

CORRESPONDENCE

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Isolation Accommodation in District Hospitals

Sir,—Dr. K. R. Llewellyn (7 October, p. 51) considers that all district hospitals should have comprehensive facilities for the accommodation of patients of all ages with communicable disease. He refers especially to small babies, who are most at risk.

I write to emphasize the importance of isolation accommodation in adult units. Unless this is readily available some patients with highly infectious conditions—for example, quinsy or a septic surgical lesion—are likely to be nursed in open wards, while others with diseases in which danger of spread of infection is minimal—for example, herpes zoster or erysipelas—are isolated in

special hospitals. Also patients with ulcerative colitis or an acute surgical emergency may be shunted from one hospital to another because their condition is at first thought to be infectious, and the treatment of a desperate emergency such as fulminating meningococcal septicaemia may be delayed because the patient is refused admission to the district hospital.

There is danger of infection in any hospital and all should be equipped to deal with it.—I am, etc.,

H. G. EASTON

Ruchill Hospital,
Glasgow

Criteria for Free School Milk

SIR,—As a local general practitioner I have during the past year assisted the school medical service in Haringey in determining the requirements for free milk among children aged 7-12. The criteria employed must of necessity be limited in view of the time available for the large numbers involved. A circular in August 1971 from the Department of Education and Science mentioned that the Secretary of State would not indicate guidelines, but the *B.M.J.* made an attempt to clarify the situation, weight being quoted as the most useful criterion.¹ With this in mind I have ensured that each child was weighed before being presented to me, and till now have received excellent co-operation from the welfare staff of the

various schools to which a circular is sent by the medical officer of health requesting appropriate assistance. These people in conjunction with the head teachers could provide useful social information which would influence one's decisions.

The pattern was pursued at the last school I visited, and when asked at a subsequent telephone call from the deputy medical officer of health if I felt I could no longer continue to participate in the scheme without the children being weighed I was dumbfounded. Apparently the welfare staff had objected to the small imposition on them of weighing the children. I drew his attention to the significance of the percentile weight charts which I always used, but he

needed no reminding and admitted that my argument was cogent. It seemed, however, that few other colleagues were adopting a similar procedure and it was suggested that there would be no objection to my eliminating it. Politics, it transpired, were to take precedence over acknowledged simple scientific thought.

After careful consideration, I have felt unable to continue these sessions with the implied restriction. To weigh 75 children personally in 1½-2 hours in addition to attempting to make a reasoned assessment, even with the limited parameters available in the circumstances, would detract from the minimal standards I feel are required. Furthermore, one would surely be hard put to it to justify a negative decision to certain irate parents if their children had not even been weighed—I am, etc.,

B. L. D. PHILLIPS

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¹ *British Medical Journal*, 1971, 4, 358.

Dangers of Diazoxide

SIR,—There has been increasing interest in the use of diazoxide in hypertension. In a review of the extensive bibliography we have failed to find any controlled studies of its use in any of the clinical situations described.¹⁻⁴ In most reports the patient's blood pressure has been compared before and after treatment. There can be no doubt that diazoxide is an effective hypotensive agent both orally and, especially, intravenously, but in the

absence of control patients, allocated at random, there is no satisfactory evidence that, in comparison with other drugs, it influences morbidity or mortality either in the short term or in the long term.

The lack of a critical approach to the evaluation of new drugs was condemned by Chalmers in 1968⁵ and again more recently⁶ he has argued convincingly that the correct time for beginning a randomized controlled trial is the first time a drug is given to any patient. At that time a comparison should be made with the current conventional therapy. Delays result in the therapeutic dilemma we now face with diazoxide. Clinical experience already indicates that the effect of diazoxide is dramatic and might be life saving but also that it is potentially dangerous. For example, within months of a report of its value in pregnancy four case studies from the same centre reported (in a different journal) that it may have caused congenital abnormalities of hair growth.⁷ The absence of any comparison between a diazoxide-treated and a non-diazoxide-treated group of patients makes it impossible to decide whether the clinical advantages are sufficient to risk such side effects.

A similar dilemma exists in non-obstetric situations. We know of several patients treated with diazoxide, by ourselves or our colleagues, while negotiations on financing controlled studies of diazoxide were proceeding. Our experience includes several patients treated with considerable success but also two patients who developed severe hyperglycaemia and three patients who died suddenly. One patient, who had had a normal glucose tolerance test, developed hyperglycaemia of 1,200 mg/100 ml 36 hours after a normal blood sugar had been recorded. A similar experience has just been reported by Harrison and others.⁸ None of the deaths could be directly attributed to the drug and they were not unexpected, as all the patients were seriously ill before diazoxide treatment was instituted.

We have no way to ascertain whether the morbidity and mortality in our patients or in those reported elsewhere have been increased or decreased as a result of using diazoxide. This question cannot be answered without controlled trials, which we have started. While such studies are being carried out we would like to suggest extreme caution in the use of diazoxide. The frequency and rapid onset of complications such as hyperglycaemia and salt and water retention indicate the need for great vigilance, even in hospitalized patients.

It must be seriously questioned whether diazoxide should be used at the present time, except in patients who are included in properly controlled trials. If rapid results are to be obtained such trials need to be extended to other hospitals.—We are, etc.,

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- 1 Mathew, T. H., and Kincaid-Smith, P., *Drugs*, 1971, 2, 73.
- 2 *Drugs*, 1971, 2, 78.
- 3 Pohl, J. E. F., and Thurston, H., *British Medical Journal*, 1971, 4, 142.
- 4 Pohl, J. E. F., Thurston, H., Davis, D., and Morgan, M. Y., *British Medical Journal*, 1972, 2, 568.
- 5 Chalmers, T. C., *Lancet*, 1968, 1, 858.

- 6 Chalmers, T. C., Block, J. B., and Lee, S., *New England Journal of Medicine*, 1972, 287, 75.
- 7 Milner, R. D. G., and Chouksey, S. K., *Archives of Diseases in Childhood*, 1972, 47, 537.
- 8 Harrison, B. D. W., Rutter, T. W., and Taylor, R. T., *Lancet*, 1972, 2, 599.

Surgical Ritual

SIR,—I agree entirely with the statement in your leading article (2 September, p. 543) that it is right from time to time to review our surgical routines and traditions, and I am sure your views on tourniquets at the foot of the bed of amputation cases and on skin preparation are valid. However, I would like to take issue with you on the question of nasogastric suction and preoperative starving of patients.

W. G. Hendry¹ and H. Ellis,² to whose papers you referred, were concerned only with gastric surgery of a non-emergency nature. They did not take into consideration the large number of other abdominal operations requiring gastrointestinal anastomoses in which nasogastric aspiration is invaluable not only in helping to decompress the stomach of fluid but also of swallowed air, which can be damaging if it passes on to distend the colon—for example, after the operation of anterior resection of the rectum.

You quoted Ellis as stating that suction was not even necessary for the majority of cases in the postoperative period after vagotomy for established pyloric stenosis. That, I think, misrepresents Ellis's paper, for you did not mention that a drainage procedure was also performed and that the purpose of the paper was to report that in 33 patients, which is after all a small series, gastric tone returned after vagotomy relatively quickly in spite of preoperative pyloric obstruction.

I think that it is true that some patients do indeed have a longer-than-necessary period of starvation before operation. However, surely this is often as a result of a nursing routine in the presence of an increasing shortage of nursing staff and preferable to the patient being mistakenly given food and drink shortly before his operation. I think, therefore, that there is a strong place for nasogastric suction and preoperative starvation being continued to be regarded as a routine, particularly when so many patients are cared for by relatively junior medical staff. I am sure the mortality rate of passing a nasogastric tube compares favourably with that of acute dilatation of the stomach, inhalation of vomit, and anastomotic leakage.—I am, etc.,

J. V. PIPER

Hillingdon Hospital,
Uxbridge, Middx

- 1 Hendry, W. G., *British Medical Journal*, 1962, 1, 1736.
- 2 Ellis, H., *Proceedings of the Royal Society of Medicine*, 1967, 60, 745.

Lead Poisoning

SIR,—I would like to support the letter of Dr. H. A. Waldron (30 September, p. 827) concerning Dr. M. K. Williams's comments (2 September, p. 586) on our paper on lead poisoning in rural Scotland (27 May, p. 488). The question Dr. Williams raised was fully discussed in the fifth and sixth paragraphs of the discussion (p. 490), but I think it worthwhile recapitulating the facts.

Dr. Williams is bemused by the magic

number 80 $\mu\text{g}/100$ ml in the 1968 statement to which I was a signatory. This, of course, referred entirely to industrial toxicity, and in this context the level is reasonable when taken in conjunction with the clinical state of the patient and also the other manifestations of lead absorption such as urinary coproporphyrin and urinary δ -aminolaevulinic acid. The statement that "levels below 80 $\mu\text{g}/100$ ml are frequently associated with symptoms and signs" and levels above this are occasionally found among asymptomatic lead workers is based on an extensive study of industrial lead poisoning by our group.¹ In dealing with the present work on lead poisoning in rural Scotland the subjects were, of course, not exposed to industrial poisoning but to an excess of lead in the water supply. Furthermore, the type of patient is different. In the industrial group we are dealing with selected strong men who have often been in their jobs for many years. In my own experience the selection takes place early in exposure, since the weaker members are quickly weeded out by early manifestations of lead poisoning. In the domestic situation we are dealing with a wide age group and also with women and children.

The significance of blood levels of between 40 and 80 $\mu\text{g}/100$ ml in humans is the subject of research in both Europe and the United States. From the results of this work, so far as I can assess, we cannot accept any rigid inflexible level such as 80 $\mu\text{g}/100$ ml in the clinical assessment of non-industrial patients who are being exposed. I am gratified that this view is shared by Dr. Waldron.—I am, etc.,

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- 1 Gibson, S. L. M., Mackenzie, J. C., and Goldberg, A., *British Journal of Industrial Medicine*, 1968, 25, 40.

Occupational Health Services

SIR,—I am very concerned that it appears as if the working party set up by the Secretary of State for Social Services on collaboration between the N.H.S. and local government (*Supplement*, 19 August, p. 148) has no intention of recommending that the new area health authorities should provide an occupational health service for the new county and district local authorities comparable to that provided at present by medical officers of health.

I know that the degree of sophistication of the services provided by the medical officer of health varies from authority to authority, but if it consists only of medical screening of all new employees to consider their fitness to enter the sick-pay and superannuation schemes it is worthwhile. I believe that in the hospital service even such simple screening is the exception rather than the rule.

If the new local authorities are forced to employ their own medical staff to provide this service there is a distinct likelihood that the job content could be enlarged and that the local authorities would employ their own medical adviser rather than receive any services from the area health authority. This would lead to a divided rather than a unified medical service. Some local authorities are already on record that after 1974 they will employ their own medical staff.

I could enlarge this letter by going into