statements of which I have photocopies that the dentist and his chairside assistant falsely represented to the coroner that the patient was horizontal.

It would be unsound on the basis of the above six cases to decry the horizontal position. I believe that the mortality would be substantially reduced if it were adopted or if at the very least all those engaged in treating dental patients under general anaesthesia or sedation were aware of the danger of a head-up tilt and exercised extreme vigilance whenever it was used.

I would gladly go through the evidence I have collected over the years with Professor Curson and Dr Coplans.

J G BOURNE

Nunton,
Salisbury, Wilts

Laparoscopy explosion hazards with nitrous oxide

SIR,—With reference to your correspondence (27 September, p 764, and 27 December, p 760) regarding laparoscopy explosion hazards with nitrous oxide, in our experience this is not substantiated. In the last 18 months we have done some 123 laparoscopies in the Medical City Hospital, Baghdad. We have done 16 sterilisations by tubal diathermy and not fewer than 12 cases where biopsies were taken from ovaries in cases of tuberculosis or for other reasons, where diathermy was used. In all our laparoscopy procedures we always used N_2O gas because CO_2 cylinders are difficult to obtain. We did not have any incident of explosion, and most of our patients stayed in hospital not more than 24 hours post-operatively, during which time no complications were reported. None of these cases were readmitted for any complications.

It seems to us that the hazard of explosion with N_2O is more theoretical than real.

S KHUNDA
K Y GHANIMA

Department of Gynaecology
and Obstetrics,
Medical City Teaching Hospital,
Baghdad

Foresight prevents blindness

SIR,—All practising ophthalmologists will welcome the selection of blindness as the focus of attention on this World Health Day, and your leading article (3 April, p 787) on this subject was timely, but it seemed to me that there were two serious omissions from the list of major causes of visual handicap. Firstly, there was no reference to the effects of age on the human eye. The long list of retinal, choroidal, and vascular degenerative conditions which inevitably deprive the aging patient of some degree of sight can scarcely be eliminated by attention to the social and nutritional factors mentioned in your editorial. On the contrary, the greater the expectation of life the greater the expectation of visual handicap.

The other omission which I found strange is the absence of any reference to blindness from leprosy. Informed opinion assesses the number of leprosy cases today at approximately 20 million, of whom 5% or one million are blind according to the usually accepted definition. Again we have the paradox that

because of the more effective therapeutic measures currently available a far greater number of leprosy sufferers have an expectation of life not far short of those not so afflicted, but unfortunately this merely makes many of them, especially lepromatous cases, candidates for progressive ocular and orthopaedic complications. It seems to me that it is right to draw attention to these two problems. While nothing effective can be done to prevent the ocular complications of senescence this is not true of those due to leprosy. My colleague and I have repeatedly drawn attention to the importance of the early recognition and treatment of the insidious blinding iridocyclitis found in leprosy together with the steps that should be taken to protect the eye when lagophthalmos and reduced corneal sensation are present.

Hospital for Tropical Diseases,
London NW1

¹ Choyce, D P, and Hobbs, H E, *Leprosy Review*, 1971, 42, 131.

Self-help groups in the smoking problem

SIR,—As general practitioner and health visitor we have attempted on two occasions to set up self-help groups in our practice headquarters. Typewritten invitations were posted to male smokers, who were asked to come with their wives to form a discussion group.

Thirty couples were asked on the first occasion. Four couples and one unaccompanied man arrived. The dimensions and the significance of the smoking problem were carefully presented and then discussed. It was clear, however, that any further group meeting would have to be led by either the health visitor or the doctor. There were no volunteers for the position of secretary or organiser. Furthermore, it was apparent that if one of the smokers was to be appointed to be secretary he would not have the co-operation of the others. There was an impression that it was regarded as not respectable to discuss one's personal problems with other people who were not bound by confidentiality. The authority of the doctor or nurse was felt to be essential.

On the second occasion 30 invitations were sent. Five couples and two unaccompanied men arrived. The principle of group therapy was at once rejected by the meeting. Each member of the group looked at the problem from a different angle. It was pointed out that the middle class is already under considerable pressure and that there are sufficient meetings each week without adding another. "We are all busy people." Various individual reasons for not abandoning the habit were put forward and examined. It was apparent that those who had come were those with least addiction to tobacco. The meeting clearly felt that coronary disease being multifactorial in origin it was therefore illogical to concentrate on one risk factor. It was believed that all risk factors should be tackled, and this would widen the interest, appeal, and effect of any health campaign promoted by the practice. Once again there was no volunteer for the position of secretary and local activist even though it was agreed that each individual had the responsibility for his own health as well as for that of others.

Therefore the principles of self-help groups in the smoking problem seem not to be acceptable in a middle-class practice in Edin-

burgh. It was emphasised that any further meetings would require the presence of those with expert knowledge. It was felt that the campaign should be one for health in a positive sense and not against tobacco—in a negative sense. Perhaps most significant of all was the observation that the really heavily addicted people had stayed away.

Is this not, Sir, yet another example of the National Health Service doing least for those who most need its help?

DAVID ILLINGWORTH
JACKIE PEPPER

Edinburgh

SI units and blood pressure

SIR,—It was a great relief to read Professor F Gross's letter (27 March, p 772) stating that the International Society had resolved to abandon SI units in recording blood pressures. May I make a plea to go further and record it in centimetres and half centimetres. To cavil at a reading of 164/90 instead of 16.5/9 is not being scientific—it is mere preciosity.

This is of practical applicability in recent years when nurses have been trained and taught to record BP readings on bed charts when a rise to, say, 19/10 is not so alarming or disappointing to the patient as a recording in millimetres (and all patients scrutinise their charts whenever the opportunity presents itself—it would be unnatural not to do so). Surely medical science would lose nothing by this, but the art would certainly benefit.

S T H JENKINS

Aberystwyth

In defence of barbiturates

SIR,—With the recent circular from CURB (Campaign on the Use and Restriction of Barbiturates)—Are Barbiturates Obsolete? (March 1976)—I feel that it is time to rise to the defence of those much maligned drugs, which have been in continuous clinical usage since the turn of the century, and with particular regard to elderly patients.

It has long been customary to condemn the use of barbiturates in older people, and we are encouraged to prescribe the much more expensive benzodiazepines and phenothiazines instead. There is no disputing the wide field of usefulness of those drugs in treating insomnia, agitational confusion, and anxiety states in the oldish. But there are many patients who have been served very well by the time-honoured hypnotic butobarbitone (100-200 mg), while amylobarbitone (30-60 mg) remains a useful daytime sedative. There is also a very definite place for sodium phenobarbitone injections (100-200 mg) for confusional states, and it is also most useful as a supplement to pethidine and diamorphine in terminal states accompanied by pain and generalised restlessness and discomfort. Sodium phenobarbitone has the added advantage that it can be given by deep subcutaneous injection and in smaller bulk than promazine and chlorpromazine, a distinct asset in very thin old people with wasted muscles. It is also valuable where the hypotensive effect of intramuscular phenothiazines may be specially dangerous. And what of the traditional tab phenobarb and theobrom as