Personal Paper

Lateral chest radiography or a chicken in every pot

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Recently one of the medical housemen in our hospital had occasion to write in large felt-tip letters across a request form for a radiograph "When I ask for a lateral, I want a lateral!" Being relatively new to the hospital and the NHS (after all a house physician's job lasts only six months), he may not have appreciated what preceded, or antedated, the circumstances that gave him cause for his outburst. These put me in mind of the joke in recent circulation, "Say, what preceded the following —9W." The answer is "Do you spell your name with a V, Herr Wagner"—not an answer that would immediately come to mind unless you had already heard the joke.

As it happens I have been concerned with the lateral chest radiograph for a long time. Many years ago I was a chest physician and then we never took lateral views, partly because we were really mainly looking for tuberculosis and partly because we were ignorant. That is how a patient could attend for years without it being discovered that he had achalasia and that his cough was due to spill from an oesophagus permanently containing about a litre of food. Then, when pulmonary tuberculosis began to run out, we all aimed to be general as well as chest physicians, and we knew that in myasthenia gravis the thymic tumour was often not visible on the best of postero-anterior films but might be plain as a pikestaff on the lateral film. We also found that carcinoma of the bronchus was replacing the vanishing tubercle and that you could miss a tightly collapsed lower lobe on the posteroanterior view and recognise it on the lateral view—if you knew where to look for it. We also discovered that the "hilar" tuberculous cavity, so difficult to treat, was actually in the apical segment of the lower lobe.

Need for bright lights

When we began to run out of lung cancer as well as tuberculosis, I decided to change my colours, and started training as a radiologist. I found a whole new world of interest at the splendid teaching hospital where I now worked. There was only one point of criticism—their chest radiographs were terrible—black as your hat—no wonder they needed bright lights to look at them! After a while not only did I get used to them but found that if you did use the bright lights (not present at any chest clinic at which I had previously worked) what had appeared black and featureless now showed not only all the detail previously seen on the "soft" chest clinic films, but showed all sorts of structures in the posteroanterior view, such as collapsed lobes and achalasic oesophagi, previously only visible on lateral views. I also realised that the Christmas snow-storm effect generally seen on chest clinic films was due to the dust on the intensifying screens,

which were regularly cleaned only in x-ray departments. It was at this point that I took half a step backwards. Even if you were a civilised educated physician, posteroanterior and lateral views need not always be obligatory, just as an occasional customer on a diet might want only "fish" rather than "fish and chips."

"St Elsewhere"

A further step in my conversion against routine lateral views occurred when I started doing two sessions a week at a subsidiary hospital, "St Elsewhere." I am one of the few who admits, nay, is proud to announce, that I work at this well-known institution. One of their characteristics which I soon recognised is the St Elsewhere Six. This is not a group unjustly martyred for their colour or political views but the six films that confront the radiologist with most new admissions. They consist of posteroanterior and lateral chest radiographs taken at the major hospital when the person is seen as an outpatient, the same views taken on admission to St Elsewhere, and the same views again taken for the day of the "round." These six films, always taken within the same week, are returned for reporting once the heat has been taken out of the situation.

I have deliberately used the term routine lateral views in the above paragraph. If I may take one of the analogies that I use in teaching postgraduates—imagine you are confronted by a giraffe. Even though this creature may never have been seen in real life, few would have difficulty in recognising it. Those taken by surprise, and sceptical at that, might think, "Perhaps it is a giant two-dimensional mock-up and not a real giraffe after all. I think I'll work round the back and head and make sure." Once having done this, it would not really be necessary to rush round to its head or tail each time it appeared to make sure it still was not a cardboard mock-up.

I mentioned early on "if you knew where to look for it" apropos of lesions on a lateral view. In the course of teaching three groups of postgraduate students a year for the past 15 years I have learnt that practically no junior doctor has any idea of bronchial anatomy as expressed in real life lesions on chest radiographs. Some may be able to draw the bronchial tree. Hardly any can recognise classic collapsed lobes, or even giant gland masses or a full oesophagus on a lateral view. I have done my best to remedy this in those who have passed through my hands.

Fish and chips lateral view

I have written mainly, so far, about what I classify as the "fish and chips" lateral view—a request made purely from habit or conditioned reflex. In the same week as I received the annotated form mentioned in the first paragraph a casualty officer, on his first day at the hospital, requested posteroanterior and

lateral views "pneumothorax." An experienced radiographer did the correct examination—namely, views in inspiration and expiration, only to receive patient and form back immediately with the insistence that a lateral view be done. Such a view is certain to be useless if he really *was* looking for a pneumothorax. If there was something else on his mind it was certainly not on the request form.

Our hospital is spread over several acres and the block containing the medical beds is a wet half mile from the main department. It is visited by the radiologist every morning, but most of the work lies in the main department, so that there are many hours when the radiographers in the medical block cannot easily obtain advice from a radiologist. We are thus periodically in the wrong when a request is held up until my visit the next morning. I also apologise abjectly to my consultant colleagues

when they complain to me at lunchtime, when presumably in the interest of democracy, their requests for lateral views are also overlooked (or suppressed).

It used to be the promise of every American politician standing for office that, if elected, happy days would be here again and that there would be a chicken in every pot. Many clinicians, senior as well as junior, act as if this happy event has occurred, and the NHS is a veritable widow's cruse, endless in its resources. Unfortunately, as we all know, this is not true. What is more, when it comes to the use of ionising radiation, as in x-ray examination, even one unnecessary film may tip the precarious balance for that patient and bring his life to a premature and unnecessary end.

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Contemporary Themes

Systematic review of the benzodiazepines

Guidelines for data sheets on diazepam, chlordiazepoxide, medazepam, clorazepate, lorazepam, oxazepam, temazepam, triazolam, nitrazepam, and flurazepam

COMMITTEE ON THE REVIEW OF MEDICINES

The Committee on the Review of Medicines (CRM) has completed a review of the benzodiazepines and has issued guidelines for use in anxiety, insomnia, and certain other conditions.

Their use in obstetrics, the treatment of epilepsy, and in children other than in anxiety, insomnia, and night terrors will be considered later. Particular consideration was given to the following aspects of benzodiazepine therapy: (1) efficacy in indications other than anxiety and insomnia; (2) long-term efficacy in all indications; (3) residual effects of therapy, particularly daytime sedation; (4) possible dependence potential; (5) withdrawal symptoms; (6) evaluation of the implications differing pharmacological and kinetic properties might have in clinical practice; (7) use in the elderly.

The CRM drew attention in its recommendations to the pharmacological differences between "long"-acting benzodiazepines, whose half life exceeds 10 hours—for example, clorazepate, diazepam, chlordiazepoxide, and medazepam—and the "short"-acting rapidly cleared compounds, such as triazolam, temazepam, oxazepam, and lorazepam. The committee recognised that the pharmacological properties of the latter group, including rapid excretion and lack of accumulation of the whole drug and active metabolites, may offer certain advantages over the longer-acting benzodiazepines, particularly in the elderly. This group may also be preferred in patients with renal or hepatic impairment and in patients where daytime alertness is required. Short-acting benzodiazepines were also considered more suitable for the treatment of insomnia not accompanied by anxiety.

Efficacy

The committee found that all benzodiazepines were efficacious in the short-term treatment of symptoms of anxiety and in insomnia. It found no evidence which could justify the pre-

ferential use of any particular benzodiazepine in either anxiety or insomnia. It concluded that the usual division of benzodiazepines into rigid treatment categories of anti-anxiety agents and hypnotics did not appear to be based on the known pharmacological or clinical properties of this group of compounds.

The committee agreed that other acceptable indications for the long-acting benzodiazepines might include the treatment of muscular spasm, symptomatic treatment of acute alcohol withdrawal, and night terrors and somnambulism in children. The committee did not consider the benzodiazepines to have antidepressant or analgesic properties and so considered them unsuitable for such disorders as depression, tension headaches, and dysmenorrhoea occurring in the absence of anxiety. It further found benzodiazepines not efficacious in the treatment of psychotic illness and recommended that they should not be used in the treatment of anxiety or insomnia in children.

The committee took particular note of the lack of firm evidence of efficacy which might support the long-term use of benzodiazepines in insomnia and anxiety. It noted and concurred with the findings of the Institute of Medicine (USA) and the conclusions of a study carried out by the White House Office of Drug Policy and the National Institute on Drug Abuse (USA) that there is little evidence that sedative hypnotics, including benzodiazepines, continue to be effective when used nightly in patients over long periods. This report further observed that sleep laboratory studies show most hypnotics tend to lose their sleep-promoting properties within three to 14 days of continuous use.¹ The committee further noted that there was little convincing evidence that benzodiazepines were efficacious in the treatment of anxiety after four months' continuous treatment. It considered that an appropriate warning regarding long-term efficacy be included in the recommendations, particularly in view of the high proportion of patients receiving repeated prescriptions for extended periods of time.