recommended by the Halsbury Committee would inflate these mind-boggling sums to 12p and 9p respectively.

This, surely is the form in which doctors and the public at large should have N.H.S. expenditure presented to them. It would then be plain to all that for the medical profession to help the D.H.S.S. to wallow a little less deeply in the financial mire in which it now flounders is not only super-erogatory but irrelevant. More important, this way of looking at the costs of the care of acute illness also offers a way of meeting those costs. If every patient in hospital, except perhaps the very young and the very old, contributed 10p a day to that hospital he could rest secure in the knowledge that this trivial premium—the cost of five cigarettes, a can of coke, a bar of chocolate, or 1½ pints of petrol—would ensure that whatever illness he had, whatever urgent service he might need, whatever unforeseen complication or reverse he might suffer, cover would be provided at any hour of the day or night. Doubling the levy to a mere 20p a day would, moreover, underwrite the desperately needed increase of salaries for nurses and ancillaries.

Politicians of all colours have long lacked the courage to tell their electors that this kind of service must be paid for. Perhaps, after all, the D.H.S.S. and the public do not want the kind of service we now struggle to provide. If so, let them say so. But neither public, politicians, nor placemen should expect the medical profession to compound their parsimonious folly.—I am, etc.,

P. J. E. WILSON

Neurosurgical Unit,
Morrison Hospital,
Swansea

Fatal Insect Stings

SIR,—In your leading article on this subject (18 May, p. 345) it was pointed out that respiratory tract obstructions—oedema of the glottis or bronchi—accounted for 70% of the deaths and that 58% of the deaths occurred within the first hour. It was also suggested that antihistamines may be injected intramuscularly or intravenously to combat the respiratory oedema; and by way of example promethazine hydrochloride 50 mg was quoted. It should be remembered that promethazine is a sedative and if injected intravenously can produce such a degree of sedation that the patient may become unconscious, a dangerous state to be in if the airway is partly blocked.

I recently saw a patient who had developed a minor degree of upper respiratory obstruction, having inadvertently eaten some pork, to which she was sensitive. Her breathing was laboured and she indicated that she could feel a sensation of swelling at the back of the tongue. I treated her with hydrocortisone intravenously to a total dose of 700 mg and at one stage I injected 5 mg of chlorpheniramine slowly into a vein. Immediately after this she became extremely sleepy and her breathing, which had until then been laboured but adequate, became slow and shallow and plainly inadequate. I found I could maintain her respiration by loud vocal encouragement and continuous tactile stimulation—in short, by shouting

and prodding—till she woke up 20 minutes later.

The fact that this was only a mild case of respiratory obstruction which ended harmlessly should not obscure the fact that the intravenous antihistamine, by depressing her consciousness, made the situation worse. Anaesthetists are trained to be aware of the danger of giving soporific drugs to patients with respiratory obstruction and I would urge that antihistamines be included in this group and should be used only with extreme caution.—I am, etc.,

CHARLES THOMSON

Department of Anaesthetics,
Newcastle General Hospital,
Newcastle upon Tyne

SIR,—I wish to draw attention to the potential danger of intramuscular or intravenous antihistamines, as recommended in your leading article (18 May, p. 345), in the treatment of acute anaphylactic shock caused by insect stings, particularly where bronchoconstriction is in evidence. Antihistamines may result in further bronchoconstriction and in any case they are probably useless in the treatment of acute anaphylaxis. The physiological antihistamine adrenaline together with intravenous corticosteroids and, of course, other supportive therapy would be the logical approach. I am rather surprised that you do not mention intravenous corticosteroids in your article.—I am, etc.,

K. K. NAYAK

Department of Clinical Research,
Philips-Duphar B.V.,
Weesp, Holland

** The sedative effects of an antihistamine may vary from individual to individual but it would be unlikely that the recommended dosage would produce serious respiratory depression in most patients. The patient quoted by Dr. Thomson was still rousable, and was fully awake in 20 minutes—a remarkably short period if the antihistamine and not the anaphylactic shock was chiefly to blame.

There is no evidence that antihistamines, in therapeutic dosage, can cause bronchoconstriction though they may not relieve it. Antihistamines should still be considered as important in the treatment of acute anaphylaxis, second only to the all-important adrenaline.

Corticosteroids are of little or no value in acute anaphylactic emergencies. We agree that once the emergency has passed they should be used to prevent recurrent or delayed reactions.—Ed., *B.M.J.*

Lawn Mower Injuries

SIR,—These summer months will produce their share of lawn mower injuries. In the United States in 1970 it was calculated¹ that there were 27m. mowers in use, resulting in 140,000 injuries during that year. (Figures for Britain are not available.) Most of these appear to be caused by rotary mowers, whose blades rotate horizontally to the ground at speeds of up to 3,000 r.p.m., the blade tips reaching a speed of 232 miles (373 km) per hour.

Lawn mower injuries are of two types:

(1) Direct injuries. These are caused by the blades of the mower striking either the operator or someone else, usually a child who has fallen into the path of the mower.

Injuries to adults usually involve the forefoot, causing at the least lacerations of the toes and, more seriously, complete or partial amputation of one or more toes, the wounds being contaminated with grass and soil. We have found² that these forefoot injuries tend to occur when the operator is using the mower going down a wet or dew-damp slope, when his feet slip from under him and slide under the protective canopy of the mower into the blades. Lasting sequelae of such injuries are disturbance of balance, limping, and diminished walking distance due to pain, especially if the hallux and/or first metatarsal are involved.

(2) Missile injuries. When small, hard objects such as stones are struck by the rotating blades they may be hurled from under the mower for distances of 50 yards (46 m) or more. Apart from causing structural damage to windows etc., they may cause serious injuries to the eye, even blindness.³ A survey in New Zealand⁴ reported that such missiles were the most common single cause of traumatic hyphema.

The following points should help prevent these accidents: (1) remove stones etc. from the lawn before mowing; (2) keep children and pets away from mowers in use; (3) remember that slopes, especially if wet, are potentially hazardous; and (4) wear robust footwear capable of secure purchase on the ground—golf shoes or ordinary shoes with spikes inserted will prevent slipping.—We are, etc.,

J. R. HULME

Basingstoke District Hospital,
Basingstoke, Hants

A. R. ASKEW

Radcliffe Infirmary,
Oxford

¹ DeMuth, W. E., et al., *Journal of the American Medical Association*, 1973, 225, 355.

² Hulme, J. R., and Askew, A. R., *Injury*, 1974, 5, 217.

³ Barsky, D., *Archives of Ophthalmology*, 1960, 64, 385.

⁴ Ferguson, R. H., and Poole, L. W., *Transactions of the Ophthalmological Society of New Zealand*, 1968, 20, Suppl. 10, p. 54.

Septic Abortion and the Dalkon Shield

SIR,—To remove an intrauterine contraceptive device (I.U.C.D.) in early pregnancy by traction on the strings, as advised by Dr. J. S. Templeton (15 June, p. 612), is very likely to cause abortion. Legal considerations apart, the risks of incomplete abortion, haemorrhage, and sepsis inherent in such a procedure must be far greater than the remote chance of intrauterine sepsis if the device remains in situ.

It seems likely that cases of septic abortion occurring in patients with I.U.C.D.s who become pregnant are due to attempted interference. If it is true that the infection can occur spontaneously, then an appropriate course of action would be to culture a high vaginal (not intracervical) swab and give a short course of antibiotics followed by a maintenance dose until the risk is considered to have passed.

The advice in Dr. Templeton's last paragraph could easily be misinterpreted by the patient as a promise of a therapeutic abortion if she became pregnant while wearing a Dalkon Shield. Such an undertaking would not come within the provisions of the Abortion Act, which, at least by implication, requires the opinions of two practitioners based on circumstances which present only