vary in their response to trauma it is possible that a large adrenergic stimulus would release a significant amount of FFA into the circulation, inducing pulmonary damage with resultant hypoxia and even fat embolism syndrome (FES). The interesting observation of Myers and Taljaard¹ that alcohol seems to be a prophylactic in developing FES may be due to diminished amount of circulating unbound FFA as a result of decreased response to stress. Since FFAs are 99% albumin-bound Liljedahl and Westermarck² and Moylan³ recommend the use of albumin following trauma to bind FFA as well as to improve peripheral circulation. In the light of our findings their advice seems important.

Carlson and Liljedahl⁴ have shown that treatment with nicotinic acid and guanethidine (adrenergic blocking agents) diminishes the rise in serum FFA concentration following noradrenaline infusion or trauma in dogs. On the basis of this finding we hope to continue our studies using small doses of adrenergic blocking agents in a randomly selected trial of severely traumatised patients to assess any therapeutic benefit.

J BROCK-UTNE

Department of Anesthesia,
Stanford University Medical Center,
Stanford, California

¹ Nixon, J R, and Brock-Utne, J G, *Journal of Trauma*, 1978, **18**, 23.

² Peltier, L F, *Surgery*, 1956, **40**, 665.

³ Carlson, L A, and Liljedahl, S O, *Acta Medica Scandinavica*, 1963, **173**, 25.

⁴ Myers, R, and Taljaard, J J F, *Journal of Bone and Joint Surgery*, 1977, **59A**, 878.

⁵ Liljedahl, S O, and Westermarck, L, *Acta Anaesthesiologica Scandinavica*, 1967, **11**, 177.

⁶ Moylan, J A, et al, *Journal of Trauma*, 1976, **16**, 341.

⁷ Carlson, L A, and Liljedahl, S O, *Acta Medica Scandinavica*, 1963, **173**, 787.

Partial meniscectomy preferred

SIR,—Interest in meniscal tears and their treatment has revived during recent years. The results of closed partial meniscectomy reported by Mr D J Dandy (29 April, p 1099) are very much in line with ours since 1975. An earlier series¹ encouraged us to improve our technique further in order to make closed meniscectomy swifter and neater with the same good primary result. We have developed a new set of instruments to be used in combination with a standard 5-mm arthroscope. The instruments are introduced on either side of the centrally placed telescope. The results in the first 18 consecutive patients have been compared with those in matched controls treated by standard open arthrotomy. (unpublished observations). Closed excision of bucket-handle or other tears is technically difficult; our first operations were time-consuming and we actually failed in three patients and had to finish the operation by the open method. After getting used to the new instruments we have now succeeded in bringing down the operating time to 15 min for both diagnosis and treatment in lateral bucket-handle tear. The convalescence after closed treatment is short: the mean durations of sick leave in our series were seven days (range 0-28, median 5) after arthroscopic excision and 41 days (21-112, median 30) in controls operated on by arthrotomy. At follow-up 13-75 (mean 39) weeks later knee function was found to be equally good in both groups. Consequently, a surgeon well versed in diagnostic arthroscopy has great therapeutic potential and the patient suffers little discomfort. We hope this will encourage wider

use of arthroscopy for the diagnosis of meniscal tears, which is now perfectly feasible even when the tear is located in the "blind" posteromedial region (unpublished observations).

Jackson² has stated in this journal that unnecessary meniscectomies do occur in spite of the known high incidence of joint degeneration several years after operation. Furthermore, we have found a three-fold increase in laxity and a 10% reduction in tensile strength in the medial ligaments after medial meniscectomy in the dog.³ Whether this also applies to man is not known, but anatomical studies of human knees serially sectioned as whole organs with all collagenous tissues in situ and examined under polarised light has disclosed intimate relations between the fibres from the medial collateral and capsular ligaments and the medial meniscus tissue (unpublished observations). This functionally integrated unit of collagenous tissue seems to be much less disturbed by partial than by total meniscectomy. Regardless of whether partial or "total," closed or open, the operation must be carried out under full visual control to avoid leaving residue capable of causing symptoms. Fortunately, arthroscopic excision of centrally located posterior residue has proved successful with our new technique, even when previous re-arthrotomy had failed to relieve the symptoms.

NILS ORETORP
JAN GILLQUIST

Department of Surgery,
University Hospital,
Linköping, Sweden

¹ Gillquist, J, Hagberg, G, and Oretorp, N, *Injury*. In press.

² Jackson, J P, *British Medical Journal*, 1968, **2**, 525.

³ Oretorp, N, et al, *Acta Orthopaedica Scandinavica*. In press.

Treatment of pneumonia

SIR,—The article on pneumonia by Dr Colin Ogilvie (25 March, p 771) is in general both rational and practical, but the following observations and recommendations are perhaps open to criticism, and should be brought to your readers' attention:

(1) Needle aspiration of the lung is liable to produce a pneumothorax which may be lethal in a very sick patient with pneumonia. If it is vital to obtain a specimen of lung "juice" for microbiological examination transbronchial biopsy, using a fiberoptic bronchoscope, is usually a safer technique.

(2) Tuberculosis does not "predispose" to pneumonia.

(3) Amoxycillin is much more expensive than ampicillin and there is as yet no proof that it is clinically more effective in the treatment of pneumonia or less toxic. It should therefore not be specifically recommended in preference to ampicillin.

(4) There is no evidence that continuous antibiotic therapy for "several weeks" in widespread destructive pneumonia with abscess formation (for example, staphylococcal) is an effective or indeed a logical policy.² If the organism has already been eliminated by a shorter period of treatment it can safely be withdrawn; if not the infection is likely to have become drug-resistant and the treatment is not worth continuing.

(5) Dr Ogilvie's indication for oxygen therapy (an arterial oxygen tension of less than 10 kPa) seems a little extravagant—

8 kPa would have been more reasonable. On the same topic, it is wrong to equate an oxygen flow-rate of 2-3 l/min by nasal catheter with an inspired oxygen concentration (by Ventimask) of 28-30%—the true figure might be nearer 35%,³ and that difference could in some cases be critical.

(6) In the treatment of an infected (turbid) pleural effusion few respiratory physicians nowadays would advise intrapleural benzylpenicillin since the value of this form of treatment has never been confirmed, even in penicillin-sensitive infections. The simplest and most effective measure in this situation, if the effusion is large, is to insert a basal intercostal tube and evacuate all the fluid immediately, while giving appropriate antibacterial drugs by the systemic route.

IAN W B GRANT

Department of Medicine,
National University of Malaysia,
Kuala Lumpur

¹ Ogilvie, C M, *British Medical Journal*, 1978, **1**, 771.

² Boyd, D H A, *British Journal of Diseases of the Chest*, 1975, **69**, 259.

³ Green, I D, *British Medical Journal*, 1967, **3**, 593.

Uniform style for biomedical journals

SIR,—I write to support Miss Maeve O'Connor's plea (10 June, p 1552) that, in the citation of references in biomedical journals, the date should immediately follow the author. Citation methods which do otherwise do not consult the convenience of the scientist whose work provides the reason for the existence of the reference. Scientists find things from their mental filing system largely on name and date—"It's in the 1963 paper by so and so." It is time-consuming if a search has to be made through a lot of fine print in the reference to find the date inconspicuously buried in the volume citation.

W H R LUMSDEN

Department of Medical Entomology,
London School of Hygiene and
Tropical Medicine,
London WC1

Schumann's hand injury

SIR,—May I be permitted a reply to Professor Alan Walker (27 May, p 1420)? On the evidence of his letter it appears that Professor Walker read our paper in haste and without full comprehension—how otherwise could he ascribe to us notions which we do not hold and opinions which we have not expressed? He feels that we obscured "certain issues," but this idea seems to flow from that lack of understanding which is liable to arise when different disciplines meet.

The first part of Professor Walker's letter deals with Schumann's cerebral illness, though he did not put it that way. Professor Ulrich and I made it quite clear that we were dealing with the condition of the composer's right hand, and we cannot believe that anyone with knowledge of medicine would have supposed that we were attempting to alter Slater and Meyer's diagnosis—namely, general paralysis of the insane. We were trying to elucidate the site and nature of the lesion responsible for the disability in the right hand.

We localised the lesion to the right posterior interosseous nerve, a conclusion supported by the many neurologists who have heard our communications on the subject. Mr K I

Nissen (20 May, p 1354) taxes us with not considering an affection of the median nerve, but this suggestion is contraverted completely by the clinical information available and therefore not worth discussion. After localisation, we proceeded in classical neurological fashion to consider possible causes of the lesion. Professor Walker scorns the idea that piano playing might be the cause of a hand injury producing chronic partial paralysis; he does not pause to consider our argument, based on personal anatomical and surgical observation, that if piano playing was related to the hand disability, then there must have been an associated anatomical variation. This caveat was an essential point in our discussion because of the absence of other reported cases among professional pianists. Incidentally, we know many rowing men and only one has developed a posterior interosseous palsy in relation to this pastime.

Lastly, Professor Walker takes us to task for our direct, acknowledged, quotation from Dr Sams, to whom we refer him, on the subject of Schumann and the finger strengthener he is said to have ordered. As a final blow, Professor Walker implies that we entertained the idea that the unproved use of such a machine was the cause of a condition present for seven previous years. Nothing we wrote supported this ridiculous interpretation.

It might be helpful if Professor Walker were to discuss the neurological problems of this tragic but interesting case with our colleagues in the department of neurology in the Medical School of McMaster University. Alternatively, we would be pleased to pursue the matter when he is next in London.

R A HENSON

Neurological Department,
London Hospital,
London E1

*.*This correspondence is now closed.—ED,
BMJ.

Kidney failure in liver disease

SIR,—With reference to your leading article (27 May, p 1375), since I was the first in this country¹ to emphasise the finding of endotoxin in the plasma of patients with hepatorenal failure and the larger series that have followed have simply confirmed this fact, may I be allowed to observe that it is time that further discriminatory work be done? The original observation followed the introduction of the limulus assay but stemmed from radio-fibrinogen studies which showed continuing fibrinogen catabolism in such patients.² This particular type of renal failure does not have the features of a Schwartzman reaction (glomerular and peritubular thrombosis) that is the standard response to endotoxin. In part this may be due to the very active fibrinolysis that is found in cirrhosis. That there is true disseminated intravascular clotting is shown by the improvement with heparin.³

Another anomaly is that these patients have high antibody titres to O antigens of Gram-negative organisms. Thus the endotoxin is likely to be present in plasma as endotoxin-antibody complexes. Yet there is no nephritis. Four factors that require exploration come to mind. Firstly, the antibodies may be of broad specificity and low affinity: such complexes are not easily precipitated by ammonium sulphate in the Farr test. Secondly, the low level of serum esterases in chronic

liver disease⁴ may imply an inability to inactivate endotoxin that has shunted past the normally active Kupffer cells of the cirrhotic liver. Thirdly, bile acid retention in cirrhotic plasma may mean that endotoxin is dissociated into subunits that are poorly antigenic and that react in a biologically different manner. Fourthly, for this previous reason, the true antitoxic antilipid A titres may actually be low in cirrhosis.

E N WARDLE

¹ Wardle, E N, *Clinical Science and Molecular Medicine*, 1974, **46**, 17P.

² Wardle, E N, *Archives of Surgery*, 1974, **109**, 741.

³ Coleman, M, et al, *Annals of Internal Medicine*, 1975, **83**, 79.

⁴ Waterlow, J, *Lancet*, 1950, **1**, 908.

Generalised urticaria precipitated by change to highly purified porcine insulin

SIR,—Allergic reactions to unpurified insulins are well recognised.^{1,2} Recently an allergic reaction to a porcine monocomponent insulin (Actrapid MC) has been reported.³ We wish to describe another case in which generalised urticaria developed after changing to highly purified porcine insulins and which has persisted despite the subsequent use of monocomponent preparations.

A 54-year-old man who has had diabetes for 18 years was restabilised on porcine insulin. He had received continuous treatment with bovine insulins from the onset of his diabetes and for many years had been taking a twice-daily admixture of soluble and isophane insulins (Weddel). Diabetic control had been far from adequate despite increasing doses of insulin (120 U daily) and following discussion it was felt that he might benefit from a more purified insulin preparation. Leo Neutral and Leo Retard insulins (Nordisk) were started and good diabetic control was achieved with a total of 84 U daily.

Five days after starting the new regimen he began to develop intermittent generalised urticarial reactions throughout the day and night which gradually increased in severity. No other drugs had been introduced during this period and he was admitted for further assessment. Systematic investigation failed to reveal any other underlying cause for the urticaria; the peripheral blood eosinophil count was normal. It is of interest that he gave a history of hay fever, but he has had no other particular allergies.

Insulin treatment was withdrawn and no new urticarial reactions developed during a 25-h period of observation. Treatment was recommenced with Actrapid MC and Semitard MC insulins (Novo), with a prompt return of urticaria, which has persisted despite trying different regimens, including a return to the original bovine preparations.

Intradermal skin tests were performed using 2 U (0.05 ml) of the following insulins: bovine soluble and isophane (Weddel); highly purified porcine Leo Neutral and Retard (Nordisk), and monocomponent porcine Actrapid and Semitard (Novo). In addition, 0.1 ml of Nordisk protamine and "medium" and of Novo methylparaben and "carrier" was injected. Equal volumes of saline were used for controls. At 30 min a 17-mm weal had developed in response to the Nordisk "medium." In addition, 8-mm weals occurred at the sites of the Nordisk Neutral and Retard insulins, protamine, and the bovine insulins. Minimal reactions to Novo carrier, methylparaben, Actrapid MC, and Semitard MC were observed, but these were not significantly different from the controls. All reactions, with the exception of the Nordisk "medium" and bovine isophane insulin, had faded within 4 h.

This patient's urticaria developed within five days of changing from conventional to

purified insulins and has persisted despite using different insulin regimens. That it was due to the insulin treatment was demonstrated by the absence of urticaria during insulin withdrawal. The possibility exists that the urticarial reaction reflects a delayed-type hypersensitivity, but immediate reactions could be demonstrated following intradermal skin tests. The occurrence of urticaria appeared to be triggered by the change to highly purified porcine insulins and it is speculated that a particular component of one of the preparations (? Nordisk "medium") acted as an adjuvant in this particular case. Fortunately, this patient's symptoms are reasonably controlled by chlorpheniramine tablets, and despite these difficulties his diabetic control has improved. Such reactions are rare complications of insulin treatment but both this report and that of Leslie⁴ indicate that they may occur in response to porcine insulins, and in both cases there was a strong history of allergy or hay fever.

We thank Mr F A P Henesey for his kind co-operation in providing the Nordisk protamine and "medium," and Dr D Leslie for providing the Novo methylparaben and "carrier."

C REISNER
D J MOUL
A G CUDWORTH

Diabetic Department,
St Bartholomew's Hospital,
London EC1

¹ Joslin, E P, Gray, H, and Root, A F, *Journal of Metabolic Research*, 1922, **2**, 651.

² Hanauer, L, and Batson, J M, *Diabetes*, 1961, **10**, 105.

³ Leslie, D, *British Medical Journal*, 1977, **2**, 736.

Legalisation of cannabis

SIR,—I am gravely disturbed by a further attempt to legalise the use of cannabis in Britain. Whatever argument is put forward by those interested in or merely indifferent to such a measure, there is universal agreement among the comparatively few pot smokers (both habitual and occasional) I have encountered as individuals that a person under the influence of cannabis is disinclined to go to work or look after his or her children and more than likely to fail to do this or any other useful work. Even more important, none of them would care to be driven in a car by such a person. These views are amply confirmed by such examinations as I have been able to make on persons so affected; they were certainly unfit to drive.

Have we not enough misery on these scores caused by alcohol that we must now be invited to add to it? The legalisation of cannabis cannot do good. It can only do harm. I look for a unanimous reiteration of this view from the profession.

A LEWIS

London W1

Confidentiality of medical records

SIR,—I was recently informed by a patient that, while attending a school medical examination with her son, she noticed that the school medical officer had in his possession copies of letters sent to me by a paediatrician at a local hospital. I made further inquiries and discovered that copies of letters from paediatricians concerning schoolchildren are sent automatically to area specialists in child health