owes its activity to liberating carbenicillin in vivo. Another journal has carried a similar advertisement which divulges this information. Does this mean that the *B.M.J.* is less demanding that the advertiser gives the information which allows the reader to relate a "new substance" to an existing agent with which he is already conversant? —We are etc.,

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1 Butler, K., in *Indanyl Carbenicillin. Proceedings of a Symposium held at the Royal Society of Medicine on 12 April 1973*, ed. H. Swarz and F. E. Storari. Amsterdam, Excerpta Medica, 1973.

Status of Ward Sisters

SIR,—The Halsbury Report[1] was produced in record time and inevitably some of its recommendations are open to question and are currently receiving comment. Contrary to Mr. R. V. Clark's statement (12 October, p. 105), district nurses are not included in the salary grade I, though it is true that health visitors and triple workers are classed grade I.

In proposing the introduction of a new higher grade for some ward sisters and charge nurses (and, among the community nursing staff, triple workers and health visitors), the intention stated in the report was to reward nursing skills at patient level, regardless of managerial or other responsibilities. Many in the nursing profession have been pressing for recognition of the clinical nurse specialist. Clearly, though the committee may have intended to encourage nurses to stay with the patient, their immediate proposals do not do this.

In the long-term proposals hope was expressed that both sides of the Whitley Council would agree without delay the other posts that should be included in grade I category. In paragraph 95 of the report a call is made for priority to be given to defining the duties of the nursing sister/charge nurse, grade I. District nursing sisters support this wholeheartedly. Closer reading of the report reveals that district nurses without district nurse training will receive grade II salary abated by £66. This is less than for grade II ward sister. The leads (for example, in the geriatric field) open to specialized fields in the hospital are not open to district nursing sisters because they are generalists. Their nursing care may be paediatric, geriatric, psychiatric, medical, surgical, supportive, preventive, or rehabilitative in nature. Their specialty is the environment in which they meet the patient and the family. It is nursing within a community setting.

As a result of its complexity, district nursing and district nurse training have been undervalued by the health professions. It will continue to be difficult to rectify the position until a higher qualification is mandatory for those nurses leading the clinical nursing team alongside general practice.

Salary grades are not the only answer to improved patient care. Maintenance of standards may be possible if demands on the service increase and at the same time a fall in recruitment of staff occurs. In the meantime it seems that those who are demonstrably capable and worthy of the higher grade are categorized with the less capable and untrained.—I am, etc.,

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1 *Report of the Committee of Inquiry into the Pay and Related Conditions of Service of Nurses and Midwives*. London, H.M.S.O., 1974.

Ethics and Halothane

SIR,—Professor J. P. Payne (12 October, p. 101) appears not to accept that many responsible and informed doctors believe in an association between repeated exposure to halothane and liver disease. If no one holds this belief, why the fuss? It is precisely because such an association is suspected that anaesthetists are anxious to conduct trials. It might be tempting to propose a trial in which one group of patients received repeated halothane anaesthetics and another group received non-halothane anaesthetics. The patients receiving repeated halothane would, however, be exposed for the purposes of experiment to something which has been suspected of causing illness and even death and the other group to something which has not been so suspected. An important duty of an ethics committee is to advise against experiments of this type.

Professor Payne states that "certain ethical committees behaved equally unwisely by interfering with the anaesthetists' right to decide what anaesthetic agent can or cannot be used in a specific clinical situation." This must be nonsense. Ethics committees are not concerned, and should not be consulted, about clinical situations as such, and it remains the duty of the anaesthetist to give the anaesthetic which he thinks most suitable for his patient. An ethics committee is, however, concerned with investigations on patients. If for the sake of the investigation one group of patients is exposed to a possible risk from which the other is spared they should not support the investigation.—I am, etc.,

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Drug Combinations for Anaesthesia

SIR,—An eminent anaesthetist is quoted in the press[1] as saying in a coroner's court, that "he would not have given Valium [diazepam] after Brietal [methohexitone] under any circumstances."

In case anyone feels he should no longer use this most valuable combination, let me assure him that for the past two years all my patients requiring endotracheal anaesthesia have been induced with intravenous methohexitone followed by intravenous diazepam (up to 10 mg) and then intubated without Scoline (suxamethonium). All patients are horizontal (unless unable to sleep flat at night) when induced and kept so for at least an hour after the diazepam injection. Rarely the blood pressure may be lowered markedly, and these precautions may be literally vital. Intubation is usually straightforward, but the use of suxamethonium is not precluded.

The main advantages, from the patient's point of view, are the absence of "Scoline pains," the impossibility of apnoea due to lack of pseudocholinesterase, and that any discomfort or malaise, surgical and anaesthetic, are later "tranquillized."

Many of my colleagues in active practice are using this method and—so far—none of us has had an anxious moment. The same applies if the diazepam precedes the methohexitone.—I am, etc.,

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1 *Sunday Times*, 6 October 1974, p. 10.

Red Skin and Dorbanex

SIR,—The erythema after intake of danthron (1,8-dihydroxyanthraquinone) as reported by Drs. Mary H. Bunney and Isabel M. Noble (29 June, p. 731) is, according to my findings,[1] a simple irritation of the skin caused by a metabolite of this laxative. In the bowel danthron is in fact reduced to its effective form, an anthron, which irritates not only the mucosa of the intestinal tract but also the skin if it is in contact with faeces for any length of time.

Chemically the metabolite is identical with 1,8-dihydroxyanthron which, as dithranol, is used in the therapy of psoriasis by irritation of the skin. After such treatment the same erythema and discolouration are seen in the treated skin area as in the perianal region after excretion of faeces containing dithranol after the intake of danthron. However, a sufficiently long contact with the faeces is necessary to produce this erythema. The condition is most frequently observed in the bedridden and paralysed and in babies.—I am, etc.,

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1 Ippen, H., *Dermatologica*, 1959, **119**, 211.

Inappropriate ADH Secretion in Chest Disease

SIR,—I note the point made by Drs. A. Spathos and C. H. Spry (28 September, p. 785) that treatment of inflammatory chest disease by fluid restriction and antibiotics may well correct the hyponatraemia. I prefer not to restrict fluids in such cases because of the thickening of bronchial mucus, as reported by Bryant,[1] unless the effects of the hyponatraemia warrant this. A warning about the use of tetracycline should once again be made because by acting as a diuretic[2] it can cause appropriate stimulation of antidiuretic hormone (ADH) owing to volume depletion.[3] The use of another drug might have prevented the hyponatraemia in the case reported. The complicating factor of smoking and nicotine intake warrants further study in relationship to chest disease and the syndrome of inappropriate ADH secretion.

Finally, the frequency of lung cavitation in the patients in whom this syndrome is described during an active bacterial, mycobacterial,[4] or fungal[5] infection suggests that some added pressure effect of the inflammatory process may stimulate para-