The General Practitioner and Neonatal Care

SIR,—Apropos my colleague Dr. Gareth Lloyd's interesting article on the new role of the general practitioner in obstetrics (11 January, p. 79), it is perhaps worth pointing out that an important aspect of obstetric care is that of the baby.

Near-universal hospital delivery and early discharge has created a situation in which babies come under the care of G.P.s at home at an age when quite a number of difficult and potentially serious problems may not have become manifest, quite apart from the possible role of the G.P. in resuscitation should home delivery again become the mode.

The Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners are both aware of the need for better training of general practitioner obstetricians, and indeed all G.P.s, in the care of the newborn infant, which until recently had come to be regarded as the province of the consultant paediatrician. The main preoccupation of obstetricians has shifted from maternal mortality and morbidity to perinatal mortality and morbidity and an increased emphasis on the newborn would seem appropriate as regards training. The creation of appropriate training posts would have the additional merit of improving what is at present a rather haphazard and thinly manned resident service.—I am, etc.,

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Charcoal Haemoperfusion in the Management of Severe Poisoning

SIR,—Dr. J. A. Vale and others (4 January, p. 5) have demonstrated the role of haemoperfusion through coated charcoal in cases of severe poisoning. The Royal Infirmary, Sunderland, admitted 937 cases of self-poisoning between January 1973 and December 1974, including 62 patients with glutethimide poisoning, five of whom were severely poisoned, in grade 4 coma, with blood levels ranging from 188.6 $\mu\text{mol/l}$ (4.1 mg/100 ml) to 345 $\mu\text{mol/l}$ (7.5 mg/100 ml). Blood levels in excess of 138 $\mu\text{mol/l}$ (3 mg/100 ml) carry an associated mortality of 50-60%^{1,2} from cerebral or pulmonary oedema and hypotension. We have therefore combined haemodialysis and haemoperfusion in treating all patients with a blood level exceeding 138 $\mu\text{mol/l}$ who were in grade 4 coma.

A Cordis Dow capillary fibre dialyser with a surface area of one square metre was used in series with a perfusion column containing 150 g of 1% acrylic-coated activated charcoal. All five severely poisoned patients completely recovered without complications. The most interesting feature was the rapid lightening of consciousness from grade 4 coma to grade 2 within two hours. The treatment was not prolonged beyond two hours. All the patients were fully conscious within 30 hours. Glutethimide levels after two hours perfusion/dialysis are shown in the table. Blood-flow rates ranged from 170-220 ml/min assessed by bubble transit times. This arousal correlates poorly with glutethimide levels and raises the possibility that intermediate metabolites of glutethimide may be removed by perfusion. Others have noted³ a poor correlation between blood glutethimide levels and the depth of coma and complexity of the clinical course.

Our therapy differs from the Guy's Hospital regimen in that, like Chang,⁴ we use short treatment times and a dialyser is incorporated in the circuit, as in Rosenbaum's⁵ perfusion system. A dialyser is essential for ultrafiltration purposes should there be any pulmonary oedema.—We are, etc.,

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Problem of the Dangerous Offender

SIR,—We read with interest Dr. P. D. Scott's recent article (14 December, p. 640) and would like to endorse a number of the points he makes. We particularly sympathize with his concern about the problems confronting this very underprivileged group of patients and echo his plea that the practice of forensic psychiatry be unified within the N.H.S. Dr. Scott was a member of the 1961

Working Party on Special Hospitals which foresaw the current difficulties and recommended regional diagnostic and treatment centres for patients presenting special difficulty. He now argues that the Butler Committee should acknowledge the special place which the prisons should have in the treatment of dangerous offenders. This is again something we would endorse. However, we feel it is only right that we should point out that his article has been overtaken by the Butler Committee's interim report.¹

The Butler Committee has recommended that the new N.H.S. units should not take aggressive psychopaths and patients immediately dangerous to the public, but so far it has made no suggestions about the containment of dangerous patients. Presumably recommendations about these will follow in the final report and Dr. Scott's suggestion will no doubt be under active consideration. The interim proposals also emphasize that the units in the N.H.S. should take both offenders and non-offenders.

The 1961 working party recognized that if the trends towards a completely open door system gained momentum very difficult problems would be created in the mental health sector. This has now happened and we believe that, if properly developed and managed, these new units will go some way towards redressing the balance. Dr. Scott suggests that new N.H.S. units will not relieve the overcrowded special hospitals, but again his paper could not take the Butler proposals into account. The difficulty in the special hospitals has been twofold. Firstly, they have been taking patients who do not require maximum security, simply because almost no secure facilities exist in parts of the N.H.S. Secondly, they have had difficulty in discharging recovered patients to peripheral hospitals. The new units would facilitate both admission and discharge of patients and, furthermore, they would form the basis of the real answer to the situation, a co-ordinated forensic and intensive care programme for each region. Such a regional programme would include regional and local intensive care units. It would ensure close collaboration with the special hospitals and with community care services. It would be closely connected to (preferably amalgamated with) the prison medical services. Co-ordinated and comprehensive forensic services can be established only if there is parallel development within the prison system and within the N.H.S.—We are, etc.,

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Effect of Combined Haemodialysis and Haemoperfusion in 5 Cases of Severe Glutethimide Poisoning

Case No.	Glutethimide					Fully Conscious After:
	Clearance (ml/min)	Blood Levels (μmol/l)				
		Before Treatment	After 2 Hours	After 13 Hours	After 14 Hours	
1	66 (column only)	225.4	101.2	128.8	—	2 hours
2	120 (column + dialysis)	188.6	115.0	—	115.0	10 "
3	104 (column + dialysis)	225.4	96.6	—	—	11 "
4	83 (column + dialysis)	345.0	220.8	—	202.4	30 "
5	—	289.8	184.0	—	—	24 "

Conversion: SI to Traditional Units
Glutethimide 1 $\mu\text{mol/l}$ $\approx$ 0.0217 mg/100 ml.

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¹ Home Office and Department of Health and Social Security, *Interim Report of the Committee on Mentally Abnormal Offenders*, Cmd. 5698. London, H.M.S.O., 1974.

SIR,—Many points made by Dr. P. D. Scott (14 December, p. 640) are borne out by our experiences in treating (often the same) alcohol- or drug-dependent offenders in psychiatric hospital, outpatient clinic, or prison.¹ Frequently the permissive regimen of hospital units proves too difficult for these often very unstable, inadequate, and insecure