Points

Disasters and BASICS

Dr JUDITH M FISHER (British Association for Immediate Care, London E4 9SY) writes: Many readers will have been moved by Dr Martin Deahl's and Dr Paolo Domizio's Personal View (28 November, p 1411), recalling feelings of "too little, too late" at the King's Cross Station tragedy. This inadequacy is shared by many doctors when they are called to cope with incidents away from the bright lights and comfortable surroundings of the surgery or hospital. The British Association for Immediate Care (BASICS) was formed in an attempt to improve prehospital care for victims of road accidents and other disasters. It provides a forum and training for doctors interested in immediate care. In recognition of this need, particularly for general practitioners, the Royal College of Surgeons of Edinburgh has agreed to establish a diploma in prehospital care. BASICS doctors trained in the use of breathing apparatus were present at King's Cross but because of the inevitable delay in appreciating the size of the incident they were called some time later. They provided on site care and a site medical officer and subsequently searched the station with fire crews and helped certify and identify the dead. They too shared the feeling of grief but perhaps less the inadequacy. New members are always welcome. At present there are only 2000 doctors in 70 immediate care schemes covering about one third of the United Kingdom. Further details are obtainable from Mr R Bailey, British Association for Immediate Care, 31c Lower Brook Street, Ipswich IP4 1AQ.

Induced abortions after the Chernobyl accident

Drs FABIO PARAZZINI, FRANCESCA REPETTO, MARINA FORMIGARO, MONICA FASOLI, and CARLO LA VECCHIA (Istituto di Ricerche Farmacologiche "Mario Negri," 20157 Milan, Italy) write: A recent report from Greece by Professor D Trichopoulos and others (31 October, p 1100) suggested that during the month after the Chernobyl accident (May 1986) about 2000 (20%) of otherwise wanted pregnancies were interrupted because of perceived radiation risk.

Since considerable anxiety was also raised by the Chernobyl accident in northern Italy we considered data on voluntary abortions routinely collected in Lombardy (population 8·9 million) by the regional department of health statistics and epidemiology. Induced abortions in Italy are free of charge and must be performed in hospitals, and the number of illegal unregistered abortions in Lombardy is probably negligible.[1,2] The table gives the number of induced abortions performed in Lombardy in 1984-6. Consistent decreases were observed in each specific month considered in relation to the previous years. The figure for June 1986 is of particular interest in relation to the Chernobyl accident, since before an abortion can be performed Italian law prescribes a week of "reflection" delay on the woman's part, and a further two or three week "health system" delay usually occurs before the procedure takes place. The number of abortions induced in June was similar to the 1985 figure and, allowing for the secular downward trends, only slightly (about 5%) above the expected number, calculated from figures for the two previous years. This slight excess may be real or merely random variation, but it is small compared with the Greek figures, suggesting that the emotional impact on women and the obstetricians' response to the accident were heterogeneous in different populations.

1 Figà-Talamanca I, Grandolfo ME, Spinelli A. Epidemiology of legal abortion in Italy. *Int J Epidemiol* 1986;**15**:343-51.
2 La Vecchia C, Pampallona S, Negri E, *et al*. Characteristics of women undergoing induced abortion: results of a case-control study from Northern Italy. *Contraception* 1985;**32**:637-49.

Numbers of induced abortions performed in Lombardy, northern Italy, 1984-6

Month	No of induced abortions in: 1984	1985	1986	Ratio: 1986 *v* 1984	1986 *v* 1985
March	3368	2938	2414	0·72	0·82
April	2773	2922	2715	0·98	0·93
May	3386	3114	2844	0·84	0·91
June	3087	2637	2668*	0·86	1·01
July	3030	3030	2799	0·92	0·92
Total January-December	35 869	32 771	30 651	0·85	0·94
Total births January-December	77 952	76 763	72 671	0·93	0·95

*Expected number of voluntary abortions on the basis of the proportion of induced abortions in June 1984-5: according to the total year figures 2556±51; according to the March-July figures 2540±50.

Peritoneal lavage in acute appendicitis

Mr MEL JONES (Willaston, South Wirral) writes: Dr H G Pledger and others (14 November, p 1233) briefly mentioned the use of peritoneal lavage as a contributing factor in reducing mortality. The effectiveness of peritoneal lavage in reducing septic complications after emergency appendicectomy has been established experimentally[1] and clinically,[2,3] yet this practice is not yet universal.[4] I found only two standard textbooks which recommended it, one in cases with "a great deal of purulent exudate,"[5] the other if the appendix is perforated.[6] This advice seems erroneous.[3] Another fallacy which inhibits its use is the theoretical risk of disseminating infection through the peritoneal cavity. This does not appear to hold true in practice.[7]

1 Stewart DJ, Matheson NA. Peritoneal lavage in faecal peritonitis in the rat. *Br J Surg* 1978;**65**:57-9.
2 Stewart DJ, Matheson NA. Peritoneal lavage in appendicular peritonitis. *Br J Surg* 1978;**65**:54-6.
3 Orr JD. Antibiotic peritoneal lavage in childhood appendicitis. *J R Coll Surg Edinb* 1984;**29**:307-9.
4 Gibson TC, Hood J, MacKinlay GA, *et al*. Bacteriology swabs during appendicectomy: sample sites and transport media. *J R Col Surg Edinb* 1986;**31**:367-9.
5 Lewis F. Appendix. In: Davis JH, ed. *Clinical surgery*. Washington: Mosby, 1987:1594.
6 Cushieri A, Bouchier IAD. The small intestine and veriform appendix. In: Cuschieri A, Giles GR, Moossa AR, eds. *Essential surgical practice*. Bristol: Wright PSG, 1982:950.
7 Williamson RCN, Kirk RM. Laparotomy: elective and emergency. In: Kirk RM, Williamson RCN, eds. *General surgical operations*. Edinburgh: Churchill Livingstone, 1987:51.

Hyperlipidaemia and life insurance

Dr J D M DOUGLAS (Fort William, Inverness-shire) writes: The guidelines of the British Hyperlipidaemia Association (14 November, p 1245) were a clear and welcome statement on blood lipid concentrations and strategies for reducing heart disease in Britain. Screening people before the age of 30 is at present opportunistic and haphazard. Wide coverage in the media has prompted some health conscious young people with a family history of heart disease to attend their general practitioner requesting measurement of their blood lipid concentrations. It is difficult, however, to know what advice to give with regard to life insurance implications. Most life insurance forms have preliminary questionnaires which cover special diets and medication. An otherwise fit young man who wishes to take out a mortgage may therefore be discriminated against when he declares his asymptomatic hyperlipidaemia when compared with his drinking, smoking, promiscuous colleague who has chosen not to see a doctor during the preceding five years. The government's white paper on primary care is designed to encourage doctors to practise primary prevention. We therefore need a clear statement from the life insurance offices about hyperlipidaemia controlled by diet or medication so that we can advise our patients on the costs and benefits of measuring blood lipids before the age of 30.

Angiotensin converting enzyme inhibition and cough

Dr SHIGENOBU UMEKI (Division of Respiratory Diseases, Kawasaki Medical School, Okayama 701-01, Japan) writes: I agree with Drs Richard W Fuller and Nozhat B Choudry (24 October, p 1025) that a dry cough due to angiotensin converting enzyme inhibitors may result from an increased sensitivity of the cough reflex by metabolism of substrates other than bradykinin, a potential candidate increasing cough reflex. I reported recently the first case of angiotensin converting enzyme dysfunction syndrome, which is characterised clinically by sporadic periodic paralysis, hypokalaemic alkalosis, normal angiotensin converting enzyme concentration, hyperreninism, and large increases in serum concentrations of angiotensin I and bradykinin persisting for more than three years.[1] I reviewed the differences between this syndrome and the clinical features caused by long term administration of the angiotension converting enzyme inhibitor captopril.[2] The results suggested that the decreased affinity of angiotensin converting enzyme inhibitor for angiotensin I or bradykinin in angiotensin converting enzyme inhibitor dysfunction syndrome produced hyperreninism and high serum concentrations of angiotensin I and bradykinin.[1,2] The clinical pathophysiology of this syndrome was very similar to that of long term treatment with angiotensin converting enzyme inhibitors. The patient, however, never complained of coughing. These results suggest that neither angiotensin I nor bradykinin plays an important part in the development of a dry, non-productive cough induced by angiotensin converting enzyme inhibitors.

1 Umeki S, Ohga R, Ono S, *et al*. Angiotensin I level and sporadic hypokalemic periodic paralysis. *Arch Intern Med* 1986;**146**: 1956-60.
2 Umeki S, Terao A, Sawayama T. A new syndrome—angiotensin-converting enzyme dysfunction syndrome. Differential diagnosis and pathogenesis. Case reports. *Angiology* (in press).

Easing pain or hastening death?

Dr NEIL WILSON (Keighley, West Yorkshire) writes: Dr M P Sykes (21 November, p 1350) expressed unease that I had precipitated death with an injection of diamorphine to a terminally ill patient (17 October, p 994). The ambiguity of the (incidentally, fictitious) passage concerned was originally accidental. I retained it, however, because it seemed to reflect accurately what I know many doctors feel—namely, that it is wrong to administer diamorphine solely to kill quickly but that when used "legitimately" to abolish severe pain its attendant depression of respiration can sometimes help ease intolerable suffering, also possibly hastening death a fraction. Obviously it is impossible to dogmatise and generalise about the wisdom of this action as each case has to be judged according to its own particular circumstances. Contrast the weary patient, in extremis and in great pain, who, with his exhausted family, seems unable to cope any longer and another patient, also in great pain, but desperately determined to survive that little bit longer to see his daughter wed the next day.

Mania induced by biochemical imbalance

Drs GABRIELLA ZOLESE and RITA HENRYK-GUTT (Shenley Hospital, Radlett, Hertfordshire WD7 9HB) write: We are grateful to Dr U Take (5 December, p 1485) for drawing to our attention the possibility that the mania and myxoedema in our patient might have resulted from administration of nifedipine. Because of his cardiac problem the patient continued to take nifedipine, and now that his thyroid dysfunction has been corrected his mood has remained normal without psychoactive drugs. It would appear therefore that a genuine case of mania in a hypothyroid subject has been reported.