Points

Inaccuracies in measuring tourniquet pressures

Mr LESLIE KLENERMAN (Northwick Park Hospital, Harrow, Middlesex HA1 3UJ) writes: Mr Jeffery Hallett (16 April, p 1267) drew attention to the inaccuracy of tourniquet gauges that are not regularly tested against mercury manometers. This has medicolegal implications, and over the past 20 years there have been at least seven reports of tourniquet paralysis as a result of a faulty gauge.[1] Prevention is possible by careful maintenance of the apparatus, but the addition of a safety valve set at a predetermined upper limit of pressure and placed between the gauge and the cuff would ensure complete safety, as suggested by Wheeler and Lipscomb.[2] This deficiency in current tourniquet design needs the attention of the manufacturers.

[1] Klenerman L. Tourniquet paralysis. *J Bone Joint Surg* (Br) (in press).
[2] Wheeler DK, Lipscomb PR. A safety device for a pneumatic tourniquet. *J Bone Joint Surg* (Am) 1964; **460**:870.

Dr K B CARTER and Dr A SHAW (Department of Clinical Physics and Bio-engineering, Glasgow G4 9LF) write: We were interested to learn of the continuing problems with tourniquet pressure gauges (16 April, p 1267). It is important that tourniquet systems are reliable and their pressure gauges accurate. British Standard BS 1780 sets out the accuracy for commercial Bourdon pressure gauges. For a gauge scaled 0-500 mm Hg to comply with this standard it should read to within ±7·5 mm Hg. Unfortunately, there is no British standard for aneroid gauges, which are the type usually used in dial style blood pressure gauges and tourniquet cuff pressure gauges. We recommend that, in the absence of a standard, manufacturers should state the accuracy of their gauges so that users can test whether they are functioning properly. Secondly, we suggest that users check accuracy over the entire working range of the gauge (perhaps at 100 mm Hg intervals) since there is no guarantee that a single point calibration will adequately test its performance.

False false teeth

Dr ANDREW AJDUKIEWICZ (London NW2) writes: Dr George Dunea (2 April, p 1125) mentioned the danger of the so called café coronary to various groups, including those wearing false dentures. Is this an American expression or are these false false teeth?

Which way general practice?

Dr S D FORD (Burton Joyce, Notts NG14 5AT) writes: . . . The worse case future for primary care is one in which nice academic structures take precedence over normal day to day muddling along. So varied are patients, doctors, and the circumstances and tools of general practice that anything remotely akin to detailed planning for them is a failure from the first penstroke. This axiom should be graven indelibly on the brows of those in positions of influence. As Ms Barbara Stocking (30 April, p 1400) says, muddling along is a well respected NHS activity because, after a fashion, it works, much to the consternation of those anancastic individuals who relish centralised planning, control, and multi-layered bureaucracy for the relief it gives from their essential insecurity. Warts and all the NHS is a noble and humane expression of care provided by the nation for the nation, it is a model for the whole world to contemplate and envy. Our greatest strength is our mildly anarchic, pragmatic, and not terribly deferential approach to getting things done on our own patch; the greatest threats in the future are the cloddish grand schemes dreamed by those who one would hope (vainly) knew better. There are no correct answers to the question, "How should the NHS be structured and run?" and any who declare themselves to be in possession of even an approximation should be regarded as one would regard the inventor of perpetual motion.

Within a broad description of the aims of health care each patient and practitioner should find their own compromise. Let us maintain a wise humility in the face of the problems that confront us and seek by a local or personal process of continuous adaptation in the structure, methods, and tools to do our best in the circumstances.

Lumbar puncture in spontaneous subarachnoid haemorrhage

Mr R ALEX DAWS and Mr A J KEOGH (Preston Infirmary, Preston PR1 6PS) write: We agree with recent articles (23 October, p 1163, and 23 April, p 1299) that computed tomography may be used for the diagnosis of subarachnoid haemorrhage, thus avoiding the necessity for lumbar puncture, and is important in those few cases of subarachnoid haemorrhage where lumbar puncture is potentially dangerous. . . . While undoubtedly an ideal, early referral for computed tomography for our neurosurgical unit and probably for others is an impossibility and is likely to remain so for some time. The restricted availability of computed tomography makes this possible in only a few hospitals in this country. Therefore, until computed tomography is more widely available we would agree with Professor E R Hitchcock (23 April, p 1299) that lumbar puncture must remain the most generally available diagnostic method and that its omission is impracticable and may lead to errors in diagnosis. We urge doctors who have primary care of patients suffering from subarachnoid haemorrhage to carry out lumbar puncture to confirm the diagnosis and thus facilitate the earliest possible admission of confirmed cases for further investigation and possible neurosurgery.

Letters to a young doctor

Dr FRADA ESKIN (Unit for Continuing Education and Management in Medicine, Department of Community Medicine, the Medical School, Manchester M13 9PT) writes: Professor Philip Rhodes (7 May, p 1496) misleads his readers by confusing the terms administration and management and by describing management as "implying that those in authority have the power to order subordinates to do something." A manager is someone who works with and through others to achieve the task, and although this may be done by telling subordinates what to do, this is only a minor part of the total managerial role.

Administration is part of management, which is defined as the process of policy making and planning for and implementing change. Administration is the day to day running of established services—that is, maintaining the status quo. It is essential for doctors to be concerned with policy making, planning, and resource allocation because of the effect on patient care. It does not require doctors to be concerned with the administration of services. In fact this is what deters doctors from becoming interested in management, and it is a misuse of their time. The skills required to manage conflict, and to work effectively with groups, committees, teams, and on a one to one basis are managerial in nature and not administrative.

Unequal legs

Dr F J IMMS (Department of Physiology, Guy's Hospital Medical School, London SE1 9RT) writes: Mr Leslie Klenerman (23 April, p 1302) draws attention to the association of an increase of leg length in children with conditions such as haemangiomatous malformations and infection, which are likely to cause hyperaemia in the limb. The increase of leg length after fractures of the femur may also be associated with increased blood flow in the leg. In adult men substantial increases of flow are found in lower limbs recovering from fractures.[1 2] These increases occur not only in the injured segment of the limb but also in more proximal and distal parts. Blood flows in the two limbs do not become equal again until at least a year after the fracture; during this time in children most of the overgrowth has occurred. Unfortunately, I cannot substantiate this argument with blood flow data for children recovering from lower limb fractures.

[1] Imms FJ, Lorde DA, Prestidge SP, Thornton CM. Blood flow through the calf during recovery from fractures of the lower limb. *Clin Sci* 1976;**51**: 297-302.
[2] Imms FJ, McGregor AA, Prestidge SP, Rudge K. Bloodflow in the feet of patients recovering from fractures of the tibia and fibula. *J Physiol* 1977;**268**: 17-8P.

A misplaced medal

Dr HOWARD SPIRO (Center for Advanced Study in the Behavioral Sciences, Stanford, California 94305) writes: The report by Dr Mary Armitage and others (12 March, p 844) raising the question of whether a Joslin medal should be taken back from a patient who had taken insulin unnecessarily for 50 years reminded me of the time when I was a house officer at the old Peter Bent Brigham Hospital in Boston. In a short period in the late 1940s several patients came into the emergency room (then known as the outdoor department) in diabetic coma. Inquiry revealed that two of them had recently received medals, the first of their kind I believe, from Dr Joslin himself, and in the good Catholic city of Boston they believed that the medals did away with their need for insulin. When they recovered consciousness we told them that a medal around the neck provided a memento and not a miracle.