extremely well, obviating the need for intra- 
thecal administration. Also we are not aware
of any evidence to suggest that penicillin aller-
gies increase 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.

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WALTER ROGERS
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Polyuria in paroxysms of tachycardia

Sir,—Your expert's explanation of the poly-
uria in paroxysms of tachycardia (8 November, p 339) is incomplete and may be incorrect. Wood 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 anti-
 diuretic hormone inhibition. This does not exclude other possible mechanisms. Medical care bears no direct relationship to cardiac output and renal perfusion if the attack is not a pro-
longed one. The polyuria is immediate but bladder emptying may be delayed.

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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 is, 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 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, and district hospitals in the NW Thames Area, and the 16 London postgraduate teaching hospitals. All replied and the results were as follows: 49 (72%) sold cigarettes, while 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, or 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 and hospital authorities on this matter. The National Association of Hospitals and Friends and the Women's Royal Voluntary Service, who provide this service, tell me that they are very ready to stop selling cigarettes in hospital shops that they run if asked by their hospital authorities.

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 could easily be demonstrated 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. Whick, February 1975, p 56

Propanidid in dysrhythmias

Sir,—Dr R J Vecht and his colleagues (Oct 18, 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 is between ventricular tachycardia and junctional tachycardia, both with aberrant ventricular conduction. In the absence of standard and unipolar leads, par-
ticipating leads 3 and 6 may help to differentiate 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 V1 favours an aberration. In general, approxi-
ately 85% of aberrantly conducted supra-
ventricular dysrhythmias show right bundle branch block form and a typical pattern of an "M" shaped and upright) pattern, as shown in lead V1. 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.

It would appear 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." Certain P waves are not visible in leads V1-V2 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.

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Lesser curve necrosis after proximal vagotomy

Sir,—Your recent leading article (29 Novem-
ber, p 487) and the paper by Professor David
Johnston (6 December, p 549) on highly
selective vagotomy for duodenal ulcer pursue two
very different goals. The former is aiming at the
damage to the duodenal ulcer, the latter at the
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
operatory mortality, minimal operative mor-
bidity, and only four patients have had recur-
rence of their duodenal ulcer.