cause of cardiovascular disease, which accounts for about half the excess mortality from smoking.

You state that there is little substantial decline in either cigarette sales or the number of people who smoke, yet you do not point out the dramatic fall of cigarette smoking in doctors, in other members of social class 1, and in class 2, especially among men. You refer to the impossible goal of stopping smoking by health education programmes, yet after the first of the two recent Thames Television programmes, "Dying for a Fag," it was estimated that about 160 000 people stopped smoking at least temporarily, and this represents about 2% of the smoking population. The fact that the tobacco industry is putting some of their workers on short time illustrates that the fall in tobacco sales which followed the recent tax increase is expected to last. It would have been more appropriate if, instead of decrying health education you had followed the B.M.A. Council's recommendation¹ in relation to smoking that "more attention should be paid to the way in which information is disseminated and attitudes are formed and an evaluation made of the methods used."

It is conceivable that in 20 years there may be evidence to show that cigarettes which include synthetic materials are indeed safer. Until this time arrives we strongly deplore the use of the term "safer cigarettes," though we agree that efforts to investigate forms of smoking which may be less lethal should be encouraged.

Doctors should give patients the same advice to stop smoking which they themselves have accepted and which has been such an important cause of the reduction in mortality from both lung cancer and coronary heart disease in the medical profession.—We are, etc.,

C. M. FLETCHER

Chairman,

KEITH BALL

Hon Secretary,

Action on Smoking and Health

London S.E.1

¹ *British Medical Journal Supplement*, 1971, 2, 91.

Better Medical Writing

SIR,—Dr. J. S. Bradshaw (26 April, p. 194) is confusing three different things: the techniques of medical writing, the correct use of the English language, and literature.

Medical writing—at least in its most important branch, that which deals with reports of original research as distinct from didactic or review articles—has no connexion with the kind of literary writing to which Dr. Bradshaw refers. It is a technique whose principles and practices are applicable whatever the language used. If the language used happens to be English of course it is best for it to be good English, but above all it should be plain and simple English, because the world's research workers do not read English with ease. Work reported in the style of T. S. Eliot, Swift, or Sir Thomas Browne, as Dr. Bradshaw recommends, would be liable to be ignored in the research laboratories of Moscow and Peking, or even in those of Baltimore or San Francisco.

Giving scientific papers a standard formal structure has solid advantages, and these

have been ably analysed elsewhere.^{1,2} It is comparable to writing hospital case-notes according to a uniform pattern. Both these practices make for orderly thinking by the writer and easy assimilation by the reader. But neither research reports nor case-notes are literature. Case-notes, incidentally, and written examinations are the first branches of medical writing that we meet in our medical career, and this is one of many reasons why notions of medical writing should be taught at an early stage. To say that undergraduates should not be taught the elements of medical writing because they already know (or should know) how to write would be analogous to saying that they need not be taught the elements of medical statistics because they already know (or should know) how to count.

The book³ which Dr. Bradshaw inaccurately calls a "pedagogic 'core' course" is, as its name indicates, intended specifically as a guide for those who want to write papers in English. Therefore, naturally, it deals with both (1) the principles of scientific writing and (2) the correct use of English in scientific writing. But the principles of scientific writing that it outlines are applicable to writing in any language.

Some authorities believe that eventually all "important" research will be reported in English, other languages being used only for papers of purely national interest. This may be true for countries whose languages practically no one else understands. But for France, the cultural leader of a huge francophone community, it is neither desirable nor necessary. Unfortunately, some French medical writers scorn, like Dr. Bradshaw, modern medical writing techniques and regard the use of the French language as necessarily linked with literary writing, thereby lowering the credibility of their country's medical literature and preventing their country's research from receiving the international recognition it deserves. According to an eminent French surgeon,⁴ ambitious young surgeons in France do not take French medical publications seriously and some French official scientific bodies do not recognize papers published in French journals. Happily, we have watchful medical editors to protect our British journals from ideas like Dr. Bradshaw's.—I am, etc.,

J. A. FARFOR

Paris

¹ Lock, S. P., *British Journal of Anaesthesia*, 1970, 42, 764.

² Soffer, A., and Weinberg, S. L., *Chest*, 1975, 67, 5.

³ O'Connor, M., and Woodford, F. P., *Writing Scientific Papers in English*, Associated Scientific Publishers, Amsterdam, 1975.

⁴ Detric, P., *Nouvelle Presse Médicale*, 1975, 4, 675.

SIR,—I enjoyed your leading article "Better Medical Writing" (12 April, p. 56) and look forward to the publication of the seminar on "Speaking and Writing in Medicine" that is scheduled for this autumn. It is a pity that more American medical writers cannot avail themselves of this learning experience. As one who has spent an entire professional career in medical communication, I am frequently chagrined by the general low calibre of English language usage by medical writers on this side of the Atlantic. All too frequently the results of excellent clinical investigations are rejected for publication simply because the authors are incapable of

expressing themselves in clear and coherent English prose. On the other hand, all of us have noted the consistently higher quality of medical writing by our British colleagues. This is why the *B.M.J.* is such a joy to read.—I am, etc.,

JOHN C. BALLIN

Director,

Department of Drugs,

American Medical Association

Chicago, Illinois

Injudicious First-aid

SIR,—I have followed with considerable interest the recent correspondence on injudicious first-aid. There seems little doubt that it is essential for personnel trained in first-aid to attempt resuscitation when it is indicated. The problem lies in the poor standard of the training given. As a corps surgeon in the St. John Ambulance Brigade, I examine in first-aid very often and am highly critical of the average standard of performance in resuscitation. It is often too painfully obvious that the candidate is trying to carry out from memory a mechanical operation read in the manual, without any idea whatsoever of the physiological principles which lie behind what he is doing. This leads to some quite remarkable performances. In my view no first-aid certificate should be granted until the candidate shows clearly that he understands not only the practice but the principles of resuscitation. This is not met by a few puffs into a resuscitation model.

I fear the blame for this unsatisfactory state of affairs must lie to a considerable degree with the medical profession. In my own area, and I suspect in many others, voluntary groups such as the St. John Ambulance Brigade have the greatest difficulty in recruiting doctors to do the training required. Some brigade divisions have not had a divisional surgeon for years and their attempts to interest local practitioners meet with no success. If resuscitation is worth doing, as it obviously is, then medical practitioners must be willing to co-operate with the first-aid organizations so that it is properly taught.—I am, etc.,

D. M. MACKAY

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London W.C.1

Dextran 70 and Thromboembolism

SIR,—I was very interested in the paper by Mr. A. L. Kline and others on this subject (19 April, p. 109) with its encouraging clinical message. I would like, however, to ask two questions: (1) Have they any reason to believe that two bottles of dextran are any more effective than one? and (2) is it possible that the increased bleeding commented on is from an overfull vascular compartment?

Dextran 70 is hypertonic, and in the absence of bleeding a 500-ml infusion could be expected to increase the blood volume by 10-20%. My own practice is to use 500 ml of dextran 70 prophylactically but in the absence of significant blood loss to give only 250 ml during surgery and the remainder postoperatively.

I have not seen increased bleeding with this regimen that could not be explained by a combination of excess fluid and vaso-

dilatation. I cannot say whether this regimen is as effective against thromboembolism as that used by Mr. Kline and his colleagues. —I am, etc.,

MERLIN MARSHALL

Department of Anaesthetics,
Newcastle General Hospital,
Newcastle upon Tyne

** Dr. Marshall sent a copy of his letter to Mr. Kline and his colleagues. A reply on their behalf from Professor L. E. Hughes is printed below.—Ed., *B.M.J.*

SIR,—I regret that it is not possible to provide definitive answers from our own work to Dr. Marshall's questions. Our use of 1000 ml of dextran 70 followed the trials reported by Bonnar and Walsh,¹ this dose being chosen because of their report of effectiveness and lack of side effects.

Jansen,² using a dose of 500 ml, found a prophylactic effect only in operations lasting less than one hour. This might suggest that 1000 ml is more effective than 500 ml, and for this reason we have been reluctant to reduce the dose for major operations. On the other hand we are concerned about the occasional case of apparent excessive bleeding and for this and other reasons we are at present investigating the use of 500 ml given the day before operation and 500 ml given peroperatively.

Stadil³ reported a regimen using 500 ml during operation and 500 ml 24 hours later in which he also increased the initial infusion in the presence of bleeding in an effort to maintain a plasma dextran concentration of 4 mg/l (0.4 mg/100 ml) for 72 hours postoperatively. This regimen also gave a considerable reduction in thromboembolic disease.—I am, etc.,

L. E. HUGHES

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Welsh National School of Medicine,
Cardiff

¹ Bonnar, J., and Walsh, J., *Lancet*, 1972, 1, 614.

² Jansen, H., *Acta Chirurgica Scandinavica*, 1972, Suppl. 427.

³ Stadil, F., *Lancet*, 1970, 2, 50.

Haemophilus influenzae Cellulitis

SIR,—Since the first report of cellulitis due to *Haemophilus influenzae* by Alexander in 1953¹ some 33 cases have been reported in the U.S.A.² but only three in the U.K., all by Turk.^{3,4} Here we report a case in which *H. influenzae* type b has been isolated both from the lesion and from blood culture.

The patient, a 1-year-old girl, was admitted to Paddington Green Children's Hospital with a two-day history of swelling and redness of the right foot, irritability, and anorexia. On examination there was evident red-blue cellulitis of the right foot with a fluctuant area over the lateral malleolus. The inguinal lymph nodes were enlarged and tender. Other findings included temperature 38°C and W.B.C. $18.5 \times 10^9/l$ ($18\,500/mm^3$), with a neutrophil leucocytosis.

A drainage operation was performed, removing purulent material, and it was noted that the underlying periosteum appeared normal, confirmed by drill biopsies taken at that time. Culture of the purulent material yielded *H. influenzae* type b and the same organism was isolated from blood culture after five days' incubation. She was treated initially with parenteral penicillin and cloxacillin which was changed to ampicillin once the infecting organism was known. The child made a slow but complete recovery.

This case fulfils most of the characteristics described for *H. influenzae* cellulitis in that it

was in a young child below the age of three and presented with fever and acute cellulitis which was red-blue in colour. It differed, however, in that the cellulitis did not involve the face as has generally been described^{2,5} and that haemophilus cellulitis does not usually proceed to abscess formation (D. C. Turk, personal communication).

We are grateful to Dr. P. J. N. Cox for permission to publish details of this case and to Dr. D. C. Turk for performing the typing of this organism.

—We are, etc.,

R. C. SPENCER
M. BARNHAM

Department of Bacteriology,
St. Mary's Hospital Medical School,
London W.2

¹ Alexander, H. E., in *Pediatrics*, ed. L. E. Holt and R. McIntosh, p. 1200. New York, Appleton Century.

² Goetz, J. P., Tafari, N., and Boxerbaum, B., *Pediatrics*, 1974, 54, 504.

³ Addy, M. G., Ellis, P. D. M., and Turk, D. C., *British Medical Journal*, 1972, 1, 40.

⁴ Cartwright, K., and Turk, D. C., *British Medical Journal*, 1974, 2, 225.

⁵ Rasmussen, J., *British Journal of Dermatology*, 1973, 88, 547.

Freedom of Information

SIR,—An all-party committee under the chairmanship of Mr. Arthur W. J. Lewis, M.P., has been formed to seek the repeal of the Official Secrets Acts of 1911 and 1939 and the introduction of a new Freedom of Information Act. As custodians of dossiers on patients, doctors are intimately concerned with the issues which would be raised in such a change of legislation.

The medical profession is concerned with these new proposals on two counts. Firstly, it is interested in the preservation of the confidential nature of medical records. Secondly, we as doctors are concerned for the protection of our patients and ourselves against the abuse of the Official Secrets Acts by agencies hostile to the best interests of the individual. A State medical service gathers, for various reasons, a vast amount of data on the individual, much of which goes into computer banks. The bulk of this information is probably harmless to the person concerned, but some could possibly be used to his detriment.

It is known that dossiers are compiled on individuals containing information from many sources; medical records are not sacrosanct, and confidential opinions detrimental to the good standing of the patient may find their way into the files. Such dossiers may constitute a black list, holding information which may be secret and damaging and might, unbeknown to the individual, ruin his career. The abuse of the Official Secrets Acts to prevent the individual concerned or his legal advisers from gaining access to his dossier constitutes an infringement of his right to a fair trial.

The purpose of the proposed Freedom of Information Act is to make it possible for an individual or his legal representative to refute false reports detrimental to his good standing contained within these black files. It is not its purpose to make confidential medical reports available to all and there is no danger that professional secrecy would be violated. The Act would prevent the abuse of professional secrecy by Government agencies and intelligence networks.

The Official Secrets Acts were emergency measures brought in at a time of war. Their existence in peacetime has come to be abused. The individual must have a right to correct what is secretly and unjustly held against him. Doctors have unwittingly become the tools of data-collecting agencies. They must insist that the Freedom of Information Act goes on the statute book to ensure that the confidential information they collect about their patients is not abused.—I am, etc.,

EDWARD C. HAMLYN

East Grinstead, Sussex

Oxygen Therapy for Pneumatosis Coli

SIR,—May I comment on the article by Dr. R. H. L. Downs and Mr. W. M. Castleden (1 March, p. 493)?

Firstly, cysts may relapse after oxygen,¹ disappearing after further therapy.²

Secondly, I question either interpretation of the idea that "the cysts are created and maintained by a fastidious anaerobic gas-forming organism." The first is that cysts are produced by a form of gas gangrene. This was rejected in the early literature, no such organism has been found, the histology is unacceptable for bowel wall infection and fatal septicaemia follows injections of gut bacteria into the bowel wall.³ The second is that some faecal organism produces peculiar gut gas which forms cysts. Cyst formation requires a pre-existing gas bubble in the bowel wall which is maintained or enlarged by diffusion of gas into it from the bowel lumen. A disruptive force must make this initial bubble, which could not result from gaseous gut distension. This could occur with dissection of air from the lung,⁴ or perhaps in this case sigmoidoscopy.⁵ No extraordinary organism is needed to produce cyst gas; rapid variations in gut gas occur in normal people; in pigs a tendency to form cysts follows feeding with polished rice.⁷

The idea that oxygen "kills the organisms and the gas is then reabsorbed" seems unlikely. Any cyst gas will resorb down the pressure gradient between cyst and tissue gas.¹ Some gas may survive oxygen therapy. To persist it must be continuously replenished by diffusion from the gut; in addition, cysts recur. Oxygen therapy will therefore cure cysts despite continued gas production capable of maintaining them.

I believe physiological mechanisms produce the necessary gaseous conditions to maintain cysts in a proportion of the population. If a cavity is then formed in the bowel wall a cyst results. Oxygen, by increasing resorption of cyst gas, allows their deflation and obliteration. New cavities or residual cavities may, however, lead to recurrence of cysts.—I am, etc.,

P. H. WRIGHT

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¹ Forgacs, P., Wright, P. H., and Wyatt, A. P., *Lancet*, 1973, 1, 579.

² van der Linden, W., *Lancet*, 1974, 2, 1388.

³ Jaeger, A., *Verhandlungen der Deutschen Pathologischen Gesellschaft*, 1906, 10, 251.

⁴ Keyting, W. S., et al., *Radiology*, 1961, 76, 733.

⁵ Marshak, R. H., et al., *Journal of the American Medical Association*, 1952, 148, 1416.

⁶ Biester, H. E., et al., *Journal of the American Veterinary Medical Association*, 1936, 88, 714.

⁷ Eveleth, D. F., and Biester, H. E., *American Journal of Hygiene*, 1933, 27, 364.