gynaecologists. I have recently operated on a patient who had had this procedure carried out, only to find a normal but perhaps shortened appendix in its normal place. It was approximately 2 inches (5 cm) long with no mesenteric attachment. The mesoappendix, which had been left long, had in fact wrapped itself around the small bowel, causing intestinal obstruction.

I understand that this technique of inversion of the appendix is quite popular in certain areas and is gaining in popularity. It would seem to me there must be dangers associated with this procedure, not the least being the fact that the patient may still be able to get appendicitis, whether it is intraluminal, intramural, or simply shortened. I have a feeling that complications of this procedure may not be reported in the literature and I would be very grateful if any details of patients suffering from complications of this procedure could be sent to me so that we can get a realistic viewpoint of the complication rate.—I am, etc.,

GEORGE H. DICKSON

Southlands Hospital,
Shoreham-by-Sea, Sussex

Who is the Dental Anaesthetist of the Future?

SIR,—Congratulations are due to Professor P. A. Bramley and his colleagues (4 May, p. 270) for their constructive attempt to initiate training of dental anaesthetists by apprenticeship. Students attending the short courses organized by the Society for the Advancement of Anaesthesia in Dentistry have always been advised to work at first under the supervision of an expert. The difficulty has been in finding sufficient teachers capable and willing to take an apprentice.

The adoption of an approved system of apprenticeship would necessitate the publication of an approved list of dental anaesthetists. This would be welcomed by all dentists wishing to make contact with an anaesthetist who is willing and able to work in their locality. At present this contact can be made only through hearsay or personal recommendation. Anaesthetists who allow their name and address to appear on such a list would be just as ethical as doctors on the obstetric list or consultants on the list for domiciliary consultations. We all seek and hope for a countrywide availability for every dental practitioner of an anaesthetist trained and experienced in modern methods for both conservative and surgical dentistry.

If it is impractical to bring the anaesthetist to the dentist, then bring the dentist and his patient to the anaesthetist at a centre fully equipped to deal with all eventualities. This system works well in several successful private practices and could be equally successful under an intelligent N.H.S. administration.—I am, etc.,

DONALD BLATCHLEY

London W.4

SIR,—The suggestion of Professor P. A. Bramley and others (4 May, p. 270) that dentists could by a scheme of "a half-day a week" instruction in dental anaesthesia be turned into qualified dental anaesthetists is simply nonsense.

Dental anaesthetics is one of the most difficult branches of the medical specialty of anaesthesia; it is no different from and no less dangerous than anaesthesia for a cholecystectomy. It is mandatory that all anaesthetics be given by medically qualified and fully trained anaesthetists. No patient should be given any anaesthetic without a full physical examination, for example.

When are dentists going to realize that anaesthetics is a *medical* specialty? If one of their own family ever required a dental anaesthetic I know who would be asked to give it—a fully qualified anaesthetist.—I am, etc.,

D. HOGG

Lyneham, Wilts

Smoking in Pregnancy

SIR,—I was one of the doctors who wrote to Mr. A. C. L. Mackie, Director General of the Health Education Council (6 April, p. 55) to criticize the leaflet showing a naked, pregnant, smoking woman. I made the point that the photograph was an example of very bad taste. Mr. Mackie does not appear to defend it from that point of view. I also said that education should be directed to an improvement of all aspects of life, that health was important but there were other values to be considered, and that it was not right to make use of material which would tend to bring the pregnant woman into contempt, even for the most admirable ends.

I do not smoke and am a man and therefore not pregnant. Because of this Mr. Mackie asserts that what I and others like me think about this matters very little. By the same token, of course, his own opinion is of no importance. I do not agree with him. What he and I and all other doctors and others concerned with health education think does matter.—I am, etc.,

R. P. RYAN

South Tyneside Area Health Authority,
South Shields

Jaundice after Halothane

SIR,—With reference to the article by Dr. W. H. W. Inman and Professor W. W. Mushin (5 January, p. 5) on the incidence of jaundice following repeated exposure to halothane it is worth noting that nearly all writers stress the wide use of halothane—80% of all general anaesthetics according to Mushin *et al.*¹ Often the problem of substituting an alternative agent as "safe and effective" as halothane is stressed, seeming to imply that it is mandatory to add a volatile agent to nitrous oxide and oxygen. A general reduction in the use of halothane would lessen the chances of susceptible individuals being rechallenged by it, as well as providing experience in alternative techniques now obviously lacking.

A sizable minority of anaesthetists use a premedication, intravenous induction, nitrous oxide, oxygen, and relaxant sequence with or without analgesic supplement and no additional inhalational agent whatsoever for 90% of their anaesthetics. Admittedly, more care is required to avoid the possibility of awareness, but by what criteria do the ease and convenience of using a blanket "almost safe" anaesthetic take precedence over the exercise of proper skill and judgement by a

specialist trained for that very purpose?—I am, etc.,

P. G. AZZOPARDI

North Adelaide,
South Australia

¹ Mushin, W. W., Rosen, M., and Jones, E. V., *British Medical Journal*, 1971, 3, 18.

Diagnostic Problems in Cervical Cancer

SIR,—In your leading article (16 March, p. 471) on this subject you drew attention to the high proportion of cases in which the panel of gynaecological pathologists set up by the Royal College of Obstetricians and Gynaecologists disagreed with the diagnosis made by the submitting pathologist; and you went on to assert that "this evidence demands a critical review of diagnostic criteria for cervical lesions in every gynaecological department."

In fact in 1966 and again in 1969 my colleagues and I set out^{1,2} to establish clearly defined morphological categories to which the various histological changes can be readily and reproducibly assigned. We did so hoping that this would lead to uniformity in reporting which would facilitate the critical review that your leading article demands.—I am, etc.,

MAGNUS HAINES

Department of Pathology,
Chelsea Hospital for Women,
London S.W.3

¹ Govan, A. D. T., *et al.*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1966, 73, 883.

² Govan, A. D. T., *et al.*, *Journal of Clinical Pathology*, 1969, 22, 383.

Amitriptyline and Imipramine Poisoning in Children

SIR,—With reference to the article by Drs. K. M. Goel and R. A. Shanks (16 February, p. 261), in the renal unit of our department, which is mainly devoted to the dialysis treatment of infants and children, we have treated two cases of severe imipramine poisoning by haemodialysis.^{1,2} The patients (aged 26 months and 4 years), who had taken imipramine in dosages of 23 mg/kg and 20 mg/kg respectively, were deeply comatose, with convulsions and electrocardiographic abnormalities on admission. Haemodialysis was started promptly and the children regained consciousness after as little as 4-5 hours. The dosages in these cases must be regarded as highly hazardous as the minimum lethal dose for infants and children has been stated³ to be only 8 mg/kg in contrast to 30 mg/kg for adults. The danger to children of imipramine in doses which would not be lethal to adults is also emphasized by the fact that two of the children reported by Drs. Goel and Shanks died after the ingestion of 15 mg/kg.

Successful haemodialysis treatment of an adult after imipramine poisoning has previously been reported by Harthorne *et al.*⁴ and that of a child by Bauditz and Barthelheimer.⁵ Compared with the conservative management of poisoning by tricyclic antidepressants the duration of coma seems to be favourably shortened by haemodialysis. The amount of imipramine recovered in the dialysate is not so small as has been supposed. Clearance studies are at present being performed by our group and will be

published in the near future.⁶ The preliminary results of in vitro lipid haemodialysis utilizing ¹⁴C-imipramine indicate a clearance of approximately 20 to 40 ml/min, depending on the type of filter, dialysate, and blood-line system used.—We are, etc.,

H. W. ASBACH
H. W. SCHULER

Department of Urology,
Heidelberg University Medical School,
Heidelberg, W. Germany

¹ Asbach, H. W., et al., in International Congress of the European Association of Poison Control Centres and the American Association of Poison Control Centres, *Aktuelle Probleme der Intensivmedizin*, vol. I, Darmstadt, Steinkopff. In press.

² Schuler, H. W., et al., *Proceedings of the European Dialysis and Transplant Association*, 1972, 9, 325.

³ Moeschlin, S., *Klinik und Therapie der Vergiftungen*, Stuttgart, Thieme, 1972.

⁴ Harthorne, J. W., Marcus, A. M., and Kaye, M., *New England Journal of Medicine*, 1963, 268, 33.

⁵ Bauditz, W., and Barthelheimer, H. K., *Archiv für Toxikologie*, 1970, 26, 133.

⁶ Asbach, H. W., Holz, F., Mohring, K., and Schuler, H. W. In preparation.

Cars or Chairs?

SIR,—Your leading article (6 April, p. 2) dealing with the Sharp Report on the mobility of physically disabled people makes the interesting point that problems caused by an inability to walk were at one time overcome by the provision of a motorized bath chair.

I suggest that there still exists a need for such a vehicle. Those unable to drive, or ineligible for a four-wheel car under the new proposals, could be provided with an outdoor electric wheel chair (for example, the Batic Power Chair), which is designed for pavement use at walking pace. At a cost per chair of about £300, alleviation of the frustrations of the physically housebound could become a financially viable proposition.—I am, etc.,

D. J. BICKLE

Guy's Hospital,
London S.E.1

Treatment of Acute Gout

SIR,—We would like to support the dose of indomethacin recommended in the Therapeutic Conference (9 March, p. 446). While we do not doubt the lack of toxicity of the higher dosage supported by Dr. D. I. Haslock (13 April, p. 121), we do not feel that such high doses are necessary.

We have collected evidence that in acute gout indomethacin at 150 mg per day can produce a strikingly rapid reduction in inflammation, as assessed by an objective, quantitative, thermographic method.¹—We are, etc.,

P. A. BACON
A. J. COLLINS
E. F. J. RING

Royal National Hospital for Rheumatic Diseases,
Bath

¹ Collins, A. J., et al., *Annals of the Rheumatic Diseases*, 1974, 33, 113.

Steroid Aerosols and Candidiasis

SIR,—The advent of effective aerosol steroids for treating asthma which do not cause systemic side effects or suppress growth has been of considerable importance to

paediatricians.¹ Enthusiasm for these drugs in some recently published studies has, however, been dampened by the finding of oral and even laryngeal infection with candida in as many as 13% of cases (Dr. M. K. Allen and others, 2 February, p. 171). In some patients this has required reduction of drug dosage. In our experience with children we had not encountered clinical thrush, and none of the patients affected in the study of Dr. McAllen and her colleagues was below 18 years. We therefore carried out an investigation to determine the incidence of candida among our children treated with long-term beclomethasone dipropionate and a control group of asthmatic children not receiving the drug. Each child was clinically examined and a swab was taken from all parts of the oropharynx and cultured on appropriate media.

The results are summarized in the table.

	Beclomethasone Group	Control Group
Number	24	33
Boys:girls	2:3:1	2:4:1
Age (years)	8.7 ± 2.8 (3–16)	6.9 ± 3.1 (3–13)
Duration of aerosol therapy (months)	12.9 ± 6.8 (2–24)	0
Dose of aerosol therapy (µg/day)	469 ± 245 (100–800)	0
No. with positive cultures	3	2

The mean ± 1 S.D. and the range are given.

No clinical cases of thrush were seen, but candida was isolated on five occasions—namely, in three out of the 24 aerosol-using children and two out of the 33 control children. There was no relationship between the dose or duration of aerosol therapy and the finding of candida nor between the use of additional oral steroids or antibiotics. Though Brown and Storey² reported thrush in four out of 31 children on beclomethasone dipropionate, they had no comparable control group. We believe that the clinical complication of candida infection does not occur as a result of aerosol steroid therapy in children, and the organism may be isolated by chance in a small proportion of asthmatic children whatever their therapy.—We are, etc.,

S. GODFREY
G. HAMBLETON
P. KÖNIG

Department of Paediatrics,
Hammersmith Hospital,
London W.12

¹ Godfrey, S., and König, P., *Archives of Disease in Childhood*, 1973, 48, 665.

² Brown, H. M., and Storey, G., *British Medical Journal*, 1973, 3, 161.

Vein Stripping

SIR,—With reference to the article by Mr. S. J. Cox and others on nerve injuries as a result of stripping the long saphenous vein (9 March, p. 415) I feel that the question is not whether stripping is best performed up through the groin or down through the ankle but whether stripping ought to be performed at all.

My antagonism to stripping is based on the following facts: (1) First described by Galen in 150 A.D., it belongs more to antique surgery or mediaeval torture than to modern treatment. (2) The theoretical in-

dications for its use in the treatment of varicose veins are weak, as inadequate perforating veins, now regarded as the cause of the disease, hardly ever communicate directly with the long saphenous vein. (3) A pathologically deformed vein with twirls and varices renders stripping virtually impossible—only normal veins can be stripped. (4) There is an appreciable risk of local postoperative complications such as haemorrhage, nerve damage, and arterial injuries (subsequent gangrene has been described). (5) One of our most easily available and increasingly used "spare parts" is destroyed. (6) Anaesthesia, admission to hospital, and a longer period on the sick list mean an economic burden for both the community and the patient.

I feel that the stripping sound is useful in removing isolated segments of vein as those under an ulcer or eczematous area, but otherwise ought to be donated to a museum. Am I alone in my view?—I am, etc.,

DAVID FREEDMAN

Jakobsbergs Sjukhus,
Stockholm

Thyopac-5 Test

SIR,—Dr. J. G. Hardy and Mr. G. M. Newble (30 March, p. 636) claim to have assessed the diagnostic accuracy of the Thyopac-5 test and that of other tests of thyroid function. It is not possible, however, to be certain of either the accuracy or the usefulness of this test from the data presented since the authors have not stated what objective criteria were finally used to distinguish between normal and abnormal thyroid function.—We are, etc.,

PATRICIA VICE
DAVID EVERED

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Royal Victoria Infirmary,
Newcastle upon Tyne

Renal Lesions of Subacute Infective Endocarditis

SIR,—Dr. J. M. Boulton-Jones and his colleagues (6 April, p. 11) appear to express some surprise that renal failure was a "striking feature" in their group of five patients suffering from infective endocarditis. They do not state how their patients were selected. This complication has, of course, been recognized for many years. Harbitz in 1899 drew attention to the frequency and intensity of renal symptoms in 16 cases of infective endocarditis.^{1,2} Furthermore, the advent of antibiotics could be expected to make this complication more likely, not less likely as Dr. Boulton-Jones and his colleagues imply, because control of the infective process with prolonged survival would allow time for non-suppurative lesions to develop.

The study described by your contributors gives an elegant demonstration suggesting an immune-complex aetiology for the glomerular lesions in three of their five patients, but the cause remained undetermined in the remaining two. They do not mention the presence of other lesions, in particular that of fibrin thrombi, or lesions in other organs in the two that came to necropsy. In a series of 40 fatal cases of