

Quite different conclusions could be drawn about the three attitude questions that exposed women's differing views. The first two reflect self perception regarding education and knowledge. Although women doctors had equal knowledge scores, they thought that all general practitioners needed more education urgently. This is arguably a positive attitude. The third reflects not an individual view but sympathy or support for other doctors' different decisions. This could be interpreted as tolerance and realism rather than negativity.

Women doctors were overrepresented in this nationwide sample. This is a credit to their willingness as a group to contribute to research regarding AIDS and reflects a distinctly positive stance.

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1 Shapiro JA. General practitioners' attitudes towards AIDS and their perceived information needs. *Br Med J* 1989;298:1563-6. (10 June.)

## HIV infection in Malawi

SIR,—We are two medical students who have recently returned from our elective at Zomba General Hospital, where Dr P A Reeve undertook his study of HIV infection in Malawi.<sup>1</sup> In April 1989 we found that 19% of patients on the medical wards had HIV related diseases. In addition we looked at all HIV testing in five randomly selected weeks between January and March 1989 and found 79 positive test results. Dr Reeve in October 1988 newly identified 39 patients as HIV positive; at this time 10% of patients on the wards had positive results. Thus in less than a year the incidence of patients positive for HIV in Zomba has doubled, showing a dramatic escalation of the problem.

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1 Reeve PA. HIV infections in patients admitted to general hospital in Malawi. *Br Med J* 1989;298:1567-8. (10 June.)

## Safe use of lignocaine

SIR,—Though I share Dr Jacqueline Anne Scrimshire's concern at the lack of knowledge of dosage of doctors who use local anaesthetics, unfortunately she takes lignocaine as her model.<sup>1</sup> Anaesthetists interested in regional anaesthesia have long appreciated that the maximum recommended dose of lignocaine without added adrenaline, 200 mg, is far too low and if adhered to would not allow it to be used for most major nerve blocks.

A dose of 200 mg was chosen as long ago as 1948, when the drug was introduced and before modern methods for estimating plasma concentrations were available. As a result the relation of these concentrations to toxicity had not been elucidated. The anachronism is further highlighted by the fact that the recommended maximum dose for lignocaine plus adrenaline is 500 mg. It has long been known that adrenaline reduces the peak plasma concentrations reached after injection at various sites, but it is ludicrous to suggest that adrenaline allows a dose two and a half times greater than with the plain solution.<sup>2,4</sup>

Most cases of serious toxicity result not from overdosage but from inadvertent intravenous injection. Virtually all the maximum doses of local anaesthetics would cause such toxicity if rapidly injected intravenously, and only knowledge and training can avoid this.

Maximum recommended doses make sense only if they are related to the procedure of local

anaesthesia being carried out. Peak plasma concentrations vary by three times according to the vascularity of the injection site.<sup>2,3</sup> There is little point in advising an inadequate dose in the mistaken belief that increasing that dose is unsafe when it is not. Most anaesthetists would give up to 400 mg of plain lignocaine to most adult patients. Though body weight is used to calculate dosage in paediatric practice, it is of no value in adults as peak plasma concentrations are not related to body weight.<sup>3</sup>

Doctors should be instructed in how much local anaesthetic is required to produce effective anaesthesia or analgesia in individual procedures, and these doses should not be exceeded.

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- 1 Scrimshire JA. Safe use of lignocaine. *Br Med J* 1989;298:1494. (3 June.)
- 2 Braid DP, Scott DB. The systemic absorption of local analgesic drugs. *Br J Anaesth* 1965;37:394-404.
- 3 Scott DB, Jebson PJR, Braid DP, Ortengren B, Frisch P. Factors affecting plasma levels of lignocaine and prilocaine. *Br J Anaesth* 1972;44:1040-9.
- 4 Mather LE, Tucker GT, Murphy TM, Stanton-Hicks M, Bonica JJ. Effect of adding adrenaline to etidocaine and lignocaine in extradural anaesthesia. II. Pharmacokinetics. *Br J Anaesth* 1976;48:989-94.

## Genetic factors in hyperactivity

SIR,—Dr Robert Goodman does not mention the fragile X syndrome as a single gene cause of hyperactivity.<sup>1</sup>

The fragile X syndrome is one of the most common X linked conditions, affecting about one in 1500 boys in most populations. Heterozygote carrier females may also show many of the cognitive and physical features. A number of behavioural problems have been described in the syndrome, including self mutilation and autism but also hyperactivity. In a group of 21 affected males aged 2 to 21 all but one showed hyperkinetic behaviour,<sup>2</sup> and a recent study including older men (aged up to 59) showed hyperactivity in half of the subjects.<sup>3</sup> The fragile X syndrome is probably an important cause of hyperactivity and should be considered in all cases.

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- 1 Goodman R. Genetic factors in hyperactivity. *Br Med J* 1989;298:1407. (27 May.)
- 2 Fryns J, Jacobs J, Kleczkowska A, van den Berghe H. The psychological profile of the fragile X syndrome. *Clin Genet* 1984;25:131.
- 3 Vieregge P, Froster-Iskenius U. Clinico-neurological investigations in the fra(X) form of mental retardation. *J Neurol* 1989;236:85.

## Guy's management out of step with consultants

SIR,—Dr Tony Delamothe's article was an accurate summary of the "opt out" issue at Guy's Hospital as far as it had unfolded by the end of May.<sup>1</sup> He drew particular attention to the assurance given by management that any decision to become self governing would be determined by a ballot of all consultants. Your readers might wish to read about an important further development.

At its meeting on 22 June the Guy's Hospital combined medical and dental committee (CMDC) (composed of the consultants of the medical and dental hospitals, and the now acknowledged "parliament" of the institution) approved the setting up of a "select committee," which was charged with "inquiring, in any way which it considers relevant, into the question of making application for hospital trust status as proposed in the government white paper." The select committee is empowered "to request any persons involved in this matter to explain or clarify

specific points or more general questions, and it may also request or receive written or verbal statements from any person or group wishing to submit such material. The select committee should render regular reports to the CMDC. It may at any time make recommendations to the CMDC to advise the management board to continue with or withdraw from further discussion and if necessary in due course support or reject application for trust status." Elections are to be held, and the select committee will be in place by the end of July.

We now feel confident that we have elected representatives to take a more active role in these negotiations than was perhaps previously envisaged and that the views of the members of the combined medical and dental committee will be taken into consideration at every stage. We urge colleagues working in other hospitals on whose behalf an "expression of interest in seeking self government status" has been made to consider taking similar steps as a matter of urgency.

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1 Delamothe T. Guy's management out of step with consultants. *Br Med J* 1989;298:1337-8. (20 May.)

\*Since this letter was written the press has reported that Mr Peter Griffiths, the senior NHS manager appointed part time to help Guy's Hospital towards self government, has withdrawn from the post. *The Times* reported that he had done this because of the medical profession's hostility to self government at the hospital. —ED, *BMJ*.

## Not such a shining morning face

SIR,—It might seem to be wanting in good taste, and I certainly intend no disrespect to the late Ronald Gibson, but I feel obliged to comment on two invidious references to homosexuality, one in his obituary itself,<sup>1</sup> the other in your related piece in *This Week in the BMJ*.<sup>2</sup>

If a "reformer," albeit one operating "stealthily from within," is capable of so gratuitously associating homosexuality with schizophrenia and extreme left wing views (in your extract from *The Satchel and the Shining Morning Face*), and throughout his life eschewed the use of an affectionate nickname because he associated it with a "proselytising homosexual," what can one expect of the less liberally minded majority of doctors?

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- 1 SL. Sir Ronald Gibson [obituary]. *Br Med J* 1989;298:1574-5. (10 June.)
- 2 Anonymous. This week in the BMJ. *Br Med J* 1989;298. (10 June.)

## Corrections

### Hazards of long distance cycling

An editorial error occurred in the letter by Dr A K Midgley (20 May, p 1380). With proper technique and correct positioning of the rider damage should not result from rides of less than 805 km and not 4000 km as published.

### Idiosyncratic dapsone induced manic depression

An editorial error occurred in this drug point by Drs A J Carmichael and C J Paul (3 June, p 1524). The reference at the beginning of the third paragraph should refer not to reference 1 as listed but to: Browne SG. Antileprosy drugs. *Br Med J* 1971;iv:558-9.