tical solution. Mr. Illich foresees a cataclysmic collapse of our present institutionalized values and Dr. Bradshaw envisages a similar end. One would like to think that this particular era of *La condition humaine* will end "not with a bang but with a sigh."

There may be many small but vital pockets of hope and resistance standing out in the Western world. Let us hope that some of these have among their number "men of medicine."—I am, etc.,

N. S. BABER

Ilfacombe, Devon

Starving Children before Operation

SIR,—Your leading article on this subject (27 July, p. 213) was both timely and stimulating. Thomas¹ has proposed an effective and practical solution to the problem of hypoglycaemia in infants and small children. This would be practicable for afternoon lists but must have severe limitations for those treated as day patients on morning lists. For over two years it has been a regular practice in this hospital to encourage patients to drink up to one hour prior to receiving premedication before general anaesthesia, using metoclopramide to stimulate emptying of the stomach. A series of over 400 cases has been performed safely.² Since the publication of your article this technique has been adapted to infants and young children as a means of raising the blood sugar during operation. The following case report will be instructive.

A child 18 months old weighing 11.1 kg was admitted as a day case for orchidopexy. At 8.30 a.m. the blood sugar was 35 mg/100 ml, though there were no signs of hypoglycaemia. The child was given 125 ml of 20% glucose flavoured with orange and metoclopramide 2.5 mg was injected intramuscularly. At 9.30 a.m. 10 mg of hyoscine *N*-butylbromide was injected intramuscularly with 500 IU of hyaluronidase. A smooth and uneventful induction of anaesthesia with nitrous oxide, oxygen, and halothane followed two minutes later. The operation ended at 10.10 a.m., when a second blood sugar estimation gave a level of 165 mg/100 ml. Three days later a blood sample was taken to assess the normal blood sugar of the child and the reading then was 85 mg/100 ml.

It seems probable that general anaesthesia administered during hypoglycaemia (blood sugar < 40 mg/100 ml)³ is attended by real risks to the patient of serious permanent brain damage.⁴ This case may point the way to a technique in which this risk may be completely avoided and which is at present being investigated in this hospital.—We are, etc.,

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¹ Thomas, D. K. M., *British Journal of Anaesthesia*, 1974, 46, 66.

² Fry, E. N. S., *Anaesthesia*. In press.

³ *British Medical Journal*, 1971, 3, 130.

⁴ Meldrum, B. S., *British Medical Journal*, 1972, 1, 379.

Treatment of Status Epilepticus with Sodium Valproate

SIR,—We were very interested in the paper by Drs. P. M. Jeavons and Jean E. Clark (15 June, p. 584) describing the encouraging results of treatment with sodium valproate in patients with epilepsy. They did not mention the use of this drug in status epilepticus and we would like to report here the treatment of such a case with sodium valproate.

A girl aged 17 years had a history of grand mal epilepsy since the age of 5 and was accustomed to having one to three fits per day in spite of careful supervision and adjustment of conventional anticonvulsant regimens. On several occasions she had been admitted in status epilepticus. This had usually responded, though sometimes only after 12–24 hours, to intravenous diazepam and/or paraldehyde with intramuscular phenytoin and phenobarbitone, together with appropriate supportive therapy as outlined in your leading article (19 February, p. 460). In December 1973, however, status epilepticus failed to respond either to the usual measures or to general anaesthesia with endotracheal intubation and assisted respiration in the intensive care unit. After six days in status she appeared to be dying, but she was then given dexamethasone, whereupon her fits diminished and she recovered during the next three to four days. It was several weeks before she regained her former mental and physical state and she continued to have daily fits in spite of medication (with phenytoin, phenobarbitone, and diazepam).

In June 1974 she was again admitted in status epilepticus. She was treated initially with the usual measures, but as she failed to improve after 12 hours she was given dexamethasone in view of her apparent response on the previous occasion. An infusion of chlormethiazole edisylate (Heminevren) by a subclavian line was also started and this prevented continuous attacks but had to be maintained at a dose which kept her unconscious except for brief periods during which E.E.G. monitoring showed generalized epileptic activity. After 10 days in this state sodium valproate 100 mg four times a day was started and the dose was increased gradually to 600 mg four times a day over five days, the tablets being dissolved in water and the solution passed into the nasogastric tube. During this period it was possible to stop the chlormethiazole gradually, the number of fits diminished as the dose of sodium valproate was increased, and the E.E.G. improved. She then made a remarkably rapid recovery, having been in status for virtually 15 days. Sodium valproate 600 mg four times a day was continued with a reduced dose of her previous anticonvulsant drugs; she had several days free from fits and was discharged home. On review six weeks later she had remained very much better, having had relatively few attacks and no side effects from the drugs.

We hope that sodium valproate will continue to help in the long-term treatment of this patient's epilepsy, as in many of the cases reported by Drs. Jeavons and Clark. However, we believe that this is the first report of sodium valproate being used in the treatment of status epilepticus. The patient had failed to respond to the supportive measures and drugs generally used together with steroids and chlormethiazole over a period of 10 days, and she recovered only when treated with increasing doses of sodium valproate during the next five days. It therefore seems worth assessing the potential value of this drug now in other cases of status epilepticus.

We thank Drs. T. Healy and A. Hodsman and the nursing staff of the intensive care unit at this hospital for their help with the supportive treatment of our patient, and we are grateful to Reckitt and Colman for the supply of sodium valproate (Epilim).

—We are, etc.,

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MICHAEL ESPIR

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Price of Prostatectomy

SIR,—The article by Mr. S. Argyrou and others (24 August, p. 511) prompts us to write briefly to describe our experience with cryosurgery for prostatic obstruction at Northwick Park Hospital.

Of 16 patients with acute or chronic retention of urine, selected for cryosurgery because severe cardiopulmonary disease made them unsuitable for major surgery or general

anaesthesia, 13 left hospital after about 10 days relieved of obstruction and the three failures were subsequently successfully treated by conventional means. So far, no patient has relapsed after periods extending up to 18 months. The operation was carried out under sedation and local anaesthesia with a liquid N₂O-cooled probe designed and made in the bio-engineering division of the Clinical Research Centre. The use of N₂O instead of liquid N₂ makes the instrument and the operation much simpler and safer and avoids the sometimes disastrous complications that have occurred with liquid N₂-cooled probes.¹

We intend to publish a detailed account of our procedure and results and to carry out a planned clinical trial on a wider range of patients, but meanwhile we would suggest that cryosurgery using N₂O may well be found to offer an acceptable alternative to transurethral resection, with all its advantages and without the disadvantage of requiring expensive equipment and a skilled and experienced operator. An instrument based on our design is being made and sold by Spemby Ltd., Newbury Road, Andover, Hants.—We are, etc.,

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B. M. WRIGHT

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Centre,
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¹ *British Medical Journal*, 1971, 2, 5.

Swimmers' Ears

SIR,—Your leading article (27 July, p. 213) gives an excellent superficial summary but if taken seriously could lead to needless restrictions on those whose recreation is swimming or scuba diving. With the scanning technique of rapid reading the focusing of attention on the last sentence, which states that "when external otitis occurs, diving must be forbidden until the skin has returned to normal," could lead many people being denied their recreation. It is hard to see how this is reconciled with your statement in the first paragraph that a fleeting application of water can hardly cause any harm even when an active eczematous process is present, or the statement by Wright and Alexander,¹ whose work you quote at length. They write: "Swimmers with otitis externa were able to continue swimming with only a limited interruption in their daily routine," and of their divers, all of whom developed external otitis, none ceased their 14 to 16 daily (8–12 hours) excursions into the water and only in a few instances did treatment fail to obtain a sterile ear canal.

For those whose recreation is scuba diving, none expose themselves to the extent that the above divers did, and far from prophylaxis being difficult in divers, as you claim, it is in practice very simple and effective. It is the competitive surface swimmers who suffer more from external otitis than scuba divers² because they spend much more time in the water, and in temperate zones the majority of scuba divers wear a hood, which prevents the flow of water in and out of the external ear canal. Prophylaxis in the susceptible person begins with the use of 5% acetic acid in rectified spirit³ after immersion, to dry the skin and maintain its normal acidity and also for its bactericidal and fungicidal properties.

In addition to maceration and the bacterial flora, in most cases the precipitating factor in setting up inflammation is, as you say, "the scratching finger (and fingernail) attempting to relieve the almost invariable itching." To the finger (and fingernail) should be added the many other objects patients admit they use to relieve the itch or other sensations they have either as a result of the maceration or as a result of referred sensations from other sources such as dental disorders. Questioning usually reveals that the scratching etc. precedes the infection and thus it could be said that the external otitis is a self-inflicted disease in such cases. Scuba divers are taught and professional divers know that they must not scratch, pick at, poke, or rub in or around the ear or they will develop external otitis. In fact, in Wright and Alexander's study the unusual feature that these professional divers should all develop external otitis was probably due to the repeated daily assault on the increasingly macerated skin by the cotton-wool-tipped ear swabs poked in and rubbed around.—I am, etc.,

NOEL ROYDHOUSE

Auckland,
New Zealand

- 1 Wright, D. N., and Alexander, J. M., *Archives of Otolaryngology*, 1974, **99**, 15.
- 2 Roydhouse, N., *Proceedings of the 20th World Congress of Sports Medicine* 1974.
- 3 Jones, E. H., *External Otitis*, 1st edn. Springfield, Thomas, 1965.

Lactose Intolerance in San Populations

SIR,—We have been interested to read the comments of Dr. J. M. Pettifor and Professor J. D. L. Hansen (20 July, p. 173) on our paper (6 April, p. 23). Their initial semantic point is well made. We can only plead that our usage of the term lactose intolerance rather than malabsorption conforms with that of the authorities we cited and of one which has recently come to our notice¹; we consequently presume the term to be the accepted one for a deficiency, or absence, of intestinal lactase. The test we employed appears, moreover, to be the standard one for the detection of lactose intolerance. It is true that any analogy with the glucose tolerance test, in which intolerance produces an abnormal rise in blood sugar, is misleading; but we must disclaim responsibility for this inconsistency in terminology.

We did emphasize the point that removal of lactose by fermentation, a safe and simple procedure if lactobacillus is used and one well in accord with the traditional practices at least of Bantu-speaking Negroes, would make the administration of milk safer. This would apply whether intolerance or malabsorption were responsible for the well-established dangers of giving lactose to children in Africa.² Adults are, admittedly, unlikely to drink 1½ litres of reconstituted cow's milk a day, but unsophisticated people faced with a flour-like food powder might well treat it as flour. It is not unknown for dried milk powder to be mixed into porridge in quite large quantities as part of feeding schemes.

As our recent letter (29 June, p. 728) will have indicated, we have come to suspect that intestinal lactase may well be induced in the Nama, a pastoral Khoisan people, and that

this induction phenomenon tends in part to obscure the genetic polymorphism. It would consequently appear that the latter is best investigated in a population of young children. This raises a number of ethical points. Our sample of Nama children was drawn with the consent of parents, school authorities, and local health authorities. The children had the test explained to them and no pressure was put on them to volunteer. The inducement held out to them (a few sweets) was too small to be overwhelmingly attractive and it was made clear to them that it represented compensation for inconvenience and not a bribe. Not all underdeveloped peoples are as sophisticated as the Nama, however, and the question may in other places, where milk is part of the diet, lead to some hesitation. We have no data on the incidence of infantile diarrhoea among the Nama and are unable to estimate what proportion, if any, of early deaths may result from feeding with cow's milk.

The question of the nutritional status of the !Kung is not as contentious as Dr. Pettifor and Professor Hansen may make it appear. They quote the results of a single study,³ which was at variance in its conclusions from those drawn by other workers,^{5,6} including one whose sojourn among the !Kung was of long duration and who replied to the study when it was first published.⁷ None of the !Kung seen by us at Tsumkwe in July/August 1973 or again in June 1974

showed signs of clinical undernutrition, and full haematological examinations carried out on them certainly failed to disclose any nutritional anaemia. It is possible that seasonal alterations in nutritional status, so frequently encountered elsewhere in Africa,^{8,11} may affect the !Kung as well, though Lee¹² could see no reason why they should, considering the availability of food resources and the use made of them.—We are, etc.,

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TREFOR JENKINSSouth African Institute for Medical Research,
Johannesburg

- 1 Losowsky, M. S., Walker, B. E., and Kelleher, J., *Malabsorption in Clinical Practice*. Edinburgh, Churchill Livingstone, 1974.
- 2 Prinsloo, J. G., et al., *South African Medical Journal*, 1973, **47**, 821.
- 3 Truswell, A. S., and Hansen, J. D. L., *South African Medical Journal*, 1968, **42**, 1338.
- 4 Truswell, A. S., et al., *American Heart Journal*, 1972, **84**, 5.
- 5 Wehmeyer, A. S., Lee, R. B., and Whiting, M., *South African Medical Journal*, 1969, **43**, 1529.
- 6 Metz, J., Hart, D., and Harpending, H. C., *American Journal of Clinical Nutrition*, 1971, **24**, 229.
- 7 Lee, R. B., *South African Medical Journal*, 1969, **43**, 48.
- 8 Richards, A. I., *Land, Labour and Diet in Northern Rhodesia*. London, Oxford University Press, 1939.
- 9 Nurse, G. T., *Central African Journal of Medicine*, 1968, **14**, 122 and 147.
- 10 Ogbu, J. U., *Africa*, 1973, **43**, 317.
- 11 Nurse, G. T., *Africa*. In press.
- 12 Lee, R. B., *Subsistence Ecology of !Kung Bushmen*. Ann Arbor, University Microfilms Inc., 1965.

N.H.S. Consultants: Progress Report

SIR,—I shall be grateful if you will allow me to present through your correspondence columns a short report on a number of important items in the field of senior hospital medical and dental staff. A great deal has been happening during the summer recess, but because in some cases discussion of these matters is not yet concluded it is impossible to make a full and formal report through the usual channels.

In its fourth report the Halsbury Review Body expressed concern about doctors and dentists having fallen behind in remuneration. Now that phase 3 of counterinflation legislation is ended we believe that the Review Body is free to exercise its independence and we have therefore submitted to it through the Joint Evidence Committee a written request for an interim award of 18%. This was backed up by oral evidence given to the Review Body at a meeting on 9 September. The Government, through the Department of Health and Social Security, has also submitted written evidence to the Review Body, saying that it sees no justification for any increase in salaries at present.

Throughout August and September panels of the consultants' working party chaired by Dr. David Owen have continued to meet. Undoubtedly discussion of contracts in this forum has broken the log-jam which for two years existed in "the usual channels." Progress is being made. In this context both we—that is, the Central Committee for Hospital Medical Services—and the working party itself have issued questionnaires to consultants for completion. I am most grateful to the thousands of senior staff and some senior registrars who have completed replies to our own inquiry. No doubt many are

replying also to the different questions put to them by the Owen working party about the shape of their average working week.

Among the staff members of the Owen working party are the president and immediate past president of the Hospital Consultants and Specialists Association. The whole "staff side" is working as one team. I have no doubt that this friendly and close collaboration between representatives of the C.C.H.M.S. and Mr. Beatson and Dr. Winter will be to the benefit of all consultants—both present and future. Also I am hopeful that by working together it may lead us towards a basis for agreement between our two associations.

The Owen working party has every aspect of terms of service in its general remit save for levels of remuneration. In addition to the contract of consultants now being studied the working party will be moving on to consider those of other senior grades, and we have also requested a special study of the problems of definition so long posed by the paragraphs in the terms of service dealing with categories I and II.

We expect soon a Departmental answer to the request made by the Joint Consultants Committee for reconsideration of all senior hospital medical officers without the special allowance. Further, our negotiators have recently met representatives of our Medical Assistants Subcommittee to discuss their own proposals for reform of contract.

Following the pay-bed crisis meeting of early July with the Secretary of State we have been keeping a close eye on the position and on threats and encroachments resulting from irregular trade union action locally. Through the Health Departments we