Thirdly, although in student teaching circles it is prudent to appear conservative about the use of heparin, I do not think that philosophical reasoning should determine the management of individual patients. If it was worth the effort of doing detailed coagulation studies it would surely have been logical to do something about the findings.

Fourthly, someone has to explain that both staphylococcal alpha toxin and the coagulase are powerful procoagulant substances that are known to cause both intravascular coagulation and acute renal failure. Staphylococci also cause tissue destruction by release of lipase, hyaluronidase, collagenase, deoxyribonuclease, and leucocidins.

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¹ Powell, D E B, *Journal of Pathology and Bacteriology*, 1961, 82, 141.

Post-alcoholic hypoglycaemia in a child

SIR,—We would like to draw readers' attention to the dangers of alcohol-induced hypoglycaemia in children. Coma, convulsions, and death have all been documented,¹ but it is possible that post-alcoholic hypoglycaemia is not well recognised as only three cases have been reported in the UK in the past six years.²⁻⁴ The mechanism is thought not to be dose-related¹ but due to the suppression of gluconeogenesis by a reduction in the ratio of oxidised to reduced nicotinamide adenine dinucleotide produced in the metabolism of alcohol.¹ The fall in blood glucose is exacerbated if the hepatic glycogen stores are already depleted by fasting.¹ The child who takes alcohol while fasting is therefore most vulnerable.

Early one morning a 3½-year-old boy gained access to the family drinks cabinet. His parents found him at 10.30 am lying on the sofa in a pool of vomitus. His speech was slurred, he was giggling, and he was unsteady on his feet. Two nearly empty brandy bottles were found on the floor nearby. They had been full the previous evening.

He was admitted to this hospital at 12.30 pm, where he was found to be of normal stature for his age and smelling strongly of brandy. He was drowsy and responded only to shaking and shouted commands. At 2 pm the ward staff noticed that his respiration had become shallow and increased to 40/min. He was peripherally cyanosed and was given oxygen via a face mask. At the same time it was noticed that he was comatose and responded only to painful stimuli. At 4 pm he began to have facial twitching and intermittent clonic jerks of his limbs. His pupils were dilated and his eyes deviated to the right. The results of investigations performed at 2 pm were: blood sugar 0.6 mmol/l (10 mg/100 ml); serum sodium 142 mmol(mEq)/l; serum potassium 2.5 mmol(mEq)/l; blood urea 6.5 mmol/l (40 mg/100 ml); pH 7.19; P_{O_2} 13 kPa (97 mm Hg); P_{CO_2} 4.9 kPa (36.6 mm Hg); standard bicarbonate 15 mmol(mEq)/l.

A diagnosis of alcohol-induced hypoglycaemia was made and he was given 50 g of glucose by intravenous infusion. His comatose state was rapidly reversed and he was able to sit up and respond to simple questioning. Further recovery was swift and uneventful.

Alcohol can cause dangerous hypoglycaemia in children. If confronted with the management of a child who has ingested alcohol one should assume that hypoglycaemia is inevitable and glucose drinks should be given prophylactically. If the child is unconscious rapid infusion of 50% dextrose is the treatment of choice. Whatever the course of action

taken, it is mandatory to regard the situation as serious.

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¹ Madison, L L, *Advances in Metabolic Disorders*, 1968, 3, 85.

² MacLaren, N K, Valman, H B, and Levin, B, *British Medical Journal*, 1970, 1, 278.

³ Heggarty, H J, *British Medical Journal*, 1970, 1, 280.

⁴ Gillam, D M, and Harper, J R, *Lancet*, 1973, 1, 829.

Brief and clear

SIR,—There comes a time in one's life when it is wise to pause and think. Should one go on with masks, tubes, and shots in the arm to put men to sleep so that the knife can cut and heal their ills? Or should one cease to try and keep up with the march of this craft which is based on both art and science?

If the last choice is made one has more time to read; but how can one read and learn from books when more words than not are long and may take a whole line to print? It is, of course, true that some terms used in science are long, but some seem to be made long and hard to grasp just for the sake of their length and to show the great skill of the scribes who write them.

The Great Physician once said, "The Son of man is come to seek and to save that which was lost." These words are few and short, but what a wealth of peace and joy they can bring to those who heed them.

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Improving the hospital service?

SIR,—The article by Dr J F Murray (28 February, p 507) purports to compare a Dutch and a British peripheral hospital and concludes with some suggestions for changes in the British NHS. Unfortunately, close examination of the article reveals a series of subjective impressions with no true comparison of hard data on either efficiency or effectiveness.

For example, the catchment population of the 240-bed Dutch hospital is only partly defined as "an expanding town of 32 000 people and its surrounding area"; the catchment population of the 350-bed British hospital is not defined at all. The fact that 160 beds in the British hospital serve "geriatric and chronic sick patients" while none of the Dutch hospital beds apparently carry out this function further obscures the comparison. Again, work load comparison is deemed "important" but is confined to the statement that "the Dutch hospital's figures were greater in 1972 for total admissions, operations, and outpatient attendance." What were the figures for the British and Dutch hospitals. By how much were the Dutch figures greater? Do Dutch clinicians keep their patients in hospital for shorter periods than their British counterparts? Has allowance been made for lower turnover in geriatric beds of the British hospital?

It is interesting that, if Dr Murray's own data on annual costs and total beds are related, the annual cost per bed in the Dutch hospital appears to be £7 500 while that of the British

hospital is £4 000, suggesting greater efficiency in the British system. One may add that, assuming that the comparative sterling figures quoted for 1972 were calculated at the exchange rate obtaining at a particular point in that year, any subsequent decline in the value of the pound is irrelevant. One further question arises—could perhaps the Dutch organisational pattern he describes, including the enhanced local autonomy he advocates, be part of the reason why, in Dr Murray's own words, "there has been overprovision of hospitals in Holland"?

One would hope that the evolution of the reorganised NHS will be influenced by overseas as well as domestic experience. Regrettably, this will not be the case if subjective impressions are preferred to objective presentation and analysis of facts.

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General practice in the Antipodes

SIR,—Lord George-Brown is reported in *The Times* (9 March, p 2) as advocating cuts in social service spending.

I have just returned from New Zealand and Australia, where I ended my visit to the Antipodes by spending four months doing locums in four busy general practices. In that time I was called out at night on only three occasions, and averaged only 1½ visits per day. Despite the fact that both countries had Labour governments there existed a punitive system of fees for both these services. Even so, I never saw anyone in my surgery who had at all suffered by not being visited at home.

Such a reduction in the time and energy spent in visiting people enabled me to deal with all the treatable casualties that arrived at the surgery. In both countries doctors are encouraged by fee-for-service payments from the Government to do this; accident victims do not themselves have to pay for this service. As you can imagine, the work load on the hospital casualty departments is considerably reduced. When visiting the local hospital I never saw a queue of any size and I was most impressed that the doctors and staff who worked there seemed more content than their colleagues in Britain.

I recall a comment I heard while doing a GP locum in England before I left when I was called out at night on what turned out to be a totally pointless errand: "I pay my taxes, and my taxes go towards paying you to visit me when I want you, doctor." If any politician asked me whether he could cut my income, reduce taxation slightly, and introduce a fee of £1 per day visit and £3 for after hours with an addition of 10p per mile paid on the spot I know what I would say.

J L OGLE

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Specialist training in thoracic medicine

SIR,—I was delighted to see the paper by Drs M G Britton and J V Collins (7 February, p 331). They make the points which have been made by others, of the need to maintain a specialist service in chest diseases within the confines of the hospital service, and perhaps this can be accepted now without any further