CORRESPONDENCE

Correspondents are asked to be brief

Safer Motoring

- W. Gissane, F.R.C.S.; T. H. S. Burns, F.F.A.R.C.S. 772
- Early Endoscopy in Haematemesis and Melaena**
D. J. B. St. John, F.R.A.C.P., and others 772
- Hazards of Laparoscopy**
M. McD. Usherwood, M.R.C.O.G.; A. D. R. Ogborn, M.R.C.O.G., and others 773
- Disability, Survival and Coalworkers' Pneumoconiosis**
D. Davies, F.R.C.P. 773
- Prodromal Symptoms of Biliary Colic or Cholecystitis**
Sir Zachary Cope, F.R.C.S. 774
- The Problem Oriented Medical Record**
E. C. Coles, M.B. 774
- Hospital Medicine Sheets**
D. A. Spencer, M.R.C.P.SYCH. 774
- Bronchospasm following Althesin Anaesthesia**
M. J. Heslop, F.F.A.R.C.S.; A. N. Crowther, B.M., D.A. 775
- Portable Anaesthetic Machine**
K. A. Anderson, M.B., D.A. 775
- Breath Management with Fetal Blood Sampling**
B. W. Eliot, M.R.C.O.G., and J. G. Hill, F.R.C.S.GLASG. 775

Copper Absorption from I.U.C.D.s

- M. Elstein, M.R.C.O.G., and B. Daunter, M.Sc. 776
- Metabolic Effects of Oral Contraceptives**
M. H. Briggs, D.Sc., and Maxine Briggs, M.B., D.P.H. 776
- Contraceptives on the N.H.S.**
L. Prudence Tunnadine, M.B.; V. E. Coleman, M.B. 776
- Renal Failure in Combined Gentamicin and Cephalothin Therapy**
P. Noone, M.R.C.PATH., and others; R. R. Bailey, M.D. 776
- Prevention of Pulmonary Embolism**
A. M. Smith, F.R.C.O.G. 777
- Unsaturated Fatty Acids in Multiple Sclerosis**
J. Martin, M.D., and others 777
- Fibrinolysis in Cholestatic Jaundice**
N. Dioguardi, M.D., and others 778
- Simple Finger Tourniquet**
M. Z. A. Salem, F.R.C.S. 779
- Australia Antigen in V.D. Clinic Patients**
T. H. Bloofield, B.Sc. 779
- Is Your Pain Really Necessary?**
P. D. Buisseret, M.B. 779
- Cardiological Change and Motor Car Driving**
G. Matthews, M.R.C.P. 779
- Recommendations under the Mental Health Act**
J. E. Duffield, D.M., D.P.M. 780

Tests of Acupuncture

- P. E. Brown, M.R.C.P.; J. D. Watts, M.B. 780
- Vibrating Umbilicus**
D. B. Jackson, M.B., and B. J. Mayou, M.B. 780
- Speech Defects in Children**
N. R. Butler, F.R.C.P., and others 780
- Artificial Insemination by Donor**
J. S. Scott, F.R.C.O.G. 781
- Authentication of International Vaccination Certificates**
A. T. Hunt, M.B., D.P.H. 781
- Telling the Patient**
Jean R. C. Burton-Brown, F.R.C.O.G. 781
- Tuberculous Peritonitis and Laparotomy**
F. P. Antia, F.R.C.P. 781
- Smallpox**
C. E. D. Taylor, F.R.C.PATH. 781
- Adrenal Failure in Bronchial Asthma**
A. O. Robson, M.D. 781
- Raw Deal for Medical Secretaries?**
K. J. Covell, F.F.A.R.C.S. 781
- Occupational Therapists and the N.H.S.**
K. J. Kimmance, M.B., M.F.C.M., and others 782
- Vocational Training for General Practice**
J. D. Simson, M.R.C.G.P. 782
- Hospital Staff Sick Leave Allowances**
M. F. Scott, L.D.S.R.C.S. 782
- Holy Land Pilgrimage**
Reverend W. P. Hedgcock, M.D. 782

Safer Motoring

SIR,—Your leading article (28 April, p. 195) supports the evidence from other countries that the majority of car occupants are fatally injured by being thrown about within or out of a relatively intact passenger compartment. Such evidence has led to laws enforcing the wearing of safety belts by front seat occupants throughout Australia (Victoria in January 1971, the other states in January 1973). The results in Victoria are interesting. First, a significant decrease in their car occupant deaths, though less than one would expect of a really efficient restraint system if radically enforced. Next, loud complaints from motorists of "unsatisfactory belt design and anchorage" directed, it seems, against car manufacturers (personal communication from Victoria).

There are those who feel, and I must confess I leaned towards their views, that in Britain the wearing of safety belts should not be made mandatory until the system fits all shapes and sizes of people over their appropriate skeletal structures. Clearly when belts are anchored to pillar and floor, and are remote from their wearers, they do not always meet this basic requirement. Yet when anchored to the car seat and close to the wearer, as the late car seat manufacturer Cox of Watford proved many years ago, the improvements in their fit, comfort, and protection are considerable¹ and meet the suggestions of Dr. K. E. Jolles (2 June, p. 549). The Cox "safety seats" were not favoured by our car manufacturers, who commented that they were "too heavy, too expensive, and could not be made to recline fully," though the last requirement is a pure sales gimmick and devoid of any overall consideration for the occupants' protection. They

were heavier than the flimsy and poorly anchored seats they were intended to replace because they incorporated firm anchorage to meet the mandatory specifications for the strength of their incorporated belts and their frame strength gave additional occupant protection. They were expensive only in comparison with the very low cost of mass production seats.

As Dr. Jolles remarks, "the search for even better belts must continue apace." The Australian motorists seem to have passed this challenge directly on to car manufacturers and I can think of no greater stimulus to improvement in occupant restraint systems than consumer demand and its direct effect on car sales in that highly competitive industry. Perhaps, after all, the Australian legislators were right in introducing compulsory belt wear even at this stage of belt design development.—I am, etc.,

WILLIAM GISSANE

Road Injuries Research Group,
Birmingham Accident Hospital,
Birmingham

SIR,—On theoretical grounds I would agree entirely with Dr. K. E. Jolles (2 June, p. 549) that retractable seat belts should be the only approved type since they allow the driver more movement than the somewhat restricting fixed type. However, I have recently obtained a car with retractable belts and I find the pressure of the belt on my chest and shoulder to be distractingly irritating—this could be dangerous.

There is a risk that the wearing of seat belts will be made compulsory before sufficient is known about them. The only

statistics available, as far as I know, show that if you are going to turn your car over or have head-on collision you will do yourself less damage if you are wearing a seat belt. I know of no statistics to show what effect the wearing of a belt might have on some drivers. Two questions come to mind: (1)—Does the wearing of a seat belt make some reckless drivers feel "so safe" that they drive even more recklessly? (2)—To what extent does the wearing of a belt inhibit normal good driving techniques, such as the application of the hand-brake at traffic lights?

The subject has recently come up as to whether seat belts are really life-saving in a head-on collision. The Monmouthshire coroner has recorded a verdict of accidental death on a motorist "who received a broken neck when wearing a seat belt in a crash involving her car and a lorry. The coroner told the jury 'it could be that the seat belt was the cause of the broken neck'."¹ Before compelling people to wear seat belts to protect them from one sort of injury, let us be quite sure that we are not encouraging other types of injury.—I am, etc.,

T. H. S. BURNS

St. Thomas's Hospital,
London S.E.1

¹ *Daily Telegraph*, 1973, 12 May, p. 17.

Early Endoscopy in Haematemesis and Melaena

SIR,—The enthusiasm and expertise of Dr. P. B. Cotton and his colleagues (2 June, p. 505) excites the admiration of all those engaged in the difficult tasks of diagnosis and management of acute upper gastrointestinal bleeding. They make a most persuasive case for urgent endoscopy as the primary investi-

gation and have emphasized matters often forgotten—such as that a lesion identified is not necessarily a lesion bleeding. However, we should like to make three points which we believe require further debate.

First, the 96% of successful visual diagnoses when the final diagnosis lay in the endoscopy area is slightly misleading, for in this series, as in others, 15% of the patients were discharged without any diagnosis having been established. The success rate should in our view be judged against this so that comparisons with other strategies can be made. When we began to use endoscopy as part of a systematized approach to upper gastrointestinal bleeding we had hoped that the “discharged without a diagnosis” rate would fall as a result of the identification of more patients bleeding from superficial lesions in the oesophagus and stomach. However, in our admittedly small series of 68 consecutive patients admitted to a combined medico-surgical service this has not been the case, though we have seen a shift in diagnostic pattern towards these lesions as the cause of the bleeding.

Secondly, because the patients of Dr. Cotton and his colleagues are a referral series and in spite of their failure to find other patients alive or dead in the hospital records we are doubtful if others will succeed in producing the same low mortality figures. Alternatively, the patients studied represent a selection reaching a London teaching hospital group and the application of the conclusions elsewhere may not be straightforward. Certainly our own results in Melbourne, where selection of admission was biased towards an elderly population of poor means, have been far less good for in spite of early identification and energetic treatment of the bleeding point six of our 68 patients died, only one from a preventable surgical error.

Thirdly, we are concerned that the authors seem to feel that endoscopy and radiology are necessarily in conflict and that one or other must be seen to emerge as better. Our experience with selective investigation does not confirm this, nor does it suggest that clinical histories as determinants of an investigative sequence are valueless. The best results—and by this we mean not only in mortality but in economy of time and number of investigations required to reach a diagnostic decision—are achieved by co-operation between clinician, endoscopist (if he is a separate person), and radiologist. We should not like to see this diagnostic team broken up by arguments over the best first buy for the most patients.

Lastly, may we be permitted to chide Dr. Cotton gently for discounting the value of clinical statistics in determining what to do next in a paper which, to the best of our reckoning, contains a percentage about patients or their investigations once every five and a half lines through 360 lines of text.—We are, etc.,

H. A. F. DUDLEY
D. B. ST. JOHN
N. D. YEOMANS

Departments of Surgery and Medicine,
Monash Medical School and Alfred Hospital,
Prahran, Victoria, Australia

Hazards of Laparoscopy

SIR,—I would like to draw attention to a further hazard of laparoscopy. In the course

of a recent laparoscopic tubal diathermy operation I had an unusual accident involving the Palmer's diathermy forceps. While taking a grip of the right Fallopian tube and isolating it from bowel I saw the terminal claw of the forceps detach from the rest of the instrument. After failing to remove the detached part with a second pair of forceps I was forced to proceed to a laparotomy in order to remove the detached part, to inspect the bowels and omentum for damage, and to complete the operation.

On subsequent examination the cause of the detachment was found to be a break of the soldered joint, which was easily repaired with silver solder. The instrument has since given no further trouble. I would thus suggest that a full check of all the joints of the laparoscope be made prior to operation as otherwise a laparotomy for “metal fatigue” may result.—I am, etc.,

M. MCD. USHERWOOD

Obstetrical and Gynaecological Unit,
The London Hospital Medical College
London, E.C.1.

SIR,—We wish to report a case of severe retroperitoneal haematoma complicating laparoscopy.

A 29-year-old para 4+0 was admitted four months after delivery for laparoscopic sterilization, which was performed under general anaesthesia. The Verres needle was inserted just below the umbilicus at the second attempt and 3 l. of carbon dioxide introduced. The laparoscope itself was inserted at the same site and diathermy and division of the Fallopian tubes performed.

When the laparoscope was about to be removed a large retroperitoneal haematoma was noted over the bodies of the lower four lumbar vertebrae and estimated to contain 1,500 ml of blood. An immediate laparotomy showed a small puncture mark in the peritoneum of the posterior abdominal wall over the haematoma. But there was no further increase in the size of the haematoma and the abdomen was closed. The patient had a five-pint blood transfusion and made a good postoperative recovery.

We now consider that the safest site for introduction of the Verres needle is halfway between the symphysis pubis and the umbilicus, with the patient in the lithotomy position and with 30 degrees of head-down tilt. We continue to introduce the laparoscope itself at the lower border of the umbilicus.

The annual reports of the Medical Defence Union for 1971 (p. 51) and 1972 (p. 17) refer to two deaths and nine serious complications following laparoscopy, including a diathermy burn of the small bowel causing peritonitis. Only one retroperitoneal haematoma complicating laparoscopy has been previously reported and this was associated with fatal air embolism.¹ A review of 20,872 cases by Siegler² included 19 deaths due to haemorrhage, peritonitis gas embolism, and anaesthesia. One thousand cases of diagnostic laparoscopy reported by Duignan *et al.*³ and 910 cases of laparoscopic sterilization reported by Jordan *et al.*⁴ were attended by a total of 22 complications and no fatalities.—We are, etc.,

ANTHONY D. R. OGBORN

Hammersmith Hospital,
London W.12

M. P. MILLIGAN
ANTHONY D. NOBLE

Royal Hampshire County Hospital,
Winchester

- 1 Jernstrom, P., *American Journal of Clinical Pathology*, 1951, 21, 573.
- 2 Siegler, A. M., *American Journal of Obstetrics and Gynecology*, 1971, 109, 794.
- 3 Duignan, N. M., Jordan, J. A., Coughlan, B. M., and Logan-Edwards, R., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, 79, 1016.
- 4 Jordan, J. A., Logan-Edwards, R., Pearson, J., and Maskery, P. J. K., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, 78, 460.

Disability, Survival, and Coalworkers' Pneumoconiosis

SIR,—It is very pleasant to get from Dr. A. I. Cochrane another episode (2 June, p. 532) in the pneumoconiosis saga from the Rhondda Fach. Sadly, it sounds like one of the final chapters, which is a great pity when so much could be learnt by another clinical and radiological survey at this time.

Dr. Cochrane states that simple pneumoconiosis is not associated with appreciable disability or loss of expectation of life. Indeed, no other overall conclusion seems possible from the figures. But in my view quite different conclusions may be drawn if the frequency of chronic bronchitis is uneven in the groups of miners. There are good grounds for suspecting that this may be so. In people with chronic bronchitis, with excess mucus secretion and narrowed airways, fewer respirable dust particles reach the alveoli.¹ As the development of simple pneumoconiosis is related to the amount of dust reaching that level, bronchitis probably gives some protection. There may therefore be a considerable excess of bronchitis in miners with category O and a decline in their number with higher categories of simple pneumoconiosis.

The possible effect can be illustrated by considering ventilatory capacity. Take groups of 100 miners with different categories of simple pneumoconiosis and a group of non-miners. Assume that chronic bronchitis occurs in 20% of the non-miners and, overall, in 30% of miners but that its distribution is uneven (see table). Award every man an expected ventilatory function score of 100 and assume that chronic bronchitis reduces this on average by 30, category 1 by 5, category 2 by 10 and category 3 by 15. The total score for the non-miners is then $(80 \times 100) + (20 \times 70) = 9,400$. The totals for the mining groups are shown at the foot of the table and these fit pretty accurately on to table III of Cochrane, Higgins, and Thomas² relating ventilatory function to categories of pneumoconiosis. This theory can go a long way to explain why miners without pneumoconiosis have poorer ventilatory levels than non-miners and it shows how substantial impairment due to simple pneumoconiosis can be concealed.

The conventional test of ventilatory function is the forced expiratory volume (FEV) and this reflects in particular air flow in large and medium-sized bronchi, areas heavily involved in chronic bronchitis. In simple pneumoconiosis, however, any obstructive element can be expected to be in the respiratory bronchioles or beyond, areas very poorly represented by the FEV. The current method of assessing obstruction in small airways is by demonstrating abnormalities in closing volume and frequency-dependence of compliance. Using the latter, small-airways disease has been demonstrated in simple pneumoconiosis³ and this may produce imbalance in alveolar ventilation and