is much less rise in blood pressure on the new low-dosage formulations.—I am, etc.,

A. M. MACINTOSH.

Cronulla, N.S.W.,
Australia.

REFERENCES

- 1 Macintosh, A. M., *Proceedings of a Symposium*, Sydney 17-18 October, 1964, p. 242.
- 2 Macintosh, A. M. in *Proceedings of the 5th World Congress of Gynaecology and Obstetrics*, ed. C. Wood and W. A. W. Walters, p. 355. Sydney, Butterworths, 1967.
- 3 Macintosh, A. M., *Medical Journal of Australia*, 1968, 2, 1010.

Maintenance Digoxin

SIR,—The purpose of my paper (20 June, p. 705) was as Dr. R. Mulroy (18 July, p. 164) says "to draw attention to the dangers attending the use of digoxin" and to highlight the need to review drug therapy in elderly patients. The present pressure on hospital beds requires a policy of early discharge as soon as acute symptoms have settled, and often this means no time to review treatment, as was possible when the patient remained in the hospital during a convalescent period. Indeed, it is a cause of concern that many elderly patients are discharged to live alone on a complex therapeutic regimen which they are unable to manage. There is therefore an increasing need for careful evaluation of all drugs, not only digoxin, which we give on a maintenance basis, with the possible exception of hormone replacement therapy.

In my own series the patients were observed over a three-month period after withdrawal of digoxin, and only considered successful if no indication for restarting treatment presented. Some were restarted within that period, and I tried to indicate which features should be considered when reviewing each case.—I am, etc.,

J. L. C. DALL.

Victoria Infirmary,
Glasgow.

Obstetric Anaesthetic Deaths

SIR,—Your leading article on unnecessary deaths in anaesthesia (23 May, p. 437) deserves close attention. Anaesthesia for maternity patients is undoubtedly a very skilled aspect of anaesthetic work, and should not be left for inexperienced anaesthetists to handle.

In Hong Kong, in the University and Government hospitals, we make it a point that only anaesthetists with considerable experience in the specialty may anaesthetize obstetric patients.

I wonder, however, whether more deaths could have been prevented in these patients if some form of regional analgesia such as epidural, caudal, or spinal had been used, and the patient remained awake and in possession of all her protective reflexes, thereby avoiding inhalation of gastric contents. This point should not be overlooked in the assessments of maternal deaths.—I am, etc.,

Z. LETT,

Chairman,
Society of Anaesthetists of Hong Kong,
University of Hong Kong.

Overcrowding in Mental Hospitals

SIR,—Dr. D. A. Spencer's suggestion (13 June, p. 667) that the necessity for the admission of mentally subnormal patients to hospital should be assessed by a panel of agencies involved is potentially a very valuable one. I wonder, however, why he suggests that the parents and relatives of the patient should be available for interview only. The parents and relatives are likely to have to sustain the greater part of the burden if a patient remains at home, and, as they have a more intimate day-to-day knowledge of the patient than any of the members of Dr. Spencer's proposed panel, surely the parents and relatives should be members of the panel.

It is time it was recognized that so-called community care very often merely means family care, with occasional home visits from salaried officials who are not involved in the day-to-day care and management of the patient. With the current difficulties patients have in getting into long-stay hospitals we shall soon be returning to the dark era when these hospitals did not exist. Perhaps, before this, one could hope that the distinction between community care and hospital care will be recognized to be a false one, and that hospital care is a proper part of comprehensive community care.—I am, etc.,

A. M. SPENCER.

Powick Hospital,
nr. Worcester.

Compression Bandaging for Oedema

SIR,—Mr. Harold Dodd's letter (25 July, p. 223) gives me the impression that the bandages are put on the oedematous legs from above downwards.

Surely to reduce the oedema bandaging should start at the toes?—I am, etc.,

C. H. JOHNSON.

London N.19.

Burden of Cerebrovascular Disease

SIR,—As Professor R. M. Acheson and Dr. A. S. Fairbairn say (1 August, p. 284) I prefer to conduct such discussions in private rather than in public, but having started one must finish.

Professor Acheson and Dr. Fairbairn believe that there is only a negligible error in their estimate of incidence—because "the vast majority of cases (cerebrovascular) will either die within a month, or spend at least one night in hospital." Our preliminary figures from the Rhondda Borough (based on corrected notification data for 8 months), suggest that at least 60% of all "clinical" strokes are never in hospital and of these 75% survive one month. Were Professor Acheson's technique to be used in the Rhondda, the true incidence might be underestimated by as much as 45%. I do not know what happens in Oxfordshire.

They use the similarity with Eisenberg's data to prove their error must be small. I consider this a dangerous argument. Have they considered the possibility of the greater use of hypotensive drugs in the U.S. altering the natural history of the disease there?

They argue, very politely, that my interest in the treatment of coronary disease at home had been influential in encouraging the general practitioner's in the Rhondda to treat cerebrovascular disease at home. It's a nice idea, but I'm sure they've never heard of my views. My colleagues and I were even unable to get permission to do the randomized controlled trial of coronary home treatment in Cardiff. It was done in Bristol by Dr. Mather.

I remain unconvinced by Professor Acheson and Dr. Fairbairn, and I don't think further argument will help. The important thing is to measure the extent of the error in Oxfordshire.—I am, etc.,

A. L. COCHRANE.

Rhoose,
Barry, Glam.

Carbon Monoxide Poisoning

SIR,—I hope that your leading article on CO poisoning (25 July, p. 180) in which you conclude that "Doctors confronted with a patient suffering from CO poisoning should, then, treat the patient by the means most effective in reducing the level of carboxyhaemoglobin—hyperbaric oxygen—and this is true of all levels of CO poisoning" will not mislead doctors. To withhold oxygen at ordinary pressure (with or without CO₂) in order to transport victims to the nearest of the 17 hyperbaric units you quote might well be fatal.

Doctors are expected by the law (and may be reminded by patients) to be acquainted with the medical literature and au fait with advances in treatment. To be ignorant is to court criticism—sometimes openly in court.

The important operative words "wherever possible" should have been incorporated into your *B.M.J.* dictum, and a reminder on the vital importance of ventilation of the less sophisticated kinds at the earliest possible stage would have eased the lot of many practitioners. Incidentally no one would accept that "this" (i.e. hyperbaric oxygen treatment) "is true of all levels of CO poisoning" (my italics). Garage hands, furnacemen, even those packed in the "Smoking" on the 5.10 could afford to leave hyperbaric oxygen until a more major CO emergency arose.—I am, etc.,

KEITH SIMPSON.

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Guy's Hospital, London S.E.1.

**Our dictum continued: "Until the patient is placed in the hyperbaric atmosphere 95% oxygen and 5% carbon dioxide should be given . . .".—Ed., *B.M.J.*

Pseudo-obstruction of the Large Bowel

SIR,—Pseudo-obstruction of the large bowel is, I agree with Drs. P. K. Caves and H. A. Crockard (6 June, p. 583), a good way of describing the syndrome of dilatation of the large bowel without obstruction.

There are two points I wish to make. Firstly, if it is by definition "not obstruction," there should be no need for colostomy, which will only make things worse. Hence, when in doubt a barium enema with gentleness but with double contrast media