

to those dilemmas. Furthermore, contrary to the views of the authors, over 40 groups have been sufficiently interested in the discussion to continue the dialogue within their organisation and to return documentation indicating their perceptions. The public is quite capable of expressing an informed view when prompted.

It is true that the public's understanding of priorities is different from that of professionals. It is also true that the public is less well informed than professionals about particular aspects of work, but that is no less true of many professionals within the NHS whose knowledge of their own, often limited, area of work is not matched by a similar understanding across a wider range of services.

Those health authorities that have sought, genuinely, to raise the level of debate on priority setting are well aware of the pitfalls; the reluctance of society at large to face the issue, and, indeed, the dangers of pretending that any one group, professional or lay, has access to the knowledge and wisdom required to manage the investment process positively. Such realisation, however, does not alter the fact that investments will be made either through some positive statement of values or by default. Which of these two methods society finds the more comfortable is not yet clear.

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1 Pfeffer N, Pollock A. Public opinion and the NHS. *BMJ* 1993;307:750-1. (25 September.)

Which insufflation gas for laparoscopy?

EDITOR.—Expense is not the only reason why helium should not replace carbon dioxide as the insufflating gas for laparoscopy, as was suggested by Bongard *et al*¹ and reiterated by Minerva.² Gas embolism is a life threatening complication of laparoscopy and more serious than respiratory acidosis caused by insufflated carbon dioxide. The severity of any gas embolism will be greatly increased if helium is used to insufflate the peritoneum.

If a vein is inadvertently cannulated by the insufflator needle and an appreciable (for example, 20 ml) pocket of gas accumulates in the right ventricle, cardiac output will be profoundly depressed until most of this volume is removed. Most gas will leave the right ventricle by dissolving in blood as it flows through the ventricle, but some gas will leave by permeation through the ventricular wall. Contrary to the statement of Bongard *et al*, neither process is hastened by the low density of helium.¹

The rate of solution of gas depends on its blood-gas partition coefficient (that is, its "solubility"); that of carbon dioxide is 50 times greater than that of helium (0.49-4.0 and 0.0098 respectively in the pressure range used during laparoscopy³⁻⁵). Permeation of gas through the ventricular wall is again much faster for carbon dioxide than for helium. The rate of permeation is proportional to the mathematical product of the diffusion coefficient and the partition coefficient. Although the diffusion coefficient of helium is about three times that of carbon dioxide "because of its low density,"¹ the partition coefficient of helium is one fiftieth that of carbon dioxide and so the rate of permeation of helium is 17 times slower than that of carbon dioxide. For both these reasons, a helium embolus is more serious than a carbon dioxide embolus.

In contrast to gas embolism, respiratory acidosis caused by peritoneal insufflation with carbon dioxide is easily treated. Most patients undergoing laparoscopic procedures are ventilated mechanically. Arterial carbon dioxide is accurately and

routinely assessed by measuring end tidal carbon dioxide pressure, and if ventilation is adjusted to maintain an acceptable end tidal pressure then respiratory acidosis is effectively abolished.

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- 1 Bongard FS, Pianim NA, Leighton TA, Pubecz S, Davis IP, Lippman M, *et al*. Helium insufflation for laparoscopic insufflation. *Surg Gynecol Obstet* 1993;177:140-6.
- 2 Minerva. *BMJ* 1993;307:746.
- 3 Hill DW. *Physics applied to anaesthesia*. 3rd ed. London: Butterworths, 1976.
- 4 Kety SS. The theory and application of the exchange of inert gas at the lungs and tissues. *Pharmacological Reviews* 1951;3:1-41.
- 5 Steward A, Allott PR, Cowles AL, Mapleson WW. Solubility coefficients for inhaled anaesthetics for water, oil and biological media. *Br J Anaesth* 1973;45:282.

Provision of paediatric intensive care

EDITOR.—In his review of Channel 4's programme on paediatric intensive care Robert Booy suggests that there are currently too many paediatric intensive care units in Britain seeing individually too few patients.¹ The evidence to support this statement is difficult to find. We do not know how many children could benefit from intensive care. We do not even know how many children use intensive care facilities. While it is agreed that larger, busier units amass the experience and skills to deliver high quality care better than smaller units, we do not actually know how many paediatric intensive care beds there are in Britain.

The Paediatric Intensive Care Society recently proposed a national audit facility to answer just these questions. Such a facility would quickly amass data to allow need to be assessed and critical differences among types of unit to be identified and would provide a database against which future innovations in paediatric intensive care may be compared. The Department of Health should be encouraged to fund this initiative as a matter of urgency. Only then will the debate on the provision of services for acutely ill children proceed on a foundation of fact rather than conjecture.

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1 Booy R. Devastation and deliverance. *BMJ* 1993;307:1074. (23 October.)

Selective abortion in India

EDITOR.—Peter D Toon's review of BBC2's documentary "Let Her Die," on the infanticide of female babies and the use of ultrasound examination for selective abortion of female fetuses in India, seems misguided.¹ Toon accuses the programme of having a tone of moral superiority bordering on racism. We wish to point out not only that we spent considerable time putting the phenomenon of female infanticide and sex determination in its cultural context but that reviewers in India have praised that very aspect of the film, saying it "lays bare, layer by layer, the social and cultural factors that lie at the root of our society's blinkered view of the girlchild."²

Dr Toon fails to condemn the gross abuse of ultrasound examination for selective abortion in India. He seems to condone doctors who make huge profits from reinforcing society's prejudice against women and defends the selective abortion of female fetuses on the grounds that a girl might grow up and be unhappy.

We also wish to remind Toon that in Britain,

though abortion is legal, selective abortion on the basis of sex is deemed unacceptable and unethical. How can we condemn it in Britain but ignore it when it is done in India? We think that that would be racist.

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1 Toon PD. Daughters, doctors, and death. *BMJ* 1993;307:875. (2 October.)

2 Chatterjee S. *Times of India* 1993 Oct 1.

Condoms: a new range of sizes

EDITOR.—Stuart J Tovey and Christopher P Bonell report a need for larger condoms for some men¹; our findings are similar. In response to a succession of male patients who complained about condoms splitting despite using the recommended technique to put them on (shown on a prosthesis in the presence of either a health adviser or doctor) we wrote to the British Standards Institute for clarification. The institute informed us that there are two sizes of condom, both specified by BS 3704, the smaller intended for use by "Far Eastern consumers." Despite the experience of the manufacturers of condoms in many countries and information from morphological studies, British men have, to date, been offered only two sizes of condom that conform to the institute's standards. The introduction soon of a new European standard, however, will give a range of sizes, thus allowing the manufacturers of condoms to tailor their products to meet the requirements of consumers.

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1 Tovey SJ, Bonell CP. Condoms: a wider range needed. *BMJ* 1993;307:987. (16 October.)

The war in Bosnia

Volunteer teams raise morale

EDITOR.—We are pleased that the *BMJ* is keeping the medical problems of Bosnia "on the boil." The personal and necessarily subjective views of Richard Villar and Louise McCorkindale on their experiences in Bosnia¹ reminded us of our own feelings when we first arrived in Sarajevo at the end of August to work as a medical team. Unfortunately, even the finest sentiments, such as those expressed by Villar and McCorkindale, are failing to influence the public, which has been alternately stimulated by the tragedy and rendered apathetic by political confusion.

Our experience in Bosnia was virtually identical with Hugh Dudley's in Vietnam.³ We also recognise that we were able only to scratch the surface of the surgical problem, and the welcome given to us by the medical professionals and the public was out of all proportion to the amount of work done. The Overseas Development Administration sponsored John Palmer, a plastic surgeon from Exeter, who amazed us with the amount of work he was able to undertake in two weeks and was clearly instrumental in helping to restart the plastic surgery service in Sarajevo.

Our team was sponsored by Humanitarian Aid with Medical Deployment and was financially supported in part by the Overseas Development Administration. We quickly became aware of the need to assess the long term complications of war injuries as well as the medical consequences of a protracted siege. Our experiences confirm Dudley's view that teams should regularly visit