the family they report since all heterozygotes will carry the same mutant gene.

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[1] Betteridge, D J, Higgins, M J P, and Galton, D J, *British Medical Journal*, 1975, **4**, 500.

More compassion needed

SIR,—Regarding Dr R M Whitington's article on dextropropoxyphene overdosage (16 July, p 172) we had a tragic incident in our family when our daughter was found dead within a period of 2½ hours after ingestion of some 50 Distalgesic tablets, source unknown. The post-mortem findings showed collapse at the bases of both lungs. She was found with her hand on the receiver of the telephone, suggesting some sudden distress. This ingestion was possibly a cri de coeur following refusal of the staff of a psychiatric teaching hospital to see her, an application she often made. Indeed, after a termination of pregnancy in January all they would offer her was a fortnightly hour with the community nurse, although this was increased when her behaviour improved.

I am writing this because behind so many poisonings lies mental instability of one kind or another, cause usually unknown. Treatment even in this day and age is often sophisticatedly cruel—indeed, if the case is deemed incurable the patient is often pushed back on to the general practitioner, who may or may not be sympathetic but is always busy. Community care is often only of a voluntary type. In this case a local church is trying to help these people but finding little help and support from the psychiatric hospital.

When choosing medical students it should be born in mind that all doctors, be they consultants or general practitioners, need the quality of compassion as much as three As at A level and that we shall all be incurable one day and shall be at their mercy.

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Tryptophan and rheumatic diseases

SIR,—In "Any Questions" recently (18 June, p 1590) your expert pointed out that there is no published evidence to suggest that L-tryptophan has an antirheumatic effect. However, it should be noted that almost all antirheumatic drugs possess the common property of displacing L-tryptophan from serum protein binding sites, thus increasing the plasma levels of the free amino-acid.[1-3] It is still not clear how, if at all, this displacement and the increased availability of free L-tryptophan are related to the antirheumatic effect of these drugs. Some workers[1] suggest that the freeing of other substances, especially short-chain peptides, may be of greater significance.

Interestingly, those antirheumatic drugs which do free L-tryptophan from serum proteins appear to possess some antidepressive effect. At least one group of workers[4] has demonstrated an inverse relationship between the level of free tryptophan in patients treated with three different antirheumatic drugs and their depressive scores on the Hamilton Rating Scale.

We have used L-tryptophan extensively as an antidepressant, and in the course of treating a large number of patients have inevitably used the amino-acid in some persons with rheumatoid arthritis. A few of these have shown a dramatic lessening of rheumatoid symptoms associated with a fall in the erythrocyte sedimentation rate. Subsequent discontinuation of the L-tryptophan in several of these cases has been followed by an increase in joint pain. It would be quite wrong to draw specific conclusions from clinical impressions in such small numbers of patients, but it may be considered desirable that formal clinical testing of the effect of L-tryptophan in rheumatoid arthritis should be undertaken.

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[1] McArthur, J N, *et al*, *British Medical Journal*, 1971, **2**, 677.
[2] Smith, M J H, Dawkins, P D, and McArthur, J N, *Journal of Pharmacy and Pharmacology*, 1971, **23**, 451.
[3] Smith, H G, and Lakatos, C, *Journal of Pharmacy and Pharmacology*, 1971, **23**, 180.
[4] Aylward, M, and Maddock, J, *Lancet*, 1973, **1**, 936.

Shortage of anaesthetists

SIR,—Over the past five years I have been the surgeon attached to a large regional health centre in Stockholm with its base hospital (Karolinska Sjukhus) some five miles (8 km) away. During this time I have performed many operations as outpatient procedures using only the various methods of local anaesthesia. The accompanying table is not a comprehensive list, but rather to give some idea of what can be done.

It seems that the time has come for British surgeons to attempt to break some of the bands that bind them to their anaesthetists. A return to old-fashioned and outdated practices is not suggested but rather that more interest be taken in the modern forms of local anaesthesia which, although widely practised in Scandinavia, seem to have been largely ignored (or suppressed) by their British colleagues.

No special equipment is required; in recommended doses the drugs are perfectly safe, the technique is easily learnt, and the costs are low. Simple tourniquets, a sphygmomanometer, and a variety of syringes and needles are all that is required. The anaesthetic agent I use is prilocaine hydrochloride in concentrations of ½% and 1% both with and without adrenaline. The methods most applicable and readily learnt are:

(1) Local infiltration with ½% solution—this is already widely used and needs no further discussion.

(2) Local nerve or plexus blocks—these can be accomplished with 1% prilocaine, though I invariably use ½% with equally good results and avoid local motor blockade. The method allows

Outpatient surgery under local anaesthesia

Operation	No performed
Varicose vein surgery	422
Removal of joint or tendon ganglion	132
Extirpation of Dupytren's contracture	47
Tendon sheath splitting	64
Peripheral neurolysis	20
Circumcision	49
Cystourethroscopy (males)	34
Removal of hydrocoele/spermatocoele	8
Extirpation of sacral pilonidal sinus	22
Herniorrhaphy	34
Extirpation of axillary sweat glands	28
Reposition of wrist fracture	26
Removal of exostoses	44
Extirpation of larger subcutaneous tumours	83
Vasoresection (allowed only since 1976)	28

2 h of surgery to an isolated limb with or without a bloodless field and is also suitable for groin (hernia) and genital operations. Each type of block is excellently described in Eriksson's *Illustrated Handbook of Local Anaesthesia*.[1]

(3) Regional intravenous anaesthesia gives the operator about 20 min and is, for example, suitable for reduction of fracture of the wrist. The technique is also described in Eriksson's handbook.

(4) Finally, topical anaesthesia, which, although widely used for oral surgery, is perhaps underestimated for use in other mucosal areas. The urethra is easily anaesthetised after about 10 min contact with a local anaesthetic gel and will allow painless endoscopic examination of the urethra and urinary bladder even in males.

I have seen thyroidectomies and laminectomies performed under local anaesthesia in Sweden, but do not advocate a total redundancy of anaesthetists. Many procedures can, however, be performed with advantage using the above methods. I prefer my patients to have fasted, but this is not essential in acute situations. Nervous patients can be given 10 mg diazepam intravenously before starting the operation. Before embarking on outpatient surgery agreement with a nearby hospital is obligatory so that rapid admission can be obtained if necessary. Only one of my patients has required acute admission to the Karolinska after surgery and that was a 75-year-old man who developed a clot retention after cystoscopy. Three others have needed overnight observation, one after excision of a pilonidal sinus and one after a vasectomy because of bleeding, while a third patient developed abdominal cramps after an inguinal herniorrhaphy.

British surgeons have too long been pampered and protected by a readily available corps of the best-trained anaesthetists in the world. My advice is to stop belly-aching and be practical. Learn the basic principles of local anaesthesia and, by doing it yourself, allow the highly skilled anaesthetists to employ their talents where most required.

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[1] Eriksson, E, (ed), *Illustrated Handbook of Local Anaesthesia*. Copenhagen, Munksgaard, 1969.

Diagnosis in cases of haematuria

SIR,—Mr A G Turner and his colleagues (2 July, p 29), describing a diagnostic service for haematuria, have understandably concentrated on the yield of unsuspected carcinoma. They have, however, failed to mention the possibility of a glomerular site for haematuria despite the fact that over 10% of their cases remained undiagnosed.

We have previously reported[1] cases illustrating the importance of renal biopsy as a diagnostic tool in those cases of haematuria