy from doses within the normal therapeutic range was in this case thought to be due to interference in the biotransformation of epanutin in the liver by the simultaneous administration of isoniazid. While hepatotoxicity due to rifampicin may have been partly responsible for the first episode of epanutin toxicity isoniazid was clearly responsible for the second. Antituberculous drugs, particularly isoniazid, should be avoided in epileptics who are taking hydantoins unless epanutin levels can be measured daily. A rise of serum epanutin to toxic levels indicates that an alternative anticonvulsant regimen is neces-

sary. Wider recognition of this dangerous interaction between hydantoins and isoniazid is clearly necessary.—I am, etc.,

JOHN JOHNSON

Department of Psychiatry,
Withington Hospital,
Manchester

- ¹ Hansten, P. D., *Drug Interactions*, 2nd edn. Philadelphia, Lea and Febiger, 1973.
- ² Woodbury, D. M., Penry, J. K., and Schmidt, R. P., *Antiepileptic Drugs*. New York, Raven Press, 1972.

Oats and Coeliac Disease

SIR,—The letters from Dr. P. G. Baker and Mrs. Elizabeth Segall (7 December, p. 588) both betray a lack of appreciation of the fact that gluten intolerance is no more a standard disease than is diabetes. Some people with gluten intolerance are able to ingest all cereals other than wheat and rye with perfect comfort; those more sensitive have to exclude oats and barley as otherwise they are ill.

As it is possible that gluten intolerance is in fact an intolerance to one or more of the polypeptides of glutamine, and as these are widespread throughout the vegetable world, it is easily understandable that some coeliacs have to exclude a much wider range of foodstuffs than those normally accepted. Maize and its derivatives liquid glucose and corn oil, onions, green and red peppers, peanuts and groundnut oil, the bean group, including coffee and cocoa beans, and tea are some of the more exotic intolerances.

The essential factor in dealing with a coeliac (of whom I am one) is that he or she should be totally well. If there is flatulent dyspepsia, heartburn, steatorrhoea, abdominal or chest pain, or skin lesions (embracing dermatitis herpetiformis and particularly including perianal soreness or eczema), if there is poor bladder control with frequency, urgency, precipitancy, or stress incontinence, or if there is headache, irritability, bad temper, bloody-mindedness, depression, or insomnia, then the dietary exclusions for that particular person are inadequate.

The failure to respond to treatment noted in some cases by Dr. Baker is a clear indication that dietary control is not adequately strict. It must also be borne in mind that a coeliac suffering from stress will have a poorer tolerance than normal. A coeliac on holiday with no worries and no stresses will have a better tolerance than he normally does. In conclusion, if your coeliac is well, his diet is adequate. If he is unwell his diet, however official, is not adequate for him.—I am, etc.,

DUNCAN MILNE

Surbiton, Surrey

Cardiovascular Disease and Peptic Ulcer

SIR,—In your leading article on the association between cardiovascular disease and peptic ulcer (28 September, p. 760) you cite the article by Brooks *et al.*¹ in support of your statement that "patients with coronary artery disease have a somewhat greater than average frequency of peptic ulcer, particularly duodenal ulcer." In fact, these authors stated that there was a "relatively small but statistically significant increase in incidence

of coronary occlusion at necropsy in patients with duodenal ulcer." They accepted that there might be common aetiological factors, but were mainly concerned that diets high in fat content used in the treatment of peptic ulcer might be contributory to the increased incidence of coronary occlusion. This possibility was not considered in your leading article.

Sandweiss *et al.*² had earlier reported that the incidence of coronary occlusion was higher in ulcer patients treated with a Sippy diet than in those not so treated. Even more convincing was the investigation carried out at 10 hospitals in the U.S.A. and five in Britain reported by Briggs *et al.*,³ who found that ulcer patients treated with milk diets had double the frequency of myocardial infarcts compared with those not so treated and with non-ulcer patients.

Other published findings also suggest that milk may be a factor in causing ischaemic heart disease.⁴⁻⁷ In my practice, of the last 14 patients who sustained an acute myocardial infarct, nine admitted to a daily intake of milk of one pint (0.6 l) or more.—I am, etc.,

J. J. SEGALL

London N.W.2

- ¹ Brooks, F. P., Sandweiss, D. J., and Long, J. F., *American Journal of Medical Sciences*, 1963, **245**, 277.

- ² Sandweiss, D. J., *et al.*, *Sinai Hospital of Detroit Bulletin*, 1961, **9**, 188.

- ³ Briggs, R. D., *et al.*, *Circulation*, 1960, **21**, 538.

- ⁴ Annard, J. C., *Journal of Atherosclerosis Research*, 1967, **7**, 797.

- ⁵ Annard, J. C., *Atherosclerosis*, 1972, **15**, 129.

- ⁶ Davies, D. F., *American Heart Journal*, 1971, **81**, 289.

- ⁷ Davies, D. F., *et al.*, *Lancet*, 1974, **1**, 1012.

Thrombolytic Therapy in Haemolytic-uraemic Syndrome

SIR,—Dr. E. Ekert (30 November, p. 533) states that children with renal failure caused by the haemolytic-uraemic syndrome should not be assessed for prolonged periods while receiving conservative treatment before they are selected for anticoagulant or thrombolytic therapy. No one would disagree with this and we are not aware of any publication which suggests it. Dr. Ekert also restates the point made in our paper (27 July, p. 217) that the efficacy of thrombolytic therapy should not be evaluated on mortality during the acute phase but on its ability to prevent long-term residual renal abnormality.

One difficulty is that in many parts of the world, including the United Kingdom, children are not referred as soon as they might be to specialist centres with facilities for dialysis. Until this situation is corrected anticoagulant and thrombolytic therapy will continue to be given at a relatively late stage of the disease. Secondly, in children not given streptokinase the high incidence of residual renal abnormality found in the Argentine (52%)¹ and in Australia (41%)² was not observed in California (9.5%).³ Differences such as these render the comparison of treatments used in different centres virtually meaningless.

The relative merits of anticoagulant and thrombolytic agents cannot be assessed in uncontrolled series employing retrospective comparison with the results of previous years but should be studied under randomized trial conditions. It will be the responsibility of participants in these trials

to encourage early referral of patients with acute renal failure so that fibrin deposition does not progress to a degree which results in irreversible renal damage. Early referral for dialysis may prove to be an equally effective, less hazardous, and cheaper form of therapy than the administration of streptokinase.—We are, etc.,

J. STUART
R. H. R. WHITE

Children's Hospital,
Birmingham

- ¹ Gianantonio, C. A., et al., *Nephron*, 1973, 11, 174.
- ² Powell, H. R., and Ekert, H., *Journal of Pediatrics*, 1974, 84, 345.
- ³ Tune, B. M., Leavitt, T. J., and Gribble, T. J., *Journal of Pediatrics*, 1973, 82, 304.

Strike Action in Hospitals

SIR,—After the industrial action of 1 March 1973 it became obvious that the traditional hospital we knew as a self-contained, disciplined community had vanished from the scene, possibly for ever. Previously, concerted action to disrupt the life of a hospital would have been regarded as totally incompatible with the care of the sick. Yet, profiting by a general devaluation of authority, everywhere evident and fostered in hospitals in particular by an increasing proliferation of administrators and committees accompanied by a corresponding loss of effective leadership and capacity for decision, the unions were able to submerge the larger issue of principle under a propaganda barrage about pay claims in themselves deserving enough, and thus to dictate one more decision contrary to the wishes of the majority of their countrymen. Hospital relationships cannot, however, be equated with those of the shop floor.

It is therefore disquieting that the current negotiations should be almost exclusively concerned with the interests of the profession rather than devoted to a reappraisal of the hospital service as a whole and the severe malaise affecting it. To broaden these discussions now might go some way to redeem the weak public position into which, inevitably, a policy of sanctions is leading the profession. Unless lost discipline, the spirit of service, and mutual respect can be restored our hospital communities, already drifting leaderless, will slide progressively into anarchy or become wholly union-dominated.

To stop the clock of collective bargaining backed by strike action, once established, may seem at first unrealistic; nevertheless there are precedents to suggest that hospitals could be seen as a special case and a plan worked out to satisfy all interested parties. In the police force, for instance, union membership is strong but strikes are forbidden, for reasons no less compelling in the public interest than those applying to hospitals. The setting up of a permanent pay-review structure for all hospital personnel, non-politically aligned and controlled, perhaps in conjunction with a single union open to all grades of staff committed to a policy of bargaining without striking, could form the basis of a scheme which would be acceptable to an overwhelming majority of present staff whose primary loyalties remain firmly attached to the hospitals in which they serve.—I am, etc.,

EDWARD SMYTH

Brook, Isle of Wight

Interim Pay Review

SIR,—Many general practitioners will be angry that the General Medical Services Committee has accepted Mrs. Barbara Castle's reassurances and called off the threatened sanctions. Her reassurances give no guarantees and mean nothing. Already the Chancellor of the Exchequer is re-writing the social contract, paving the way to further wage restraint. The B.M.A. should have insisted on the interim award or carried out its threat of imposing sanctions. It will soon regret it did not do so. Its threat of mass resignations is also an empty one, and unnecessary.

Sanctions now, such as refusing to issue certificates of sickness, would have done far more to convince the Government of the G.P.s' determination. I suspect that many G.P.s are not convinced that the Review Body is independent. Lord Halsbury's alleged remarks that led to his resignation have left doubts. The profession has also been successfully divided by Mrs. Castle's arrogance to the consultants and charm to the G.P.s and junior doctors. It is sad to see that our gentlemanly negotiators are no match.

It seems likely that the Government will soon be seeking massive loans from bankers abroad. Like all bankers, they will impose certain conditions. I suspect the first will be a wage freeze. What will Mrs. Castle's assurances mean then? Or the threat of resignation? Instead, our patients will be wailing, "Where have all the doctors gone?" —I am, etc.,

M. S. SWANI

Birmingham

SIR,—So that is it! The "independent" Review Body and the Government have decided that we are worth only 7% increase to counteract inflation from April 1973 to April 1974.

Ever since 1966 the profession has been subject to government restrictions on negotiations through the various freezes, squeezes, and stages. Doubtless they feel that by refusing an interim award now they can appear generous in April by offering about 20%, thereby short-changing the profession by a similar amount.

After this slap in the face surely the time has come to say to the Government that we are no longer prepared to subsidize the N.H.S.; that if they cannot pay for a health service then the patients must contribute directly; that all doctors, whether full-time or part-time employees of the N.H.S., have the right to do as they wish with their off-duty time—whether they choose to see private patients or play golf is no concern of the Government.

We must forget about petty sanctions such as refusal to sign certificates, and implement stage II of the B.M.A. sanctions plan by immediate resignation from the Health Service and charging per item of service.

Our patients are much better protected from genuine hardship than they were in 1948, with the much wider range of social security benefits now available, and despite pleas of poverty still manage to spend £300m. a year on gambling and vast amounts on tobacco and alcohol. I cannot help but feel that a pound each way on their health

when required would prove a better investment.—I am, etc.,

J. R. H. HEAP

Fakenham, Norfolk

SIR,—The following resolution was passed by this Division at a recent meeting.

"That this Committee accepts with dismay the Supplement to the Fourth Report of the Review Body. It asks the B.M.A. to seek an undertaking from the Review Body that a definite decision on an increase in remuneration be made by 1 April 1975 and further asks that the Government publish this report with their decision by such date. If these requests are not met then sanctions should be imposed as from 1 April 1975."

We hope that the problems with the Review Body and those of the consultants' and junior hospital doctors' contracts will be kept as entirely separate issues.—I am, etc.,

A. F. CRICK

Honorary Secretary,
Medway and Gravesend Division, B.M.A.

Gravesend

SIR,—We, the undersigned general practitioners of the Isle of Sheppey, are becoming increasingly concerned about the rapidly rising costs of running our practices. Heating and lighting charges have increased by about 20%, telephone costs by about 30%, and petrol costs by even more. Practice maintenance and car replacement expenses have also increased greatly in the last year as have employment of locum fees. Such increases in allowances for practice expenses as we have received are, in our experience, inadequate to meet these extra essential costs. We understand that a large increase in insurance stamp charges for "self employed" doctors is coming in April.

The tragic state of the country's economy is appreciated and doctors have made their contribution to help by accepting relatively small increases in income in comparison with other working groups of the population. However, we consider that it is not a tenable situation that we continue to subsidize a family doctor service which it would seem that the country cannot afford.

We are sending a copy of this letter to our local medical committee and district management committee. We hope that other doctors who share our concern will write to you and to their local committees. In this way it is hoped that something will be done soon, either to help us with these increasing costs in administering our practices or to alter our terms of service so that a less full and more realistic cover can be offered to our patients.—We are, etc.,

A. MADWAR
Chairman
M. AHMED
R. M. BEST
B. W. BETTERTON
H. C. BOURKE
L. COOK
R. T. D. FITZGERALD
S. K. HARON

M. F. MCNAMARA
J. C. H. NICHOLAS
H. M. A. NOBLE
F. RAO
S. SHARIFF
D. S. UPPAL
J. WYLIE
D. A. YOUNDALE

Isle of Sheppey,
Kent

SIR,—We, the undersigned general practitioners of Leek, wish to record our dissatisfaction and disillusionment with our