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.

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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 N₂O gas because CO₂ 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 N₂O is more theoretical than real.

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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.

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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 preciousness.

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.

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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

token treatment of hypertension in the elderly—if there is a need for any treatment at all in such cases? The hypotensive and diuretic effect may be minimal, but all the safer for that, and there will be none of the disturbing side effects of the more potent hypotensives that are often misused in older patients.

Of course, we must always discriminate, and treatment of old people for the conditions I have mentioned is so often a matter of trial and error. My own experience is that there is still a useful place for the humble barbiturates in geriatric practice, and not only in "anaesthesia and the management of epilepsy."

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Beta-blockers in the treatment of chronic glaucoma

SIR,—Your leading article (24 January, p 180) and the letter from Mr C I Phillips (6 March, p 584) sustain the hope of a full understanding of the constitutional factor in glaucoma and a treatment with a correspondingly high success rate.

In the meantime there is available a treatment of very appreciable utility employing Hydergine, which is claimed to impede the propagation of sympathetic nerve impulses. The effects of this preparation along with reserpine for mild control sedation are described in a paper of 1958.¹ The treatment was found effective as a general therapy for chronic glaucoma. In one respect it had a special and measurable value: it was therapeutically successful in 50% of cases unresponsive to classical treatment—including surgery.

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¹ Mackie, E G, *British Journal of Ophthalmology*, 1958, 42, 1.

Food choking and the "Heimlich maneuver"

SIR,—Your leading article on the "Heimlich maneuver" (10 April, p 855) provides a timely reminder of the need for prompt action when a foreign body has been inhaled. However, I should like to inject a note of caution regarding its use in circumstances other than the "café coronary." Other foreign bodies may be inhaled, and these may be fatal. Indeed, a young woman died in the Middlesex Hospital in 1973 following inhalation of a piece of chewing gum.¹

It is this common oral commensal which presents a particular danger to the victims of other trauma, notably racing drivers and other sportsmen. In such circumstances, the "Heimlich maneuver," apart from the risk of gastric laceration,² may aggravate other intra-abdominal damage. It would be advisable for all those likely to treat sportsmen who chew gum to be aware of this risk and to be proficient at direct visualisation of the vocal cords.

D G McLINTOCK

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¹ Scadding, F H, personal communication.

² Visintine, R E, *Journal of the American Medical Association*, 1975, 234, 415.

Varicose veins in developing countries

SIR,—It has been suggested that varicose veins were probably the commonest disorder presenting to general surgeons in Western countries and that the condition may be present in up to 50% of an adult population.¹ A detailed survey of a whole community in the USA revealed a prevalence of varicose veins of over 30% in men and over 50% in women over the age of 40 years.²

In contrast varicose veins appear to be relatively rare among traditionally living people.^{3 4} In Western countries varicose veins are almost invariably more common in women than in men, and pregnancy is assumed to be a causative factor. Five studies in India³ indicated that they were more prevalent in men.

In a university department of obstetrics and gynaecology, the legs of 1000 consecutive patients admitted for confinement were examined. In five of these there was evidence of well-established varicose veins, and six others had varicosities of a mild degree, making a total of 11 or approximately 1%. Prior⁵ studied the prevalence of varicose veins in Polynesians and found it to be related to contact with Western culture but not to pregnancy when age was taken into consideration. Guberan *et al*⁶ similarly found no relationship to pregnancy in European women when adjustment was made for age.

This raises the question whether pregnancy per se is a cause of varicose veins or whether it is merely a factor exacerbating existing venous defects. Further epidemiological studies of this nature are required to help to clarify the aetiology of such a common condition as varicose veins.

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¹ *Lancet*, 1975, 2, 311.

² Coon, W W, *et al*, *Circulation*, 1973, 48, 839.

³ Burkitt, D P, *British Medical Journal*, 1972, 2, 556.

⁴ Burkitt, D P, in *Refined Carbohydrate Foods and Disease*, ed D P Burkitt and H C Trowell. London and New York, Academic Press, 1975.

⁵ Prior, I A M, *Proceedings of Pan-Pacific Surgical Congress*, Hawaii, 1975.

⁶ Guberan, E, *et al*, *Journal for Vascular Disease*, 1973, 2, 115.

Doppler angiography

SIR,—In their description of Doppler angiography in the detection of occult deep vein thrombosis, Dr T K Day and others (13 March, p 618) have given a rather too gloomy picture of the usefulness of the Doppler ultra-sound flowmeter. They state that in our series¹ two patients died from pulmonary embolism. In fact one patient died and another presented with massive leg swelling without prior detection of thrombosis. The flowmeter accurately detected two other femoral vein thrombi, and in two further patients calf thrombi were detected by tenderness on examination. These results are not impressive, and at the time we concluded that effective prophylaxis is far preferable to attempts at early detection with the apparatus now available.

In Dr Day's series Doppler angiography failed to detect 31% of the non-occlusive

femoral and popliteal thrombi, and it is to be hoped that further work in simplification and increased accuracy, to which he refers, will produce a more useful method of detection.

D NEGUS
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¹ Negus, D, and Rickford, C R K, *Proceedings of the Royal Society of Medicine*, 1974, 67, 703.

Improving the hospital service

SIR,—Some points in Dr A L Bussey's (20 March, p 714) and Mr P A Hill's (10 April, p 902) criticisms of my article warrant attention. Tables of "hard" facts were part of the original draft, but were removed, because a valid statistical comparison was impossible, and by editorial pruning. None the less, conclusions can surely be drawn when data are widely disparate such as a three-fold difference in the number of ancillary and administrative staff employed, when the overall workload is similar. I think the following figures on workload and staff employed for 1972 will satisfy your correspondents on these points.

	Dutch Hospital	UK
Admissions	6,800	5,685
Inpatient operations ..	3,585	2,439
Outpatient operations ..	1,823	1,300
Outpatient consultations	70,089	63,700
Bed occupancy	91 %	81 %
Catchment area ..	120,000	110,000
Staff		
Administrative/clerical ..	19	49
Building/engineering ..	4	24
Ancillary	51	167
All staff (excl. specialists/consultants)	280	541

I feel both correspondents are being deliberately ingenuous on some points. As regards Dr Bussey's comment on running costs, I had innocently used the 1974 exchange rate in my calculations, but the 1972 rate of 8.2 guilders to the pound would give £1.2 million for the Dutch hospital, which includes capital repayment, against £1.4 million for the UK hospital, which does not.

Mr Hill, in adding up blocks, should surely have noticed those on the bottom line on the Dutch management diagram had been combined into one for the UK hospital. This was due to the editorial pruning. My point remains that the UK system is more complicated, employs more personnel, especially if area and region are taken into account, and is less responsive to local needs.

There has been local over-provision of beds in Holland, a fault now remedied by stricter licensing. On the credit side hospitals are up to date in contrast to the large percentage of old, inefficient buildings in the United Kingdom.

Like your correspondents I hope to see an improvement in the delivery of health care, and this was my motive in presenting another system for comparison. A favourable reception, particularly among a wide range of people who work in the hospital service, has convinced me that it was a useful exercise.

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