As many dental anaesthetics are still given in the upright position, it seems important in such circumstances for the anaesthetist (1) initially, to check that the back rest of the dental chair will depress quickly and smoothly (some do jam) enabling the patient to be supinated at once; (2) to be conversant with the procedure for dropping the arm rest and moving the patient sideways out of the chair if the back rest jams; and (3) to monitor the pulse throughout the anaesthetic.—I am, etc.,

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Dexamethasone in Malignant Hyperpyrexia

SIR,—A child of 6 years weighing 22·5 kg about to undergo adenoidectomy was given 100 mg thiopentone, 30 mg suxamethonium, and 1% halothane. After approximately two minutes he was sweating and felt very hot; anaesthesia was discontinued. At this stage his temperature was 39·25°C and there were no signs of muscle rigidity. In view of the report by Dr. F. R. Ellis and others (2 November, p. 270) he was given 4 mg of dexamethasone intravenously as an initial steroid dose. His rectal temperature fell rapidly to 38°C within three minutes. No further treatment was given and cooling was not required. His postoperative serum creatine phosphokinase level was 24 U/l. Further investigations are being undertaken and will be reported; it seems probable, however, that instant steroid therapy is extremely important in any patient with *suspected* malignant hyperpyrexia.—We are, etc.,

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Florence Nightingale's Illness

SIR,—In his review of my book *Creative Malady* (16 November, p. 414), Dr. Henry Rollin takes issue with me on the nature of Miss Nightingale's illness.

The essential facts are these. In July 1856 she returned from her arduous and successful task of rescuing the remains of the British Army in the Crimea from administrative neglect and incompetence. Against intense opposition she succeeded in getting a Royal Commission established. She did most of its work and drafted its report at great speed. In August 1857 she became ill and remained an invalid till she died in 1910. I suggested that this illness was a psychoneurosis occasioned by the conflict between her passionate desire to avenge her "murdered children" (the British soldiers who died in the Crimea) and the dissipation of her time and energy, particularly by her mother and sister. Her illness enabled her to succeed. Dr. Rollin maintains "that one outstanding feature was her obsessionalism, and the vulnerability of obsessionals is well known. Not surprisingly, in 1857, when her prodigious report was finished, she cracked. All her symptoms from then on could be explained in terms of an irreversible depressive illness, aggravated later, as Sir George suggests, by the menopause and possibly an addiction to morphine." What was truly remarkable was the vast output of lucid, cogent, and well-informed reports, minutes, warrants, and regulations and summaries for the Minister's use that flooded from the invalid's couch between 1857 and 1868. Is this characteristic of a depressive illness and did Miss Nightingale crack? She certainly changed her way of life, but she was even more formidable on the invalid's couch than she had been in society, as the War Office learned to its cost.—I am, etc.,

GEORGE PICKERING

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Safety and Fibreoptic Bronchoscopy

SIR,—The letter from Dr. I. W. B. Grant (23 November, p. 464) stressing the inadequacies and dangers of fibreoptic bronchoscopy merits further discussion. Here we may usefully contrast his experience with that of 193 American bronchoscopists surveyed in a recent paper.[1] This survey covers both large and small centres and is based on the massive total of 24,521 fibreoptic bronchoscopies, arguably giving a more solid base for generalization than a single centre's experience.

Dr. Grant implies throughout his letter that there is a measure of danger in performing fibreoptic bronchoscopy in centres without available rigid bronchoscopy. The American survey, however, found very low rates for both minor complications (0·2%) and major complications (0·08%). Even more tellingly, examination of their data shows only three cases in the 24,000 where treatment of a complication could have been helped by the presence of rigid bronchoscopy or thoracic surgery. While caution is always advisible in assessing new techniques, this widely based survey can surely offer substantial reassurance.

The letter questions the reliability of local anaesthesia for fibreoptic bronchoscopy and even labels it a "barbarous practice." This contrasts strongly with our experience in performing over 150 fibreoptic bronchoscopies satisfactorily under local anaesthesia. This impression is confirmed by the paucity of complaints found on systematically questioning patients afterwards. Local anaesthesia was also chosen for 84% of fibreoptic bronchoscopies in the American survey. Especially in a medical system based on private practice a truly barbarous method would surely be less popular.

Problems with obscuration of bronchoscope vision by mucus and blood were also mentioned in the letter. These difficulties do not appear substantial in most published series, which confirms our own experience that these problems are not insurmountable. Another suggested disadvantage was the difficulty in obtaining adequate biopsy samples with the fibreoptic technique. Our experience, on the other hand, confirms that of several large series which show high biopsy success rates, often higher than with rigid techniques.

Restriction of fibreoptic bronchoscopy to centres already equipped with rigid bronchoscopy is advocated by Dr. Grant on grounds of safety and cost. The complication rates discussed above suggest that fibreoptic centres with normal supporting facilities pose few safety problems. The costs of running such centres can be substantially reduced by sharing an endoscopy room with gastrointestinal endoscopy, which is at present expanding rapidly. Most of the costs of this facility can then be shared by the two specialties—trained staff, cold light source, suction apparatus, resuscitation equipment, etc.

Doubtless the strongest argument for expansion of fibreoptic centres is simply the increasing number of bronchoscopies needed each year to meet the ever-growing tide of lung cancer. Some 15,000 bronchoscopies are needed annually now.[2] Sooner or later existing centres with rigid bronchoscopy will be unable to cope. Time will force the establishment of more fibreoptic centres. In preparation for this development, we would be well advised to include fibreoptic bronchoscopy in the training of the next generation of chest physicians.—I am, etc.,

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1 Credle, W. F., Smiddy, J. F., and Elliott, R. C., *American Review of Respiratory Disease*, 1974, **107**, 67.
2 Benetts, F. E., *British Journal of Hospital Medicine*, 1973, **10**, 71.

Sticky Eye in the Newborn

SIR,—The recent comment by your expert (26 October, p. 222) that sticky eye in the newborn caused by T.R.I.C. (trachoma-inclusion-conjunctivitis) strains of chlamydia group A is of "a similar order of rarity" to gonococcal infection ("one case a year at one large maternity unit") and "usually does not appear until the second week, perhaps when the baby has been sent home" differs from our experience in Liverpool maternity units over the past 13 months.

We have investigated 25 newborn infants with mucopurulent conjunctivitis developing between three and eight days after birth; these were unselected cases except in so far as some had failed to respond to chloramphenicol or neomycin eye drops. Eye swabs were examined by the non-irradiated McCoy cell technique.[1 2] Chlamydia were isolated, with primary inclusion counts ranging from 1 to 9,000 per coverslip (median count 600), from eight infants (32%). Chlamydia were also isolated from cervical swabs of four mothers of these positive infants (counts 300-5,000) and from urethral swabs of one of two fathers examined; two mothers yielding negative swabs had already received antibiotics for puerperal pyrexia and one refused examination. In a further 12-day-old infant with sticky eye, already treated four days with antibiotics, chlamydial culture was negative, but a cervical swab of his mother, who had an offensive lochial discharge, was positive. In another family eye swabs of a 3-day-old baby yielded only gonococci, but gonococci and chlamydia were isolated from cervical swabs of the mother. Overall, there were five proven cases of gonococcal ophthalmia, from one of which chlamydia were also isolated.

All the chlamydia-infected eyes improved clinically within a few days of beginning chlortetracycline eye ointment, given for three to four weeks. After treatment further eye swabs were negative in six cases; in the seventh case culture was again positive two weeks after treatment and the eighth infant was found positive two weeks after defaulting after two weeks' treatment.

Chloramphenicol therapy may suppress