extremely well, obviating the need for intrathecal administration. Also we are not aware of any evidence to suggest that penicillin allergy increases the risk of adverse reactions to chloramphenicol. Consequently it would appear that when the organism is sensitive to chloramphenicol this drug is the treatment of choice for bacterial meningitis in the penicillin-allergic patient.

M PHILLIPS
WALTER ROGERS
THEODORE TONG

University of California,
Department of Clinical Pharmacology,
San Francisco General Hospital,
San Francisco, California

[1] Moellering, R C, jun, and Swartz, M N, *New England Journal of Medicine*, 1976, **294**, 24.
[2] Fisher, L S, *et al*, *Annals of Internal Medicine*, 1975, **82**, 689.
[3] Petz, L D, *Postgraduate Medical Journal*, 1971, **47**, suppl, p 64.

Polyuria in paroxysms of tachycardia

SIR,—Your expert's explanation of the polyuria in paroxysms of tachycardia (8 November, p 339) is incomplete and may be incorrect. Wood[1] was attracted by the hypothesis that polyuria is the result of a transient diabetes insipidus. Thus the diuresis may be related to left atrial distention, non-osmotic stimulation of the baroreceptors, and subsequent antidiuretic hormone inhibition.[2 3] This does not exclude other possible mechanisms, but it bears no direct relationship to cardiac output and renal perfusion if the attack is not a prolonged one. The polyuria is immediate but bladder emptying may be delayed.

D KOHN

Medical Department B,
Kaplan Hospital,
Rehovot, Israel

[1] Wood, P, *British Heart Journal*, 1963, **25**, 273.
[2] Luria, M H, Adelson, E I, and Lochaya, S, *Annals of Internal Medicine*, 1966, **65**, 461.
[3] Maxwell, M H, and Kleeman, C R, *Clinical Disorders of Fluid and Electrolyte Metabolism*, 2nd edn, p 241. New York, McGraw-Hill, 1972.

Segregated smokers

SIR,—Your call for a greater protection of the majority of the public who do not smoke from aggravation by those who do is most welcome. It would, however, carry greater weight if, as a profession, we gave a better example in our hospitals.

We could do much more to protect non-smokers in our wards. The *Which?* survey[1] showed that 68% of smokers and 77% of non-smokers thought that smoking should not be allowed on hospital wards. For many years my own have been non-smoking wards and I have found that most smokers are grateful for the help they get to stop smoking while in hospital, and very few have complained. Those patients suffering from terminal disease or who are unwilling to stop can usually be moved to side wards.

I recently inquired into the sale of cigarettes in 83 large hospitals, including the 12 London teaching hospitals, the 33 teaching hospitals outside London, 21 district hospitals in the NW Thames Area, and the 16 London postgraduate teaching hospitals. All replied and the results were as follows: of 68 hospital shops 49 (72%) sold cigarettes, while of 81 ward trolley services 38 (47%) sold cigarettes. It is a disgrace that nearly three-quarters of our hospitals still sell cigarettes and surely makes a mockery of preventive medicine. How can we expect patients to take notice of our advice on smoking if we continue to sell cigarettes in our hospitals and often make ill-gotten profits thereby for staff amenities? I recently visited a well known chest hospital where many patients are admitted for the treatment of lung cancer, chronic bronchitis, and coronary heart disease and I was amazed to find a prominent display of cigarettes in their hospital shop. It is surely the responsibility of medical committees to advise area health authorities on this matter. The National Association of Leagues of Hospital Friends and the Women's Royal Voluntary Service, who provide us with such an excellent service, tell me that they are very ready to stop selling cigarettes in hospital shops that they run if asked by their hospital authorities to do so.

May I suggest a few principles which could be adopted on smoking in hospitals? (1) Cigarettes should not be sold in any acute general hospital. (2) Non-smokers should have the right to be nursed in smoke-free wards. (3) Non-smoking should be the norm in all acute medical and surgical wards. (4) Hospitals should provide segregated areas for smokers. An approach to the problem on these lines by all hospitals would do much to demonstrate that we actually do consider the prevention of 50 000 premature deaths from cigarette smoking each year a matter of priority.

KEITH BALL

London W1

Hon Secretary,
Action on Smoking and Health

[1] *Which?*, February 1975, p 56

SIR,—I am, of course, well aware of your establishment's views on smoking. Whatever my own views on smoking, however, I feel I must take issue over this article (31 January, p 244) as I feel that the style and the composition failed to attain a standard worthy of the importance of the subject, nor indeed of a leading article in the *BMJ*. I had the sensation when reading it that not only had the writer's anti-smoking militancy been over-stressed but that there was perhaps a smack of the chauvinism and casuistry so familiar in one who has recently stopped smoking. Was there possibly even a suggestion among the subject matter of withdrawal symptoms? Those trite chichés, "this obnoxious practice," "inflict their offence on people who resent it," "the non-smokers, as well as being right . . .", and "there are already too many people saying No," might look in place coming from the mass media or from a politician, but do little to grace a learned journal.

To "puff carcinogens" is, to my mind, unbridled exaggeration. Surely the minute traces of tobacco tars joining those of many other "indictable substances" in the atmosphere can be of little significance. The theme of segregation of social undesirables, either as therapy or punishment, is to my mind archaic. In practice it could be said with justification, I think, that segregation has proved of very doubtful value in either context and in many instances has proved actually harmful. As to the benison of "pure air," one imagines that—if I myself may resort to chiché—this would be more likely to win the plaudits of the militants than those of ordinary folk. Again, if we are to have stipulated "smoking areas" may this not lead to demands for other areas earmarked for further doubtful attributes and activities? On the one hand should we segregate those with halitosis, or bromidrosis, or those who use the "wrong" suntan ointment? On the other hand should we have areas for teenage sex play and perhaps for mugging and even less acceptable activities too?

Finally, Sir, is it no longer customary to accord capital letters to the West End of London? And, since smokers are stated to be brainwashed, should we assume that non-smokers' brains are unwashed?

J P F LLOYD

Oxford

Propanidid in dysrrhythmias

SIR,—Dr R J Vecht and his colleagues (18 October, p 143), report a case (No 1) in which ventricular tachycardia reverted to sinus rhythm during induction of anaesthesia with propanidid.

I would, if I may, question the diagnosis of ventricular tachycardia as it would appear that the most important ECG leads for the interpretation of the condition have been omitted—namely, the standard and unipolar leads. It may be argued that the differential diagnosis in this case includes atrial tachycardia and junctional tachycardia, both with aberrant ventricular conduction. In the absence of standard and unipolar leads, particularly leads 2, 3, AVF, and AVR, differentiation between these two is difficult.

In my opinion no ventricular tachycardia is evident in the ECG tracings reproduced with the article and I am convinced that they are more suggestive of a junctional tachycardia with aberrant ventricular conduction. Lead V_1 favours an aberration. In general, approximately 85% of aberrantly conducted supraventricular dysrrhythmias show right bundle-branch block form and a triphasic ("M" shaped and upright) pattern, as shown in lead V_1. Rapid junctional tachycardia at a ventricular rate of close to 200/min usually shows aberrant conduction. A regular baseline is frequent in junctional tachycardia and unusual in ventricular or atrial tachycardia. In nearly all of the ECG leads presented the baseline is regular.

Lead V_1 appears to show P waves at P-P intervals of 0·3 s and they precede each QRS complex, supporting my view that this was a junctional tachycardia of "upper junctional type." Certainly P waves are not visible in leads V_2-V_6 owing to the high ventricular rate, but the R-R interval in all the leads presented is also 0·3 s, which confirms the origin of this arrhythmia.

S HOMSEK

Germiston Hospital,
Germiston, South Africa

Lesser curve necrosis after proximal vagotomy

SIR,—Your recent leading article (29 November, p 487) and the paper by Professor David Johnston (6 December, p 545) on highly selective vagotomy have again drawn favourable attention to this operation for duodenal ulcer. I feel qualified to comment as I have over the past five years collected a personal series of 260 highly selective vagotomies for duodenal ulcer and for its complications. The results have in general been very satisfactory and I shall be reporting them in full in due course. However, to date there has been no operative mortality, minimal operative morbidity, and only four patients have had recurrence of their duodenal ulcer.

Br Med J: first published as 10.1136/bmj.1.6006.398-a on 14 February 1976. Downloaded from http://www.bmj.com/ on 13 April 2024 by guest. Protected by copyright.