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Five-day Wards in 1974

SIR,—It seems certain that the shortage of nurses is going to continue and will bring about great changes in the pattern of hospital care of patients. Five-day wards reduce the burden on the nursing staff and can make use of nurses who could not work a seven-day week. They also demonstrate that the traditional patterns of hospital care are not fixed and immutable. Five-day wards are particularly suitable where the medical and technical component of hospital care is large and the nursing component small. My hospital has been running a five-day ward for nearly a year and the service has been mainly concerned with patients undergoing cardiac catheterization, coronary angiography, and bronchoscopy, who are admitted for 24-48 hours.

Your leading article (13 April, p. 71) rightly draws attention to the way in which this service can reduce waiting lists and to the very high turnover and work load involved. Our junior medical staff has responded nobly to this challenge, and the major difficulties have arisen on the secretarial side. A full-time ward clerk is an absolute necessity. The work of the medical secretary is also greatly increased by the high volume of work, and a lot of her time is spent filing reports from the pathology and x-ray departments which did not arrive while the patient was in the ward.

It seems quite impossible to put these simple points over to hospital administrators. I would strongly advise any doctor considering a five-day ward not to begin until a full-time ward clerk is established and until there has been a substantial increase in his secretarial staff. I do not consider it improper for a consultant to be involved in the documentation of patients and the filing of

reports, but it should not be a substantial charge on his time, as it is on mine.—I am, etc.,

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Gammaglobulin and Congenital Rubella

SIR,—We were pleased to read Dr. Catherine S. Peckham's report (16 February, p. 259) of the benefits to the fetus from the use of immunoglobulin (gammaglobulin) prophylaxis for mothers exposed to rubella during pregnancy. Dr. Peckham found that the incidence of fetal infection (5/26) and congenital defect (1/26) was much decreased in the infants of mothers who were given immunoglobulin at the time of rubella contact and who subsequently had a sub-clinical rather than a clinical attack of rubella. This was encouraging to those of us who have long wondered whether there was definite evidence that immunoglobulin could be used to modify the effects of maternal rubella on the fetus.

However, when we looked retrospectively through our own case histories we found that there were 22 pregnant women who had been given immunoglobulin during the first trimester at the time of rubella contact. Only 11 subsequently developed clinical rubella, yet all 22 children were infected—indeed, 10 of the 11 children whose mothers had subclinical attacks had multiple rubella defects (the eleventh child is too young for definite assessment). Our group is only small, and selected because the children were mostly considered defective before they came to us. However, if the effect proposed

by Dr. Peckham were true, in our 22 cases we would not have expected the numbers of clinical and subclinical maternal infections to be equal; the majority of mothers should have had clinical attacks.

In addition, we know of two cases in which use of immunoglobulin caused marked delay in the mother's serological response so that a correct diagnosis of rubella was not made during pregnancy, and both infants were born with congenital rubella defects.¹ For this reason we have been cautious when using immunoglobulin for rubella prophylaxis during pregnancy.

There may be many reasons why our findings apparently conflict with Dr. Peckham's. However, we agree with her that if gammaglobulin is used the greatest benefit is likely to be obtained if it is of high rubella antibody titre and is administered as soon as possible after contact. Follow-up of such mothers for seroconversion is essential.—We are, etc.,

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¹ Forrest, J. M., Honeyman, M. C., and Murphy, A. M., *Medical Journal of Australia*, 1973, 1, 745.

Cannulation of Internal Jugular Vein

SIR,—I agree with Dr. B. S. Jenkins and his colleagues (27 April, p. 225) that it would be unfortunate if the report of extensive neurological damage after cannulation of the internal jugular vein by Dr. C. E. Briscoe and others (23 February, p. 314) should discourage the use of a valuable technique.

Following a recent similar but luckily unjustified fright I should like to amplify their remarks. Dr. Jenkins and his colleagues deal with placement of the cannula (though it is to be regretted that their plea for a longer catheter was nullified by their error in recommending a length of "at least 15-20 mm" when they presumably meant 15-20 cm). Assuming accurate placement, two further problems remain. Firstly, the risk of subsequent rupture of the vein wall by the tip of the catheter, as illustrated in two cases by Dr. C. J. Rudge and others (7 July 1973, p. 23). And secondly, the ease with which a long catheter can become withdrawn, especially as owing to its mode of insertion part of it is often surrounded by an introducing cannula or needle guard, inside which the catheter may freely slip. As one or more drips are attached a considerable weight has to be borne by whatever method of securing is followed, usually adhesive tape of some form applied to the small hub and the necessarily short length of thin catheter. As gravity overcomes this adhesion the catheter slips out in a tunnel of strapping. Usually it is resecured with more strapping over the proximal end, resulting in a period of delay before it continues its outward journey until the tip of the catheter leaves the vein and the infused solution is extravasated.

It is a paradox that the average short cannula used peripherally is provided with a flange or projection for stabilization, whereas the average catheter used in much more dangerous country is not. Apart from the unsatisfactory solution of securing the catheter to the chest wall by suturing, it would be helpful if manufacturers could supply a retaining device which could be firmly clipped on to the hub of the catheter and used for stabilizing it. Further, it is not possible to ascertain the length of most catheters when in situ (other than by radiology). A marking should be incorporated on the hub giving the length of the catheter so that the amount in the body can be instantly checked.

Finally, to guard against sequelae due to both displacement and rupture of the vein wall I would suggest that each time any locally toxic drug is infused it should be demonstrated that there is a free flow of blood back into the syringe regardless of the length of time the catheter has been satisfactorily in use.—I am, etc.,

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Cephalosporins in Bronchitis

SIR,—My clinical results with the cephalosporins in patients with chronic purulent bronchitis are not so poor as Drs. Susannah J. Eykyn and I. Phillips suggest (6 April, p. 59). In pilot experience 32 patients were treated with cephalexin 2-6 g daily—23 for two and 9 for three weeks.¹ Twenty-one improved with treatment, correlated closely to results of disk sensitivity on the pathogens isolated. Strikingly, all given two weeks of treatment relapsed during the next few days; in contrast six out of seven responding to three or more weeks of treatment maintained their sputum as mucoid afterwards.

Relapse so uniformly after two weeks of

apparently successful treatment is unique in my experience of antibiotics, but prolonging the period of treatment gets over this weakness. This was shown clearly in a double-blind trial, when cephalexin 1 g twice daily was compared with a placebo, in the prevention of purulent exacerbations of bronchitis.² The 55 patients were treated in hospital over a 10-week period. Cephalexin was significantly superior in several important respects.

At present I administer cephalexin (1) to patients when antibiotics have failed and when disc tests show sensitivity of the responsible organism; (2) cautiously to those with a history of antibiotic sensitivity; and (3), since it is remarkably well tolerated, to those with gastrointestinal upsets from other antibiotics. I have no experience with cephradine. For desperately ill patients failing to respond to other antibiotics cephaloridine 6 g daily by intramuscular injection remains among the most powerful regimens in patients with purulent chest infections.^{3 4}—I am, etc.,

A. PINES

East Herts Hospital,
Hertford

- 1 Pines, A., et al., *Clinical Trials Journal*, 1970, 7, 393.
- 2 Pines, A., *British Journal of Clinical Practice*, 1972, 26, 209.
- 3 Pines, A., et al., *British Journal of Diseases of the Chest*, 1967, 61, 101.
- 4 Pines, A., et al., *British Journal of Diseases of the Chest*, 1971, 65, 91.

Coping with Minor Casualties

SIR,—We agree with your leading article on this subject (2 March, p. 339) that there is a problem, but we disagree with the remedies suggested.

Casualty departments cope with patients who fall into two classes: (1) those suffering trauma—either major or minor—and (2) casual attenders seeking "primary care." Minor trauma and primary care are "general practice" by definition. It does not follow, however, that such care should always be provided from group practice premises. It would be a grossly extravagant use of resources if all group practice premises had to remain open for 24 hours a day. In our experience 50% of the patients coming to the casualty department have no local general practitioner. Such patients can often be more effectively and economically dealt with in a hospital-based department. On the other hand it is illogical that a casualty department from which major trauma is excluded should be the responsibility of an orthopaedic surgeon. Clearly this is an area in which general practitioners should be concerned, and they are probably in the best position to ensure that such departments are not abused.

We have four years' experience of running a radio-linked on-call service for the local casualty department. If more general practitioners are going to accept this sort of responsibility, however, we believe there are some problems which must be resolved.

Firstly, difficulties arise—to paraphrase a sentence in your article—when overburdened general practitioners are called away from patients who have made appointments to see them to deal with patients with minor complaints who present in the casualty department.

Secondly, it is an unreasonable imposition

to ask senior general practitioners to turn out at night, travelling maybe up to six miles, to deal with cases most of which are trivial when competent nurses and junior doctors are resident on the site. It is also an uneconomic use of medical skills. This situation has arisen largely because of fears of litigation. It is time that the profession took a firm stand in this matter. Greater responsibility is accepted routinely by district nurses, midwives, and factory nurses in other settings. Moreover, lack of exposure to this sort of work will lead inevitably to a generation of doctors which is competent in resuscitation in the intensive treatment unit yet is unable to decide when an abscess should be opened or how to cope with a simple fracture. We do not believe that the problems of minor casualty work can be solved so long as the profession allows itself to be ruled by fears of litigation.

Summarizing, we believe that emergency minor trauma can be more efficiently and more economically provided from a hospital department when this is available. Much of the simple and routine work can, and therefore should, be done by junior doctors and nurses resident on the site. Experienced general practitioners should, however, be in charge of these departments and they should have consultant status. They should be supported by an on-call roster of local general practitioners and assisted by clinical assistants and junior hospital doctors as the work load justifies. One of their duties would be to ensure that a general practitioner principal is always on call to assist and advise the junior doctors and nurses resident on the site whenever required.—We are, etc.,

E. O. EVANS
MICHAEL COIGLEY
J. V. V. LEWIS
N. A. WOODWARD
JEAN HODSON
A. R. MCWHINNEY
D. FERGUSON

H. G. NICOL
A. N. GANNER
ANDREW LOCKIE
A. MURRAY
G. W. SYKES
J. F. HUGHES
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Stratford-upon-Avon

Gonorrhoea of the Pharynx

SIR,—Your leading article on gonorrhoea of the pharynx (4 May, p. 239) asks how common is this condition in Britain. Since July 1972 routine investigations for gonorrhoea in the female in this department have included throat cultures. To date 6,362 women have been examined, of whom 4,373 presented no bacteriological evidence of gonorrhoea. Gonococci were recovered from the lower genitourinary tract in the other 1,898 cases, and in 16 of these neisseriae identified as gonococci were isolated in throat culture. These 16 cases were distributed sporadically over the period of investigation; there were no symptoms and only minimal clinical signs attributable to the throat infection.

Immunofluorescent techniques might show that the incidence of gonococcal infections of the throat in females in this city is higher than the 0.8% found in women with other evidence of gonorrhoea and the 0.2% in the cases as a whole. Even so, the condition would appear to be very much less prevalent in Birmingham than in parts of Scandinavia and America and to provide little at present in the way of a public health problem. Nevertheless, you are right