Corticosteroids in Asthma

Sir,—The excellent report by Dr. K. Maunsell and others (16 March, p. 661) confirms that steroids can be used as a long-term measure in the management of asthma, and that side-effects are related to the average dose of steroids used, rather than to the length of treatment. No mention is made, however, of whether other bronchodilator agents are used in conjunction with the prednisolone. It is my practice to give conventional bronchodilator drugs (usually ephedrine or orciprenaline) in a regular oral dosage in addition to the steroids, as I believe this reduces the dose of prednisolone required, and so lessens the likelihood of side-effects.

I have recently been using disodium cromoglycate (Intal) for prophylactic treatment and although the number of patients so far is small I am satisfied that most of them have been able to reduce their dose of prednisolone.—I am, etc.,

C. M. GREENBERG
Cambridge.

Intracardiac E.C.G. in Pacemaker Electrode Insertion

Sir,—We have found the intracardiac E.C.G. a valuable technique in pacemaker electrode insertion in over 300 routine procedures when it was used as a supplement to fluoroscopy and in 10 "blind" emergency procedures without fluoroscopy. We present our experience to clarify certain aspects of the technique. Drs. G. Bay and E. Sivertsen (21 October 1967, p. 838) have discussed in detail the technique of electrode insertion. Tothill, H. R., 1963, 29, 291.

REFERENCES
8. Sutton, R., Anaesthesia and Cardiac Arrest Meeting of British Cardiac Society. To be publised.

Dental Anaesthesia

Sir,—The Ministry of Health's report on dental anaesthesia has the seal of authority. It has been widely circulated and publicised; however, it does not reach the general national press ; and now in your editorial comment (24 February, p. 462) it is given an additional boost. Before being finally accepted as gospel it should be looked at critically.

According to the argument put forward in the report, dental anaesthesia has never been so dangerous, and yet the facts show that dental anaesthesia has never been so safe. In 1952 there were 21 million administrations in England and Wales. Now there are 2 million a year (report, page 19). But the mortality has fallen dramatically. In the years 1949–51 there were 62 deaths; in 1965–67, 17 a year (page 9). Now there are six a year (page 24, Table 3). And of these six four are occurring in dental patients anaesthetised in hospitals (i.e., by anaesthetists) and only two in dentists or dental surgeons, where, according to the report, all but a small proportion of the two million administrations are given—and this surprisingly low mortality in dentists' surgeries despite the fact that over a million of the administrations are given by dentists, and over 400,000 of these by the dentists performing the operation (page 28, Appendix D).

But there is another reason for regarding the report as biased. A year before it was published, and while its authors were still collecting evidence, I published evidence showing that it really made little difference what anaesthetic was used in dentistry or who gave it. Unaccountable deaths in young, healthy patients occurred with doctors and even with specialist anaesthetists. By far the greatest danger was the traditional upright position of the patient, which was directly responsible for nearly all the deaths and morbidity; and the remedy was to abandon this position. I sent a copy of my communication to the authors of the report. The
report contains no mention of it whatsoever, nor of the danger to which it drew attention.

There are hints that the Minister of Health is about to introduce restrictive regulations that may prove too stringent and probably will save not a single life. Before this action is taken the report should be read again, starting with the facts. Meanwhile it would be grossly unfair to pick on catastrophes that have occurred with dentists, while ignoring identical ones that have occurred with doctors and specialist anaesthetists—particularly when the prevention of nearly all such catastrophes is to simple.—I am, etc.,

SALISBURY, WILLS.

J. G. BOURNE.

REFERENCES


Hirschsprung's Disease

Sir,—We note with interest the conclusions in the article by Dr. A. Bennett and colleagues (24 February, p. 487). They make no reference to a previous report by Ehrenpreis1 in which he demonstrated terminal adrenergic fibres in aganglionic bowel in Hirschsprung's disease by this technique. Similar studies are being carried out in this department (Rayner and Muggah).2 We have observed increased fluorescence in the muscle layers of the abnormal segment, but are not convinced that this is a constant finding throughout the aganglionic area. We are in agreement with Dr. Ehrenpreis and Dr. Bennett et al. that in normal human colon the adrenergic nerve fibres are distributed mainly to the intramural plexuses around the ganglion cells. There are remarkably few terminal adrenergic fibres in the muscle layers.

In 1965 we3 made the first report of the absence of normal inhibitory response in aganglionic muscle from Hirschsprung's disease to nicotine. We suggested that the adrenergic inhibitory system might be defective or absent. After further work we suggested exactly the same explanation as Dr. Bennett et al. are now putting forward: that the myenteric ganglia are involved in the inhibitory system of normal human colon.4,5

We still consider that a defective sympathetic system is an important factor in the inability of an aganglionic segment to relax in the normal fashion, thus causing intestinal obstruction. This is not synonymous with the absence of sympathetic tissue as suggested by Dr. Bennett et al.—We are, etc.,

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REFERENCES


Occult Hypoalbuminaemia

Sir,—Anaesthetists are aware of the need for fluid therapy in dehydrated patients preparing for surgery. There is, however, a group of patients where the need for rehydration is not obvious on clinical or routine biochemical examination, who nevertheless require considerable fluid replacement to prevent hypoalbuminaemic problems appearing during induction and maintenance of anaesthesia. The patients concerned fall into two categories:

(1) The larger group, who are elderly and may or may not have been ill for many days before coming to surgery, whose fluid intake is habitually inadequate.

(2) Younger patients who have been ill in hospital or at home for three to four weeks with malaise and some degree of anaemia as part of their symptomatology.

In neither category are we discussing patients with disorders of the alimentary tract which would cause their fluid balance to be monitored. In fact, the patients under discussion are failing food and fluid orally and do not present signs or symptoms which as yet cause their fluid balance to be charted prior to surgery. Patients being treated with diuretics may present a similar picture, but here the problem is readily anticipated.

Clinically the patient appears to have lost weight, there is a loss of subcutaneous fat, and although the eyes are not grossly sunken the orbital spaces above and below the eye are not full. The mouth and tongue are not noticeably dry. Slight pallor is present, although the conjunctivae are pink. Some loss of skin elasticity is apparent but is usually attributed to loss of fat. Superficial veins—for example, on the back of the hand—are easily seen but are small. The pulse rate is not unduly raised, while pulse volume does not provoke concern. Blood pressure is normal for the age or correlates with a previous recording. Routine preoperative investigations reveal a haemoglobin approximating to 80%, while serum sodium, chloride, potassium, urea, and bicarbonate are within normal limits. Apart from the veins on the dorsum of the hand, this description would fit the majority of elderly and infirm, lean, elderly people. We tend to accept this clinical picture as one entirely due to fat loss.

An induction of anaesthesia venepuncture is a little frivolous request that this occurs a fall in blood pressure greater than would be anticipated following a careful induction based on the patient's weight, age, and general fitness. The hypotension tends to persist during maintenance of anaesthesia. Where the blood loss during surgery has been negligible, the intravenous infusion of normal saline greatly improves the pulse volume, blood pressure, and fullness of superficial veins. In the immediate postoperative period further saline is required to maintain this improvement. The loss of more than 300 ml. of blood provokes a severe fall in blood pressure, which is not usually reversed until at least twelve the lost volume of blood is transfused. More blood or saline is required in the immediate postoperative period to maintain the improved pulse volume, blood pressure, and full veins. On the first postoperative day haemoglobin and serum electrolyte estimations reveal a severe anaemia and a biochemical acidosis. The prompt replacement of normal saline, while frequently a fall of sodium and chloride is found in those patients who received blood transfusion. Patients who received normal saline and blood in excess of surgical loss are found postoperatively to be better both clinically and haematologically. It is important to realize that routine haematological and biochemical values are expressed as ratios in an existing blood volume and are therefore not necessarily a guide to the actual size of that volume. This fact is evident when blood volume estimations reveal considerable hypoalbuminaemia not previously suspected in these patients. If this hypoalbuminaemic syndrome is suspected, the safety of intravenous therapy may be assessed by the rapid infusion of increments of 50 to 100 ml. of normal saline. Improvement of pulse volume and reduction of venocentricity reveals the need for further fluid, which will improve the orbital and skin signs of dehydration. Subsequent haemoglobin and electrolyte investigations will then be a more valid guide to the blood and electrolyte requirements of the patient. As these patients respond to central nervous depression drugs like any other shocked patient, a supplementary blood transfusion is prevented by the recognition and preoperative treatment of this syndrome.—I am, etc.,

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Pelvic Examination

Sir,—I am astonished to read (9 March, p. 591), "It is generally conceded that pelvic examination is best carried out with the patient on her back and her legs supported by a nurse or in stirrups." Surely such facilities as a nurse (and two would be needed) and stirrups are not often available in doctors' surgeries, in patients' homes, or in some gynaecological outpatient departments. As to the suggestion that it is a better method from the point of view of information gained it is very much a matter of opinion. Indeed, this would be a matter of experience according to an individual doctor's initial training and subsequent practice.

Frankly I consider that the left lateral position with both legs well flexed is by far the most sensible, as not only does it provide better both for the pelvic information for which he is looking, but, incidentally, it is the ideal position for inserting a Cusco's speculum when obtaining a routine cervical smear; and it conceals some consideration to the patient's comfort, with consequent sparing of embarrassment.

There must be many gynaecologists who would agree that the left lateral position has much to commend it and who will continue to instruct their students accordingly.—I am, etc.,

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REFERENCES


SIR,—Your leading article (9 March, p. 591) on "Bedside Teaching" states, "It is generally conceded that a pelvic examination is best carried out with the patient on her back and her legs supported by a nurse or in stirrups. This is the technique used as routine in Canada and in the U.S.A., whereas in Britain we emphasize the less satisfactory lateral position..."