plugs in the treatment of otitis externa in divers, but that the last comment in the article, "diving must be forbidden until the skin has returned to normal," is more appropriate?—I am etc.,

C. R. LUCAS

Southsea, Hants

SIR,—In your leading article which discusses external otitis associated with prolonged contact with water (27 July, p. 213) you suggest that divers might avoid such contact by the use of Vaseline-coated ear plugs. I think the opinion of most divers is that ear plugs should not be used under any circumstances—firstly, because the pressure exerted by the water is quite sufficient to push an ear plug into the deeper part of the meatus, thus necessitating surgical removal; secondly, if the plug is sufficiently impacted in the external meatus the pressure in the middle ear will cause considerable pain and possibly perforate the ear drum. Perhaps Vaseline alone swabbed around the meatus before diving would prevent the maceration of the skin which you describe.—I am, etc.,

T. SMYTH

London Hospital Medical College

SIR,—While unable to claim an infallible cure for the problem of swimmers' ears I can offer a method of prophylactic treatment as far as I am aware entirely successful in the group of swimmers and divers with which I have been associated. Exposure to water consisted of weekly sea dives (Monterey Bay, California) to average depths of 50 ft (15.2 m) together with two or three dips a week in private chlorinated pools—perhaps half this rate in winter. Treatment consisted in dropping into the ears three to four drops of 1% acetic acid in alcohol. This dessicates the sodden epithelium and re-establishes the slightly acid pH, which I am told is desirable.

An itchy ear usually indicates an excessive collection of cerumen or scales, and I have not yet had cause to regret recommending their removal by gentle manipulation of a "Q-tip" or cotton bud. While this is vastly better than a dirty finger nail one must always stress the gentleness.

I am not sure of the reasoning behind your caveat (27 July, p. 213) against dessicants, unless your comments were applied to the established disease. My recommendations, I would emphasize apply only prophylactically.—I am, etc.,

J. A. LACK

West Dulwich,
London S.E.21

Respiratory Complications of Obesity

SIR,—We were interested to read your leading article on this topic (8 June, p. 519). We think it is worth stressing that in obese persons with normal lungs the increase in resting ventilation is generally appropriate to the increased carbon dioxide production and oxygen uptake, in contrast to the disproportionate increase in alveolar ventilation found in some other conditions (for example, pulmonary thromboembolic disease¹) and also in contrast to the decrease found in the Pickwickian syndrome.

You state that the Pickwickian syndrome occurs in some 10% of obese subjects, but unfortunately this is not substantiated by any reference in the text to published work and may well be an over-estimate. In our experience the Pickwickian syndrome is rare, though more commonly obesity complicates the alveolar under-ventilation found in some chronic bronchitics. While the syndrome is fascinating, we feel that it should not predominate in a discussion of the respiratory complications of obesity, for the inequality of ventilation and blood flow to which you refer remains a constant cause of hypoxaemia in the obese, becoming especially important when added to by other factors such as abdominal surgery.²

Though Charles Dickens described the fat boy Joe, after whom the syndrome is named, in *The Pickwick Papers* in 1837, few realize that two cases were described in the eighteenth century by Dr. John Fothergill.³ One of these was cured by weight loss and in the other "all the viscera were perfectly sound" at necropsy. This was pointed out by Simpson in 1958⁴ but Joe continues to enjoy medical as well as literary immortality.—We are, etc.,

M. J. B. FAREBROTHER

Northern Counties Chest Hospital,
Newcastle upon Tyne

G. J. R. MCHARDY

University Department of Respiratory Diseases,
City Hospital,
Edinburgh

¹ Jones, N. L., and Goodwin, J. F., *British Medical Journal*, 1965, 1, 1089.

² Alexander, J. I., et al., *Clinical Science*, 1972, 43, 137.

³ Fothergill, J., *Complete Collection of the Medical and Philosophical Works*, ed. J. Elliot, p. 525. London, John Walker, 1781.

⁴ Simpson, N. H., *New England Journal of Medicine*, 1958, 259, 34.

Maternal Deaths in Scotland

SIR,—I refer to your leading article on the recent report of an inquiry into maternal deaths in Scotland¹ (29 June, p. 683). Being one of the authors of this report, I was distressed to see that some of our statistics have been misinterpreted.

The article states that "there was an avoidable factor on the part of the patient in 50% of deaths, of hospital medical staff in 48%, of the general practitioner in 27%, and of the hospital nursing staff in 3%." However, if one looks at the table on p. 66 of the maternal death report it will be seen that these are percentages of the deaths with avoidable factors only and not percentages of the total deaths. The report shows that in 32% of all deaths an avoidable factor was considered to be present.

As you will appreciate, the situation is less serious than would appear from your article and I would be grateful if this could be made clear.—I am, etc.,

LOUISE GILES

Edinburgh

¹ Scottish Home and Health Department, *A Report on an Enquiry into Maternal Deaths in Scotland 1965-1971*. Edinburgh, H.M.S.O., 1974.

* * We regret our error.—Ed., B.M.J.

Death in Hospital

SIR,—In answer to Dr. J. D. W. Whitney and others (6 July, p. 45) he may be interested in why I do not notify general practitioners of deaths by telephone. On phoning

practitioners in South London I am usually answered by receptionists, deputizing agencies, or the telephone operator offering me another number which will probably turn out to be a deputizing service.

After tracking down the owner of one of the local lock-up surgeries there is a pause before a slightly embarrassed admission that he couldn't quite visualize the deceased but, "thanks all the same, old chap." Disheartened I replace the receiver remembering that in fact the patient had been admitted via the Emergency Bed Service and the deputizing service.

Finally I would counter Dr. Whitney's requests with two from the hospital end. Firstly, the ending of all deputizing services and secondly, even more important to good communications between us, the abolishment of the E.B.S., the bane of all admitting officers.—I am, etc.,

CHRISTOPHER J. BENNETT

Sudbury, Suffolk

Cleft Lip and Palate

SIR,—Some of the statements in Mr. I. F. K. Muir's useful article (13 July, p. 107) may be disputed.

(1) While cleft lip with or without cleft palate (C.L.P.) or, more commonly, isolated cleft palate (C.P.) occurs as part of many recognizable syndromes, some of which are mendelian, there seems to be no evidence of a recessive contribution to cases of C.L.P. without associated malformations. The genetic contribution in the majority of these appears to be polygenic.^{1,2}

(2) C.P. is commoner in girls than boys but is by no means confined to females, even in the familial cases, as Mr. Muir states. Male index cases with affected sibs have in fact been observed and had a higher proportion of affected sibs (6%) than female index cases (2%)—evidence of polygenic inheritance in this group.

(3) Statements like "it is very likely that any further female children will have clefts" or "the dangers of further children being affected are very great indeed" may be misleading in genetic counselling, and numerical estimates should be given where possible. Empirical risk figures for various types of family are available.^{1,3} These indicate that in a family with one child and a first-degree relative of one or other parent affected by C.L.P. the risk to a further child is approximately one in 10 and not one in 80 as Mr. Muir states.—I am, etc.,

N. R. DENNIS

M.R.C. Clinical Genetics Unit,
Institute of Child Health,

London W.C.1

¹ Fraser, F. C., *American Journal of Human Genetics*, 1970, 22, 336.

² Carter, C. O., *British Medical Bulletin*, 1969, 25, 52.

³ Woolf, C. M., *Journal of Medical Genetics*, 1971, 8, 65.

Removal of Tattoos

SIR,—Mr. B. D. G. Morgan (6 July, p. 34) describes the removal of tattoos by various plastic methods. I wonder whether other surgeons are aware of the fact that it is possible to do this in a much simpler fashion by using a power dermatome. With this it is possible to split the dermis and so remove the tattoo leaving unpigmented dermis

behind. This method is most useful in patients with tattoos which have been inflicted by the modern method, using transfers and electric needles, as in these cases the penetration of the pigment is not very great. It is important when doing this to make the clearance in one swoop and to do this it is essential that the surgeon should go as deep as possible without actually cutting through the dermis. This is a much quicker method than has been described and a much more satisfactory one. If too superficial a plane has been chosen it is still possible to remove the deeper remnants with dermabrasion.—I am, etc.,

GEORGE T. WATTS

General Hospital,
Birmingham

Allergy to Aspirin

SIR,—We were interested to read in your leading article (27 July, p. 216) on allergy to aspirin the statement that "Aspirin-sensitive asthmatics frequently have nasal polyps, but polypectomy does not alleviate the symptoms or control the asthma."

Polypectomy may certainly relieve the nasal symptoms for a time, but as regards the control of asthma the operation may precipitate asthmatic symptoms which have not in fact been previously overt. We are both familiar with such cases, and indeed one of us (F.D.H.) saw some years ago a man aged 55 years, who had never at any time suffered from asthma previously, develop severe status asthmaticus after polypectomy. His asthma continued variably for some five years until he failed to return to the clinic. A second, rather milder case in a man aged 40 was seen some years later: again, asthma appeared initially in severe form only immediately after polypectomy.—We are, etc.,

F. DUDLEY HART
E. H. MILES FOXEN

Westminster Hospital,
London S.W.1

Age Limit for Contraceptives

SIR,—Dr. Elizabeth M. Elliott (27 July, p. 260) suggests that the Family Planning Association's "wholehearted support for the decision to impose no age limit on supplies of contraceptives" under the Health Service was a decision which did not have the weight of the F.P.A. clinic doctors behind it. May I point out that there is a perfectly democratic method open to any doctor who does not agree with F.P.A. policy and that is through the F.P.A.'s Clinic Doctors' National Council? Indeed, Dr. Elliott was invited to attend a meeting of the council—comprising her colleagues from all over Great Britain—in November 1972 to discuss her controversial views. She did not attend.

Dr. Elliott continues to work for the F.P.A. and is chairman of one of the branch doctors' groups. If she and her branch doctors agree about any of the points she wishes to make it is open to her to put these up in the form of a resolution to the council.—I am, etc.,

ELIZABETH GREGSON
Deputy Chairman,
F.P.A. Clinic Doctors' National Council

Formby, Liverpool

Diabetic Autonomic Neuropathy

SIR,—Your leading article on this subject (6 July, p. 2) draws attention to the need for tests which are simple and easily performed.

No reference was made to the use of the psychogalvanic response¹—that is, the change in electric potential between electrodes applied to the skin of a limb that occurs in response to certain stimuli and which is abolished by interruption of the sympathetic pathways. This response is easy to demonstrate at the bedside using an E.C.G. machine.² It provides an immediate indication of sympathetic activity in a limb. It has proved particularly useful in diabetics with peripheral vascular disease since there is little advantage to be anticipated in performing a sympathetic ganglionectomy on a patient in whom a neuropathy has already led to sympathetic denervation. The test is also valuable in verifying the success of chemical sympathectomy.

Lentle³ has investigated the psychogalvanic response in diabetics and found it to be abolished in all his patients with florid neuropathy.—I am, etc.,

GORDON HEARD

University Hospital of Wales,
Cardiff

- 1 Heard, G. E., *British Journal of Surgery*, 1964, 51, 629.
- 2 Lewis, L. W., *Current Researches in Anaesthesia and Analgesia*, 1955, 34, 334.
- 3 Lentle, B. C., *The Complications of Diabetes Mellitus*, M.D. Thesis, University of Wales, 1967.

Measurement of Side Effects of Drugs

SIR,—The conclusions drawn by Drs. E. C. Huskisson and J. A. Wojtulewski (29 June, p. 698) go some way beyond the evidence they present and seem in part unjustified. At one of the two centres where their study was performed patients were asked only the non-specific question: "Have you noticed any new symptoms which might be related to the treatment?" At the other centre a check list asking about 21 possible side effects was *also* used (my italics). The authors do not say whether at the second centre the non-specific question was asked before or after the patient was asked the questions on the check list, nor do they compare the answers of the patients to the non-specific question with the *same* patients' answers to the check list questions. Such a comparison would provide a more critical test of the authors' conclusions.

We have compared the results of using non-specific questioning and using a check list in assessing unwanted effects of pentagastrin in medical students.¹ Five, seven, and nine minutes after receiving an injection the subjects were asked whether they felt anything unusual, and only then were they asked specific questions from a check list. Non-specific questioning elicited a total of 31 symptoms in 13 of 15 subjects given pentagastrin and none in those given saline. The check list questions elicited a total of 48 symptoms after pentagastrin (mean three per subject) and nine after saline (mean one per subject).

As in the study by Huskisson and Wojtulewski, each method of questioning elicited a different type of information. The responses to non-specific questions showed a wide range of unwanted effects that seemed noteworthy to the subjects, whereas the check list questions provided a much better

estimate of the incidence of those effects that were asked about. The two methods should be regarded as complementary not as alternatives, and it is wrong to conclude that "since check lists increase the incidence of irrelevant complaints they should not be used."—I am, etc.,

ANDREW HERXHEIMER

Department of Pharmacology and Therapeutics,
The London Hospital Medical College,
London E.1

- 1 Barrowman, J. A., Herxheimer, A., and Kits, T. P., *Clinical Pharmacology and Therapeutics*, 1970, 11, 862.

Kidneys for Transplantation

SIR,—I was interested to note that in the statement on artificial feeding of prisoners prepared by the Central Ethical Committee of the B.M.A. and approved by Council (6 July, p. 52) attention was drawn to the fact that doctors must always bear in mind their obligation to preserve human life.

It is a great pity that this body does not call this obligation to the attention of the hundreds of hospital doctors who continue, either through ignorance, disinterest, or both, to allow viable cadaver kidneys to be lost to the transplant surgeons waiting for the opportunity to save the lives of their patients.

Still in Britain thousands of young lives are lost every year through lack of cadaver kidneys for transplantation, and hundreds are relegated to lives of uselessness and wretchedness on kidney machines. Every week thousands of viable, life-saving kidneys are burnt in crematoria or buried six feet down in graveyards, taking with them the chance of life or rehabilitation to the many young sufferers from end-stage renal failure.

If all doctors would remember their obligation to preserve life, and not just the lives of their own patients, then this tragic situation would come to an end.—I am, etc.,

ELIZABETH WARD

Chairman,
Silver Lining Appeal of the National
Kidney Research Fund

Bordon, Hants

Effects of Posture on Limb Blood Flow in Late Pregnancy

SIR,—The paper by Dr. G. B. Drummond and his colleagues (15 June, p. 587) is most interesting as we are currently involved in a similar study. Their work supports the findings of Eckstein and Marx,¹ who measured blood pressure changes in the upper and lower limb in pregnant patients at term, supine and with uterine displacement. They found a significant decrease in femoral blood pressure in the supine position, while upper limb pressures increased or remained unchanged.

However, I feel the conclusion drawn by Eckstein and Marx from their study applies also to the work of Dr. Drummond and his colleagues. Eckstein and Marx concluded that decreased blood pressure is more indicative of lower aortic obstruction than of lowered cardiac output following vena caval obstruction. This would appear equally relevant to blood flow studies. The term aorta-caval occlusion would therefore appear preferable to vena caval occlusion, in that both the major abdominal vessels are compressed and produce deleterious effects on uterine perfusion—aortic occlusion by direct