

who were subsequently registered as congenital rubella cases (11 August, p 396). The Office of Health Economics estimated that between 200 and 250 children are born annually (in non-epidemic years) with congenital rubella syndrome.<sup>2</sup> After the 1978 epidemic, 1500-2000 rubella-damaged babies are expected to be born this year.<sup>3</sup>

An estimate of the cost of the care of a person living from 16 to 65 years of age in a Spastics Society home is £173 000 at present day costs. If loss of earnings is added at, say, £5 000 per annum, the total cost becomes £373 000. Clearly the costs vary with the degree of handicap. It is therefore against the background of this order of expense that one should evaluate a screening programme. However, I think it is debatable whether any screening programme should have to justify itself on the basis of economics alone.

Is, then, Dr Wilson questioning the habit of serotesting before vaccination? We know that rubella vaccine can be teratogenic, but this varies with the immune state of the mother at the time of vaccination, the gestational age of the fetus, and the type of vaccine used. One study<sup>4</sup> of 65 seronegative women vaccinated in early pregnancy who went to term showed that all were delivered of normal babies. The study estimated the risk of major malformations to be less than 5.5%. However, doubts about the safety of the vaccine become irrelevant in a properly designed survey, which would exclude pregnant women at the time of vaccination and provide effective contraceptive advice for three months afterwards. A compromise may be the policy of taking and storing blood at the time of immunisation, testing it only if it is subsequently discovered that, inadvertently, the woman was pregnant. On the basis of the results, a therapeutic abortion may be advised.

Certainly a screening programme involving adult women is difficult and costly. Certainly the uptake rate will be less than 100% but I would not like to predict the 25% suggested. However, these are no reasons for abandoning the attempt to prevent some rubella-damaged children.

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<sup>1</sup> Wells, N, *Birth Impairments*, p 27. London, Office of Health Economics, 1978.

<sup>2</sup> *British Medical Journal*, 1978, 2, 1441.

<sup>3</sup> Preblud, S R, et al, *British Medical Journal*, 1978, 2, 960.

#### Labetalol in severe tetanus

SIR,—We read with interest the reports of treatment with labetalol in tetanus (28 April, p 1121; 28 July, p 274), and wish to report our experience of continuous intravenous infusion of labetalol in a patient whose arrhythmias and hypertension persisted intermittently for three weeks.

A 70-year-old woman pricked her finger while gardening and the wound became infected. Trismus developed six days later and after a further two days she developed respiratory spasms and paroxysms of supraventricular tachycardia and hypertension. She was paralysed with intravenous pancuronium, ventilated, and sedated with large doses of diazepam and phenoperidine. Repeated intravenous boluses of propranolol were given in an attempt to control the episodes of tachycardia and hypertension. The next day an intravenous infusion of labetalol (1 mg/min) was begun but paroxysms of tachycardia continued. Four hours later she became hypotensive and oliguric but these features resolved when the labetalol was

stopped. The following day she had a sustained supraventricular tachycardia and hypertension, which persisted for four hours after labetalol infusion was recommenced. The infusion was continued for 10 days, during which time there were no episodes of tachycardia lasting more than 30 seconds. In the 10 days after labetalol was stopped the paroxysms of supraventricular tachycardia recurred, on average two or three times each day; but this period coincided with the time when the patient was being weaned off the ventilator and was receiving less sedation. These episodes were treated with intravenous boluses, initially of propranolol and later of verapamil, which appeared to be more effective than the propranolol.

The rapid fluctuations in arrhythmias and blood pressure which occur in tetanus make it difficult to assess the effects of sympathetic blocking drugs in this disease, because an apparent therapeutic response to an intravenous bolus may reflect spontaneous resolution. In this case, however, the episodes of supraventricular tachycardia were less frequent and less severe during labetalol infusion and recurred when the drug was stopped, although sedation was also decreased at this time. We conclude that labetalol infusion (1 mg/min) is unlikely to correct an established arrhythmia but may be useful in prophylaxis in severe tetanus. It is not, however, a substitute for adequate sedation and may cause hypotension initially.

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#### Emphyteusis

SIR,—By chance, I came across the word emphyteusis in the *Shorter Oxford English Dictionary*. It has been known since 1618 and its literal meaning is implanting, the word in a legal term denoting "a perpetual right in a piece of another's land." I see no reason why this melodious word should not be adopted by cardiologists with reference to pacemakers. Only recently, after all, neurologists have appropriated the banking term deficit. The Greek equivalents of implant and implantee must be left to Hellenists.

I must declare my interest: I carry a pacemaker between my right pectoral muscles and the superficial integument. I would much prefer to be known by a soft Greek expression than by the ugly neologism implantee.

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#### Makerere University Medical School

SIR,—Many doctors throughout the world are concerned with the fate of this famous African medical school. My wife and I have just returned from a four-day visit to Makerere, where we were able to assess the present situation. Contrary to some rumours, the medical school has never ceased to function and has sustained its large student intake and heavy teaching programme. At the time of our visit some final examinations were being conducted with scrupulous attention to their organisation.

The enormous problems which have faced the medical school are by no means over, but this would seem to be an opportune time to

pay tribute to the university and hospital staff who have remained in Uganda, often at personal sacrifice, and have maintained high standards in such difficult conditions.

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#### Minor operations in general practice

SIR,—May I add to the correspondence that has followed Dr J S Brown's article (16 June, p 1609)? The problem I should like to highlight is the provision of the services of the central sterile supply department (CSSD).

I am denied free use of the CSSD for my minor surgery service because, according to my district administrator, it is DHSS policy that GPs will not be provided with sterile supplies. I can, however, be supplied with the CSSD facilities I require if I pay a recurring sterilisation charge for each pack. Therefore my partners and I are expected to pay for the privilege of reducing the surgical waiting list at our local hospital.

As Dr Brown's article has shown the cost-effectiveness of minor surgery within general practice, surely we should now be given some active help and encouragement to provide a service which benefits both the patient and the over-stretched hospital service.

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#### Functional budgeting

SIR,—I have only recently had brought to my attention the letter from Mr P J E Wilson (2 June, p 1485) on functional budgeting. Although you have published a reply to this from Messrs Todd and Worsley (21 July, p 213), I feel that as so many of Mr Wilson's arguments are inaccurate I should write to you as an officer at the "sharp end" who has a very satisfactory budgeting system in operation.

It grieves me to see that some consultants are still very suspicious of the concept of budgeting. I feel that this suspicion stems from an ignorance of why we must have this kind of system; the benefits that can accrue from it, both from the viewpoint of the budget holder and also from that of the management team; and the part that all staff can, and should, play in the control of expenditure—even medical staff. Mr Todd and Mr Worsley pointed out the salient argument that medical staff have it in their power to commit considerable resources—they put it at least 60%, but I would venture to suggest that the figure is much higher when we look at the total effects of patients being admitted to hospital, including catering, laundry, etc. Medical staff have through the ages felt that they should not be controlled over their expenditure and that they should have the divine right to spend whatever they wish.

We have had such a budgeting system in this district for over three years now. All managers are involved, including the medical staff. This involvement has been largely at their own request and I am sure that they would bear testimony to the fairness of the system and the benefits that they reap. As well as the service-providing specialties such