our system is as nearly perfect as could be wished. It is very simple and consists of three stages:

(1) If a doctor writes to any pharmaceutical company requesting deletion from their list, this is immediately honoured in respect of that company.

(2) If he writes to several companies, to us direct, or through the Association of the British Pharmaceutical Industry requesting the cessation of literature, his address plate is transferred to a special list which we term "Journals Only." This ensures that journals and official pronouncements continue while literature ceases.

(3) If he requests deletion from all mailing lists or from any journals list the address plate is removed to a suspense file and he receives nothing.

The choice is entirely his. May we point out, however, that he is one of the tiny minority. Our list research department received nearly 13,000 letters from doctors in 1967, and it is clear from our records that doctors themselves feel that they cannot long do without the literature issued by the pharmaceutical industry. The majority of those who request deletion from the list eventually ask for full or partial reinstatement. In fact we receive many more requests for addition to than deletion from our mailing lists.

The final point which arises from Dr. Samuel's letter is his apparent surprise that official publications are distributed by this company. The explanation is, however, simple. It is recognized by these official bodies, as well as by pharmaceutical manufacturers and periodical publishers, that the lists maintained by the Medical Mailing Company are the most accurate available for the distribution of information to the medical profession. In 1967 a total of 87,560 items were examined and 22,994 corrections made to our lists to ensure an accuracy of 99.9%.—I am, etc.,

GAVIN R. THOMSON,
Joint Managing Director,
The Medical Mailing Company Ltd.

London W.13.

Problems in Amphetamine Usage

SIR,—I was somewhat surprised to read the views of Dr. H. E. Lewis regarding the problems in amphetamine usage (27 April, p. 243). He appears to have overlooked several fundamental points on the misuse of amphetamine.

Firstly, patients very often become dependent on amphetamine through the prescribing of this product for the treatment of obesity; this includes the products Durophet and Durophet M. These two products, together with plain tablets of amphetamine and diethylpropion, have for some time been sold on the black-market under a wide variety of slang names, such as "black bomber," "bennies," "black and tans," "French blues," and "purple hearts," etc. All these drugs are included in the Drugs (Prevention of Misuse) Act, 1964, because they are recognized as drugs which can lead to tolerance, dependence, and abuse. It was stated in the *British Medical Journal*[1] that the drugs dexamphetamine, phenmetrazine, diethylpropion, and amphetamine, in view of their addictive properties, should be prescribed only in exceptional circumstances.

The letter from the Chief Medical Officer of the Ministry of Health (23 March, p. 754) does not suggest that any evidence has been brought to light over the last seven years to modify this opinion. It seems peculiar, at least, to suggest that altering the formulation of such a potentially dangerous drug as amphetamine can make any difference to its harmful effects. Does such a change alter the pharmacology of amphetamine? Dr. Lewis may be correct when he says that there are pharmacological differences between various members of the amphetamine family and related compounds. However, he has failed to point out that compounds substituted in the benzene ring, such as chlorphentermine and fenfluramine, appear to be safer in practice than the other products.

A recent paper (30 March, p. 796) suggested that fenfluramine may prove not to have any dependence-inducing properties at all because of its lack of harmful effects on sleep, whereas amphetamine, phenmetrazine, and diethylpropion cause such harmful effects and also produce dependence.

Dr. Lewis quoted from a "Today's Drugs" article (23 March, p. 753) which stated that depressive patients are likely to become dependent on these drugs. The same article goes on: "For these reasons stimulant drugs should be used only after giving the matter very careful thought, and even then the doctor should prescribe the drugs only in short courses to tide the patient over a particular crisis or with a definite aim such as a return to work."

It therefore seems to me that, in the absence of evidence to the contrary, it is safer to prescribe a non-stimulant like fenfluramine for obese patients.—I am, etc.,

London W.1. RICHARD HART.

REFERENCE

[1] *Brit. med. J.*, 1961, 2, 306.

Metabolic Acidosis in Burns

SIR,—In his article on metabolic acidosis in burns (30 March, p. 809) Dr. M. J. T. Peaston has satisfactorily documented this fact. His own comments include reference to shock as well as renal failure being possible causes of this condition. It would be interesting and helpful to know how many of his patients were in a state of clinical shock during the period of observation. Similarly, although overall fluid and electrolyte balance for the total period of study is specified, this gives no indication of the adequacy of renal function during the first 24 to 48 hours after the burn, and blood urea and creatinine levels would be helpful to try to assess the importance of the two postulated causes for the observed acidosis.—I am, etc.,

ADOLF SINGER.

Mount Sinai School of Medicine,
New York, U.S.A.

Air Bubbles in Plastic Syringes

SIR,—Further to the inquiry by Dr. C. C. M. Watson (27 April, p. 246), I would like to offer the following simple remedy. The syringe is held vertically, needle uppermost, and a further 1 ml. of air drawn in. If the syringe is then flicked gently all the bubbles coalesce and can be expelled together. Unfortunately the above technique does introduce the theoretical risk of infection, but surely no more than the prior injection of air into multi-dose containers before aspiration, which was a widely used practice.

It should also be pointed out that the new syringe should be carefully tested before use, as aspiration of blood during venepuncture is impossible if the plunger is stuck, which occurs in a small but significant proportion of cases.—I am, etc.,

Liverpool 12. R. E. D. HAMM.

Comprehensive Care

SIR,—There is much discussion about the future role of the general practitioner and district nursing sister (6 April, p. 41). We shudder to think of the future role of the district nurse when we consider how she is "used" on the district at present. General practitioners seem reluctant to delegate nursing duties to the nurse. Do our medical colleagues think that after three years' training in a teaching hospital we are skilled only in giving bed baths and enemata? Need both doctor and nurse visit the same patient, the nurse to wash the patient, the doctor to administer an injection?

After many years of training and nursing, nurses should be considered capable and able to make suggestions concerning nursing care—for example, treatment of bed sores, varicose ulcers, rehabilitation, etc. Furthermore, do our colleagues also think that after five years' experience as midwives nurses are still only fit for "cleaning up," and that they are making a "fuss" about raised blood pressure or albuminuria in the antenatal period?

Anxious to give as extensive a service as possible to the community, many nurses undertake postgraduate study in public health, child welfare, and child development. Here again it is disheartening to find that few general practitioners appreciate the role of the health visitor in the community beyond the fact that she participates in the "baby clinic." Some general practitioners, not to be outdone, organize a baby clinic in their own surgeries. Health visitors would be pleased to discuss social problems, to refer children for vaccination and immunization, to refer any child in whom they suspect some deviation from normal in physical, mental, or emotional development to their medical colleagues, and be delighted to relieve them of the need of spending precious time weighing babies and advising mothers about feeding and weaning.

District nursing sisters have no wish to set up as rivals to the general practitioner, only to fulfil the role for which they are trained. We and our nursing colleagues are willing to fulfil this role both now and in the future if the general practitioners will allow us.—We are, etc.,

ISABELLA F. MCBRIDE.
HELEN C. SUNTER.

Maybole,
Ayrshire.

Anaesthesia for Insertion of Arteriovenous Cannulae

SIR,—Two alternatives have been suggested to overcome the problem of anaesthesia for insertion of Teflon Silastic arteriovenous cannulae.[1] One is the use of brachial plexus block, and the other general anaesthesia. Brachial plexus block has been