Neither of the patients had used other drugs, changed their diet, had any serious illness, or taken more of either medicine than the recommended dose. Both patients were being assessed regularly in an experienced thrombosis service centre.

Flurbiprofen is a known in-vitro inhibitor of platelet release and to a lesser degree platelet aggregation.^{2,3} It has been successfully used in a patient with spontaneous platelet aggregation.⁴ Unfortunately, the bleeding time was not assessed in these patients. A prolonged bleeding time, however, does not account for a prolongation of the prothrombin time as observed in these patients.

The only documented investigation of an interaction between flurbiprofen and a coumarin (phenprocoumon) showed slightly enhanced anticoagulation. The authors considered the interaction of little clinical importance.⁵ We recommend that if these drugs are used concurrently, the Thrombotest time should be monitored regularly. Additional prospective interaction studies are required.

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¹ Owren PA. *Lancet* 1959;ii:754-8.

² Cockbill SR, Heptinstall S, Taylor PM. *Br J Pharmacol* 1979;67:73-8.

³ Rosenberg JC, Sell TC. *Arch Surg* 1975;110:980-3.

⁴ Politis-Tsegos G, Wolff S, Shaw S, Mitchell TR. *Br Med J* 1978;ii:1323-4.

⁵ Marbet GA, Duckert F, Walter M, Six P, Airenne H. *Curr Med Res Opin* 1977;5:26.

Chaplain to casualty

SIR,—Robin Lapwood (17 July, p 194) seems to have had two purposes in stationing himself in a casualty department: to comfort those in distress by sympathetic listening and to offer the option of comfort from the Christian religion. I have no quarrel with his first purpose; no doubt he fulfilled his function successfully. I am disturbed, however, that he merged these two purposes without making clear to patients from the outset the reasons for his presence. To this end he was disguised as a doctor. Only when people had already unburdened themselves to a sympathetic person did they realise they had been talking to a chaplain. Perhaps Mr Lapwood's motive for maintaining this disguise was his awareness that patients might otherwise have declined to talk to him, since most of the inhabitants of Great Britain are not Christian. Many would feel it an unwelcome intrusion to be prayed over and given a short course in Christian dogma while in such distressing circumstances. It is not, however, Mr Lapwood's Christianity per se I object to, but his impersonation both of someone vaguely medical and of a detached but sympathetic comforter when he was neither medical nor detached. He was sailing under false colours on two counts.

Another consideration is that of medical confidentiality. In the situation Mr Lapwood describes a lay person was allowed to be present at consultations under the assumption by the patient that he was at least paramedical. Would all the patients be equally happy to give their stories in front of a chaplain in a clerical collar? Or to any other lay person in the role of

comforter for that matter? Should they not at least be informed of that person's identity and given the option of excluding him from the consultation? Surely when one enters hospital one should be assured that one will be dealt with by hospital staff, except when it is clear that non-staff, such as various voluntary workers, are present.

I commend Mr Lapwood's work as comforter. I object most strongly, however, to his incorporation into the medical team and to the deception involved in camouflaging his role as chaplain.

V HARTLEY-BREWER

Bath

*.*We sent a copy of this letter to Mr Lapwood, who replies below.—Ed, *BMJ*.

SIR,—The vignette of a Christian rampant, inveigling his way into cubicles, ostensibly to soothe the sick and dying, but really only to administer an emergency course in Christian dogma (after first restraining the patient for compulsory prayers) fills me with as much disgust as it so obviously does Dr Hartley-Brewer. Indeed my revulsion is greater than hers since, apparently, this wolf in sheep's clothing is none other than myself. I am sorry my article was so ineptly written as to allow room for such an unfortunate premise. As a Christian I do have profound convictions about man's need for God's forgiveness, but I believe also that man has a God-given right to choose his own destiny. To act as Dr Hartley-Brewer suggests would denigrate rather than commend my faith.

When present at consultations it was always with the patient's consent, except when they were unable to communicate, whereupon the medical staff themselves would decide whether I should be called in. The staff regarded me as a full member of their close-knit team, not as a "lay person," and my white coat was worn (at their suggestion) as an outward sign of this. The ease of access to patients my uniform allowed was a privilege I would not abuse; rather I feel I used it wisely with distressed patients who, in the context of casualty, fear not the man in the dog collar so much as the air of death his black clothing suggests. I sought to communicate God's acceptance of me in my acceptance of others. Accepting their rejection was thus integral to my ministry. It is something Dr Hartley-Brewer's wolf could never understand.

ROBIN LAPWOOD

Bury St Edmunds,
Suffolk

Careers of doctors qualifying in Britain in 1974

SIR,—The "Talking Point" article (14 August, p 522) was most interesting, informative, and surely reassuring to those who have been expressing concern about medical unemployment.

It had, however, one significant deficiency. The writers state that they "had been looking at the career preferences of doctors qualifying in the *United Kingdom*," and yet despite the sampling frame for such doctors having been obtained from their medical schools in the United Kingdom and updated from the *Medical Directory*, Medical Register, and the General Medical Council, they have

failed to include any medical graduates from the Queen's University of Belfast.

Some 120 doctors graduate annually from Queen's, and Belfast is in *Northern Ireland*, an integral part of the United Kingdom. That so many doctors should be overlooked, a greater number than from any single London medical school and all but one of the provincial schools listed is surely a sad omission, and although I am sure not intended, could be taken as a slight on either the British nationality so highly valued by the majority of Ulstermen or, worse still, on the status as doctors of Queen's University graduates, of whom I am proud to be one.

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*.*We sent this letter to Dr Parkhouse, who replies below.—Ed, *BMJ*.

SIR,—I should like to thank Dr Gilmore and others who have written to me personally for drawing attention to a misleading statement in our article (14 August, p 522). We apologise sincerely for this.

The position is as follows: in 1972 and 1973 we surveyed the career preferences of qualifiers from the Sheffield and Manchester medical schools. In 1974, for the first time, we pushed the boat out and sent questionnaires to the qualifiers from all the medical schools in England, Scotland, and Wales. Hence the term Britain in the title of our recent article. The success of the 1974 study was such that we decided in 1975 and subsequent years to include the Queen's University of Belfast. Thus it is correct to say, as in our first paragraph, that we have for some years been looking at the career preferences of doctors qualifying in the United Kingdom. Regarding the 1974 study, however, we should, of course, have referred under our description of methods to the sampling frame for doctors qualifying in England, Scotland, and Wales. If this error has given offence, as well as causing possible misunderstanding, we greatly regret this. Since 1975 we have had full and enthusiastic responses from Belfast graduates, and we much appreciate this.

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Electric convulsion therapy apparatus

SIR,—Dr A A Robin (7 August, p 441) wrote about the report of a working group set up by the Secretary of State for Social Services on electric convulsion therapy equipment. As the representative of the Royal College of Psychiatrists on that working group it is appropriate that I should answer his criticisms.

Dr Robin says that the advice to discontinue sine wave stimulation was reached by confusing the aim of producing the desired therapeutic effect with *minimum* energy with that of producing an adequate bilateral clonic seizure with *minimum* energy. He suggests that the working group assumed that all bilateral clonic seizures are associated with equal therapeutic benefit. This is not so: the word "adequate" covers the probability that seizures are not "all-or-nothing" phenomena and that there may be an optimal pattern of cerebral

seizure which requires more than a threshold stimulus.

The term "sine wave" need but should not be stretched to include modifications such as the "chopped" sine wave of, for example, the Ectron Mark 4 equipment, or even short square pulses. Confusion arises from the lack of a commonly accepted terminology for the different waveforms delivered by electric convulsion therapy equipment. I do, however, think it unlikely that there will be any misunderstanding, even on superficial reading of the report, of the intentions of the working group: to replace equipment which is truly unsatisfactory. It may, for example, lack a timing device as well as deliver a sine wave stimulus. To this extent the analogy with drugs is false.

Users have always been constrained by what equipment manufacturers supply, and there really is little choice. Ectron is now the only British manufacturer, and there is little likelihood that any British competitor will appear. Alternative equipment, for example the German "Konvulsator," American "Mecta," and Australian "Kabtronics," are hardly known or tried in this country.

Most replacement equipment is likely to be of constant-current type. Clinical trials are needed, and it is to be hoped that Dr Robin's letter will indeed encourage users to make properly controlled observations of their equipment's efficacy. The phased replacement of some equipment, advised by the report, with 20- to 30-year-old apparatus going first cannot surely, however, be called impetuous.

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Asbestos and the media

SIR,—In your "Medicine and the Media" article on our documentary *Alice—A Fight For Life* about the dangers of asbestos (31 July, p 372) you state that the programme "begged many questions." You give three examples which I would like briefly to answer.

You mention a mesothelioma which "had occurred only a few days after the worker joined the industry." The point we were making was that the man in question had lived next door to an asbestos factory for over 15 years. Fibrous dust from an enormous waste dump in the factory yard blew daily into his house and garden. We showed photographs of the waste dump and an interview with his widow describing the tiresomeness of "dusting three or four times a day." The clear implication was that his mesothelioma was environmentally induced, but we felt bound to mention his working at the factory at the end of his life. It was the potential danger to the public living in houses near this factory that we were drawing attention to. The man's occupational exposure was mentioned in case we were accused of hiding the fact, although we emphasised that because of its nearness to the onset of disease it could not have been the cause.

Similarly, we made it very plain in interview and commentary that the 12-year-old child who died of mesothelioma had been severely exposed to asbestos dust. His father, a heavy goods vehicle mechanic, often brought work home and had taught him how to blow out the asbestos dust from brake drums several years before he died.

As for the question of the contribution of smoking to the excess lung cancer deaths found in asbestos workers, we would agree that the industry recruiting only non-smokers would help reduce this particular death toll. Implementing such a policy is, however, another matter. We visited an American asbestos company claiming to have a strict no-smoking policy, but evidence to the contrary was widespread. Moreover, mesothelioma has never been linked to smoking in any way, and it is the tragedy and suffering of this disease which, while asbestos is still used to any extent at all, will still be with us.

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Unusual complication of perforated appendix

SIR,—I would appreciate an opportunity to reply to the letter of Mr Z H Krukowski and Mr N A Matheson (31 July, p 380) as I feel that certain points need clarification. Firstly, I would agree that no clinical trial has been performed to compare the efficacy of tetracycline lavage with metronidazole in patients with acute appendicitis. I feel it is unreasonable, however, to compare directly the results of separate trials owing to the different conditions under which they may have been carried out. The two examples I quoted (5 June, p 1705) are but a small proportion of a much larger number of trials testifying to the benefit of metronidazole in this condition.

The evidence from Stewart and Matheson's original paper¹ does indicate that tetracycline lavage reduces the incidence of wound infection. The point raised in the article by Mr H J Thompson and Mr W S McKerron (15 May, p 1442), however, was that of residual intraperitoneal infection after appendicitis with generalised peritonitis and the necessity for subsequent reoperation. To quote the figures from Stewart and Matheson's paper, the incidence of residual intraperitoneal infection was 8% (6 out of 72 patients) in patients having no lavage, compared with 7% (4 out of 58 patients) in those treated with tetracycline lavage ($\chi^2=0.1$; $p>0.1$). The claim of a reduction in the reoperation rate from 4% to zero is based on figures of three out of 72 patients having no lavage, compared with none out of 58 patients receiving tetracycline lavage ($\chi^2=2.4$; $p>0.1$). Hence a claim that peritoneal lavage reduces the incidence of reoperation for residual intraperitoneal sepsis based on these figures does not have secure statistical backing. I would add that all these figures appear to come from a retrospective analysis of case records and not a randomised prospective controlled trial. If it is accepted that *Bacteroides* species are important pathogens in the septic complications of peritonitis secondary to appendicitis² it would therefore be logical to use an agent to which these organisms are sensitive. So far as I am aware there have been only a few isolated reports of metronidazole resistance among *Bacteroides* species and in general these have been associated with the long-term use of the agent. In contrast, 20-70% of *Bacteroides* species are resistant to tetracycline.³

Finally, there is a theoretical disadvantage in using tetracycline in children—namely, the deposition of the drug in developing teeth,

leading to their staining and in some instances to dental hypoplasia. For these reasons the *British National Formulary* advises that tetracycline should not be used in children under 12 years of age.

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- ¹ Stewart DJ, Matheson NA. *Br J Surg* 1978;65:54-6.
- ² Leigh DA, Simmons K, Norman E. *J Clin Pathol* 1974;27:997-1000.
- ³ Gorbach SL, Bartlett JG. *N Engl J Med* 1974;290:1289-94.

Bromocriptine in management of large pituitary tumours

SIR,—We share Mr D T Hope's wish (24 July, p 296) that the casual reader should not be misled by our paper (26 June, p 1908). It seems clear that patients with an extrasellar extension of a pituitary tumour but with good visual acuity should be treated initially with a dopamine agonist, such as bromocriptine. We also agree that at present patients with deterioration of vision to the point of imminent blindness require urgent referral to a neurosurgeon. Such cases are fortunately not common and there were none in the present series. Eight of our 19 patients presented with visual symptoms. Nine had visual field defects and in nine the visual acuity ranged from 6/12 to 6/60 in the worse affected eye. In none was the visual loss rapid. On treatment with bromocriptine visual acuity improved in five of these patients and, as stated in the paper, of nine patients with visual field defects, seven improved and five of these had normal visual fields at the time of the report. It seems therefore clear that visual symptoms, fields, and acuity can improve as bromocriptine therapy shrinks the pituitary tumour and can become normal.

Visual deterioration did not occur in any patient, and in all four in whom tumours failed to shrink and were operated on there was post-operative improvement in the fields. It is obvious that should the fields deteriorate or the visual acuity become worse during bromocriptine treatment, urgent neurosurgical referral is required.

The fact that vision improved in most of our patients led us to recommend the closely supervised use of bromocriptine as the first line of treatment for most patients since there is a good chance of achieving visual recovery with preservation of pituitary function. No form of treatment of pituitary tumours is without risk. The decision about the best management of the individual case must be made after careful consideration of all the clinical and radiological data and the risks attending each form of treatment. This includes balancing the possible consequences of delay with medical treatment against the occurrence of early and late complications of surgery and radiotherapy. Our data show that when these criteria are fulfilled and close ophthalmological supervision is maintained treatment with bromocriptine is safe and has a useful place in the management of pituitary tumours, including those with large extrasellar extensions.

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