¹²⁵I-fibrinogen in the diagnosis of deep vein thrombosis

SIR,—I read Dr V C Roberts's paper on this subject (3 August, p 455) with great interest. I agree with him that standardisation of the method is important, as it is used in different ways in many clinics. However, I believe Dr Roberts's plea for standardisation will be difficult to implement clinically. Any new way of using the method would have to have considerable advantages compared with those described by Browse and Negus¹ or Kakkar *et al.*²

My plea is for an improvement of the method by using instruments with a greater accuracy than those commonly used. The choice of the instrument may also reduce the time of the investigation. In ¹²⁵I-fibrinogen studies many clinics are using a simple count ratemeter with direct readings on the scale (percentage of the heart count). Counting ratemeters are useful when one is measuring high activity in blood circulation studies. In static situations, such as ¹²⁵I-fibrinogen scanning, the accuracy and precision of the scaler are always greater than that of the ratemeter.³ For example, at 5000 counts/min and the time constant of 15 seconds the equilibrium time is more than one minute. In practice the superiority of the scaler is also greater as the investigation time is reduced.

As a suitable instrument I am using a portable mini-scaler and a detector with a diameter of 50 mm. The total reproducibility, including the expected statistical error and geometrical error, was found to be 5% with repeated measurements over the heart and the legs. The investigation time is less than five minutes.⁴ In addition, the background activity is always subtracted.

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¹ Browse, N L, and Negus, D, *British Medical Journal*, 1970, 3, 615.

² Kakkar, V V, *et al*, *Lancet*, 1970, 1, 540.

³ Charkes, N L, *Lancet*, 1973, 1, 1191.

⁴ Forsberg, K, *Läkartidningen*, 1975, 42, 4040.

C-Film as a contraceptive

SIR,—Dr M V Smith and his colleagues of the Family Planning Association, reporting the results of a clinical trial of C-Film used as the sole method of contraception (2 November 1974, p 291), recorded nine pregnancies among 45 women during 175 person-months of exposure to risk. This represents a use-effectiveness pregnancy rate of 62 per 100 woman-years.

We were surprised at these results because they were so much at variance with our own preliminary data. This study has now been completed.¹ My colleagues and I assessed C-Film as the sole contraceptive at three family planning clinics in Sweden, including the WHO Clinical Research Centre at this hospital. It was used by 237 women for a total of 1866 months. During this time 14 pregnancies occurred, which gives a use-effectiveness pregnancy rate of nine per 100 woman-years.

Most of the failures were the result of incorrect use, the true method failure rate (theoretical effectiveness) thus being about 2 per 100 woman-years. While we would not recommend C-Film as an alternative to

oral contraception or the intrauterine device, we consider it offers good contraception for the reliable user—always provided she receives proper instruction.

Almost certainly the explanation for the very different results lies in this question of reliable usage and proper instruction. A pregnancy rate of 62 per 100 woman-years, as reported by Dr Smith and his colleagues, would ordinarily be expected in women using no contraceptive method at all.

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¹ Frankman, O, Raabe, N, and Ingemansson, C A, *Journal of International Medical Research*, 1975, 3, 292.

Sight in new-born babies

SIR,—Many of your readers will have seen a pamphlet, "Keep Baby Warm" (Cat No CW6), issued by the Health Education Council. It is one of "a series of practical hints to parents on the everyday health and safety of their young children."

The advice and the facts given in the pamphlet appear unexceptionable except in one important detail. The second sentence, commenting on new-born babies, reads, "Although their eyes are open, they cannot see." There is now abundant evidence to show not only that new-born babies can see but that they are perceptually alert. Although this error does not detract from the central message of the pamphlet it is, nevertheless, a serious oversight since it may inhibit parents from important interaction with their babies in the first few days and weeks of life. I feel sure that general practitioners and paediatricians, in particular, will wish to take every opportunity to correct this error.

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Long-term prophylaxis with beta-adrenoceptor blockade after myocardial infarction

SIR,—We read with interest the paper from the multicentre study on this subject (27 September, p 735). We have reported¹ a similar trial. In this 500 patients admitted to a coronary care unit, usually by mobile coronary care service, received either practolol 300 mg 12-hourly or an identical placebo by random selection. The tablets were started in the patient's home. In those with infarction there was no overall difference in mortality, reinfarction, or important complications during the two-year follow-up. In one subgroup, those with an initial tachycardia, there was a reduction in mortality, which was still present at one year.

Unlike the multicentre trial, we found no preferential effect in patients with anterior infarction. Practolol did not influence the subsequent progress of patients admitted to the coronary care unit who did not have myocardial necrosis. Our results therefore differ from those of the multicentre trial and of Wilhelmsson and others,² although, of

course, the design of the trials was different. We feel that the use of beta-blockade in patients presenting with acute myocardial infarction and tachycardia requires further study.

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¹ Barber, J M, *et al*, *Acta Medica Scandinavica*, in press.

² Wilhelmsson, C, *et al*, *Lancet*, 1974, 2, 1157.

GP obstetrics in the future

SIR,—I was interested in the suggestion of Mr M Elstein and others (27 September, p 765). I would entirely agree that intrapartum obstetrics should be carried out only by those adequately qualified, and that the present requirements for the obstetric list are inadequate. Shared care offers a satisfactory compromise, although I feel that Dr Elstein's term "office obstetrics" gives the wrong impression of what general practitioner care should be.

I differ from them in the suggestion that GPs from different practices should arrange a rota for inpatient care of each other's patients. The unique value of the general practitioner obstetrician system is that it allows the GP continuity of care. This is the one thing my patients seem to value and it is the one thing that allows us to reach as high a standard of care as that of routine hospital obstetrics. We know our own patients to a degree that the hospital obstetricians can never match. Once we sacrifice our continuity our standards of care will fall and, from the patient's point of view, we might as well have referred them to the full-time obstetricians for care in the first place.

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Side effects of clobetasone butyrate

SIR,—In their paper on the activity of clobetasone butyrate and its effect on pituitary-adrenal axis function (13 September, p 626) Dr D D Munro and Miss Lyn Wilson refer to hydrocortisone 17-butyrate as "a preparation claimed to be as safe as hydrocortisone." I would be interested to know in which scientific paper this claim was made. In 1973 Hendrikse and Moolenaar¹ reported suppression of hypothalamic-pituitary-adrenal function by hydrocortisone 17-butyrate applied under occlusion to the whole body surface.

Of course we are all looking forward to a preparation with as favourable a ratio as possible between therapeutic effects and side effects, local as well as systemic. The local side effects of corticosteroids are the most obnoxious; systemic side effects are to be feared only with gross overtreatment. The fact that epidermal thinning of pigskin treated with clobetasone 17-butyrate is less than when treated with fluocinonide, the same as when treated with triamcinolone acetonide, and more than when treated with hydrocortisone is rather weak evidence that clobetasone 17-butyrate will cause less atrophy in the human dermis than corticosteroids of comparable therapeutic effectiveness. It is regrettable, however, that

hydrocortisone 17-butyrate was not included in this part of Dr Munro's and Miss Wilson's experiments.

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¹ Hendrikse, J C M, and Moolenaar, A J, *Dermatologica*, 1973, 147, 191.

Aeromedical evacuation of the seriously ill

SIR,—The excellent article by Wing Commander H F Oxer (20 September, p 692) has drawn attention to the problems involved in aeromedical flights. Having assessed a patient as suitable for transportation by air the doctor or hospital is often faced with the problem of organising a suitable flight. The St John Ambulance aeromedical service operates a unique voluntary 24-hour international emergency travel service by air ambulance charter or by airline scheduled flights for the escort of patients to or from any part of the world and within the UK. Air ambulance flights are particularly useful for seriously ill patients who may require considerable in-flight care. There is the additional advantage of being able to land at a much greater number of airports, the patient thus having to travel shorter road distances between airport and hospital.

The St John aeromedical service charts the following aircraft: HS125 jets, Cessna Golden Eagles, Navajo Chieftains, Islanders, Aztecs, and Senecas. Each aircraft has advantages and disadvantages compared with the others but with the range of aircraft available a comprehensive service is provided. On every flight a volunteer team of two or three air attendants (selected from a register of doctors, nurses, and lay members, all of whom have undergone additional aeromedical training) take standard medical packs which include oxygenation, automatic ventilation, resuscitation, intubation, and intravenous equipment. At present the service covers the whole of Western Europe and North and West Africa.

When escorting cases on airline scheduled services the St John service makes the necessary booking arrangements for stretcher fittings or sitting patients and for dealing with customs and immigration, the Foreign Office, embassies, and consuls. All St John air attendants carry the necessary international health documents. Patients are escorted to or from any part of the world and the air attendant will, if necessary, accompany the patient from the hospital bed in Britain to the hospital bed in the destination country or vice versa. I should be pleased to supply further information on request.

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Rhesus sensitisation associated with IUD in pregnancy

SIR,—The title and conclusion of the above article by Dr J S McCracken (20 September, p 684) suggest that the intrauterine device (IUD) was the agent responsible for causing sensitisation and production of antibody in the Rh-negative mother. However, there are other more likely explanations for the sensitisation. She could have been sensitised

by the 1967 full-term pregnancy and not stimulated by the subsequent abortions, or she could have been sensitised by one of the abortions, even the second one, which could represent a failure of anti-D γ -globulin. Again, women have been known to become sensitised and produce antibody in a first pregnancy and thus her last pregnancy could have sensitised her and produced the antibody before term irrespective of the IUD. Allo-sensitisation and production of antibody in the same pregnancy are rare, however, and this would argue against the IUD as a likely cause.

In view of the other possibilities and the rarity of antibody appearing in the first sensitising pregnancy, we would consider the evidence against the IUD to be extremely weak.

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Patients or criminals?

SIR,—If, as your leading article (11 October, p 70) states "a single institution cannot . . . set out to be a therapeutic community and at the same time have the security of a prison," then what kind of community is a hospital such as Broadmoor supposed to be?

For obvious reasons much attention is rightly given to the needs of those patients who are likely to leave Broadmoor in the near future. No one would dispute the fact that such patients need psychotherapy, and to be well enough to leave is one of the goals. But what of the needs of those who are unlikely to leave?

It is a bleak outlook if a single institution, such as this hospital, cannot be both a therapeutic community and at the same time have the security of a prison. Patients who live in a hospital "without limit of time" live in a secure setting, though, in the interests of humanity, they also have a right to live in a therapeutic community. To this end the therapeutic energy of all professional disciplines converges.

If the concept of a "therapeutic community" is sacrificed on the altar of "security" (or vice versa), then an essential quality of the life within Broadmoor Hospital would be lost. Patients who may never leave and, vicariously, the wider community would be the losers.

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Epidemiology of poliomyelitis in Scotland

SIR,—We wish to correct from 11 to 10 the number of poliomyelitis cases in Scotland during 1970-4 reported in our letter (2 August, p 304), because of a late corrected diagnosis of meningioma in one of the serologically diagnosed cases. This illustrates the uncertainty of virological diagnosis when patients are investigated too late for successful virus isolation or detection of unequivocal rising antibody titres. The high titres of antibody in this patient may have been due to known close contact with children who had recently received oral polio vaccine.

Despite the difficulty of interpretation, the finding of unchanging but unusually high antibody titres should not be ignored since

in some cases it provides the only virological evidence available, suggesting "recent infection," the significance of which must be interpreted in the light of the associated clinical and epidemiological data. The practical lesson remains—the need for clinical awareness of the possibility of poliomyelitis and for the prompt submission of appropriate stool and blood specimens to facilitate early virological confirmation.

We are grateful to Dr W J Patterson, Community Medicine Specialist, Ayrshire and Arran Health Board, for notifying us of the altered diagnosis and providing other information about this case.

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Enteric-coated aspirin overdose and gastric perforation

SIR,—The short report of enteric-coated aspirin overdose and gastric perforation (11 October, p 85) will no doubt be added to the apocrypha of aspirin toxicity, but certain aspects of the case and case report make it very unlikely that this was "a case of fatal gastric perforation due to Safapryn." The following doubts immediately spring to mind.

The patient was being treated for arthritis with Safapryn six tablets, phenylbutazone 300 mg, ampicillin 1 g, and ethylestrenol 2 mg daily and nitrazepam 5 mg nightly. Why do the authors immediately attribute the gastric erosions and perforations to enteric-coated aspirin when phenylbutazone is a perfectly respectable gastric irritant, and since when have ampicillin and ethylestrenol been used for treatment of arthritis, even of arthritis unspecified? More important, what role did a paracetamol overdose of 16.75 g play in this 83-year-old patient's sudden deterioration and death? As the residues of 67 Safapryn tablets were found in the stomach it implies that she ingested 67×250 mg of paracetamol. The blood paracetamol level is well within the toxic range, although to assess critically this level one would need to know the temporal relation between her overdose—presumably unknown—and death and also her renal and hepatic function. Death may occur with paracetamol overdoses of 5-20 g, and liver damage may be expected after the ingestion of more than 15 g.¹ No comment is made on the histological appearances of liver and kidneys.

In conclusion, the gastric ulcers and perforations found may well have been terminal events following a fatal paracetamol overdose, and the enteric-coated aspirin residues little more than innocent bystanders.

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¹ Proudfoot, A T, and Wright, N, *British Medical Journal*, 1970, 3, 557.

Low-dose heparin and prevention of venous thromboembolic disease

SIR,—Your leading article (23 August, p 447) on low-dose heparin and the prevention of venous thromboembolic disease covers the subject well but calls for some comment when it moves on to consider other prophylaxis.