

Following a recent similar but luckily unjustified fright I should like to amplify their remarks. Dr. Jenkins and his colleagues deal with placement of the cannula (though it is to be regretted that their plea for a longer catheter was nullified by their error in recommending a length of "at least 15-20 mm" when they presumably meant 15-20 cm). Assuming accurate placement, two further problems remain. Firstly, the risk of subsequent rupture of the vein wall by the tip of the catheter, as illustrated in two cases by Dr. C. J. Rudge and others (7 July 1973, p. 23). And secondly, the ease with which a long catheter can become withdrawn, especially as owing to its mode of insertion part of it is often surrounded by an introducing cannula or needle guard, inside which the catheter may freely slip. As one or more drips are attached a considerable weight has to be borne by whatever method of securing is followed, usually adhesive tape of some form applied to the small hub and the necessarily short length of thin catheter. As gravity overcomes this adhesion the catheter slips out in a tunnel of strapping. Usually it is resecured with more strapping over the proximal end, resulting in a period of delay before it continues its outward journey until the tip of the catheter leaves the vein and the infused solution is extravasated.

It is a paradox that the average short cannula used peripherally is provided with a flange or projection for stabilization, whereas the average catheter used in much more dangerous country is not. Apart from the unsatisfactory solution of securing the catheter to the chest wall by suturing, it would be helpful if manufacturers could supply a retaining device which could be firmly clipped on to the hub of the catheter and used for stabilizing it. Further, it is not possible to ascertain the length of most catheters when in situ (other than by radiology). A marking should be incorporated on the hub giving the length of the catheter so that the amount in the body can be instantly checked.

Finally, to guard against sequelae due to both displacement and rupture of the vein wall I would suggest that each time any locally toxic drug is infused it should be demonstrated that there is a free flow of blood back into the syringe regardless of the length of time the catheter has been satisfactorily in use.—I am, etc.,

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Cephalosporins in Bronchitis

SIR,—My clinical results with the cephalosporins in patients with chronic purulent bronchitis are not so poor as Drs. Susannah J. Eykyn and I. Phillips suggest (6 April, p. 59). In pilot experience 32 patients were treated with cephalexin 2-6 g daily—23 for two and 9 for three weeks.¹ Twenty-one improved with treatment, correlated closely to results of disk sensitivity on the pathogens isolated. Strikingly, all given two weeks of treatment relapsed during the next few days; in contrast six out of seven responding to three or more weeks of treatment maintained their sputum as mucoid afterwards.

Relapse so uniformly after two weeks of

apparently successful treatment is unique in my experience of antibiotics, but prolonging the period of treatment gets over this weakness. This was shown clearly in a double-blind trial, when cephalexin 1 g twice daily was compared with a placebo, in the prevention of purulent exacerbations of bronchitis.² The 55 patients were treated in hospital over a 10-week period. Cephalexin was significantly superior in several important respects.

At present I administer cephalexin (1) to patients when antibiotics have failed and when disc tests show sensitivity of the responsible organism; (2) cautiously to those with a history of antibiotic sensitivity; and (3), since it is remarkably well tolerated, to those with gastrointestinal upsets from other antibiotics. I have no experience with cephradine. For desperately ill patients failing to respond to other antibiotics cephaloridine 6 g daily by intramuscular injection remains among the most powerful regimens in patients with purulent chest infections.^{3 4}—I am, etc.,

A. PINES

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- 1 Pines, A., et al., *Clinical Trials Journal*, 1970, 7, 393.
- 2 Pines, A., *British Journal of Clinical Practice*, 1972, 26, 209.
- 3 Pines, A., et al., *British Journal of Diseases of the Chest*, 1967, 61, 101.
- 4 Pines, A., et al., *British Journal of Diseases of the Chest*, 1971, 65, 91.

Coping with Minor Casualties

SIR,—We agree with your leading article on this subject (2 March, p. 339) that there is a problem, but we disagree with the remedies suggested.

Casualty departments cope with patients who fall into two classes: (1) those suffering trauma—either major or minor—and (2) casual attenders seeking "primary care." Minor trauma and primary care are "general practice" by definition. It does not follow, however, that such care should always be provided from group practice premises. It would be a grossly extravagant use of resources if all group practice premises had to remain open for 24 hours a day. In our experience 50% of the patients coming to the casualty department have no local general practitioner. Such patients can often be more effectively and economically dealt within a hospital-based department. On the other hand it is illogical that a casualty department from which major trauma is excluded should be the responsibility of an orthopaedic surgeon. Clearly this is an area in which general practitioners should be concerned, and they are probably in the best position to ensure that such departments are not abused.

We have four years' experience of running a radio-linked on-call service for the local casualty department. If more general practitioners are going to accept this sort of responsibility, however, we believe there are some problems which must be resolved.

Firstly, difficulties arise—to paraphrase a sentence in your article—when overburdened general practitioners are called away from patients who have made appointments to see them to deal with patients with minor complaints who present in the casualty department.

Secondly, it is an unreasonable imposition

to ask senior general practitioners to turn out at night, travelling maybe up to six miles, to deal with cases most of which are trivial when competent nurses and junior doctors are resident on the site. It is also an uneconomic use of medical skills. This situation has arisen largely because of fears of litigation. It is time that the profession took a firm stand in this matter. Greater responsibility is accepted routinely by district nurses, midwives, and factory nurses in other settings. Moreover, lack of exposure to this sort of work will lead inevitably to a generation of doctors which is competent in resuscitation in the intensive treatment unit yet is unable to decide when an abscess should be opened or how to cope with a simple fracture. We do not believe that the problems of minor casualty work can be solved so long as the profession allows itself to be ruled by fears of litigation.

Summarizing, we believe that emergency minor trauma can be more efficiently and more economically provided from a hospital department when this is available. Much of the simple and routine work can, and therefore should, be done by junior doctors and nurses resident on the site. Experienced general practitioners should, however, be in charge of these departments and they should have consultant status. They should be supported by an on-call roster of local general practitioners and assisted by clinical assistants and junior hospital doctors as the work load justifies. One of their duties would be to ensure that a general practitioner principal is always on call to assist and advise the junior doctors and nurses resident on the site whenever required.—We are, etc.,

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MICHAEL COIGLEY
J. V. V. LEWIS
N. A. WOODWARD
JEAN HODSON
A. R. MCWHINNEY
D. FERGUSON

H. G. NICOL
A. N. GANNER
ANDREW LOCKIE
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Gonorrhoea of the Pharynx

SIR,—Your leading article on gonorrhoea of the pharynx (4 May, p. 239) asks how common is this condition in Britain. Since July 1972 routine investigations for gonorrhoea in the female in this department have included throat cultures. To date 6,362 women have been examined, of whom 4,373 presented no bacteriological evidence of gonorrhoea. Gonococci were recovered from the lower genitourinary tract in the other 1,898 cases, and in 16 of these neisseriae identified as gonococci were isolated in throat culture. These 16 cases were distributed sporadically over the period of investigation; there were no symptoms and only minimal clinical signs attributable to the throat infection.

Immunofluorescent techniques might show that the incidence of gonococcal infections of the throat in females in this city is higher than the 0.8% found in women with other evidence of gonorrhoea and the 0.2% in the cases as a whole. Even so, the condition would appear to be very much less prevalent in Birmingham than in parts of Scandinavia and America and to provide little at present in the way of a public health problem. Nevertheless, you are right

to draw the attention of the profession to the fact that gonococcal infection of the pharynx occurs, that the clinical condition is sometimes severe and, contrary to the findings here, not always accompanied by genital infection, and also that our knowledge of the sexual practices of the population is scanty.—I am, etc.,

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Lithium and Weight Gain

SIR,—Your leading article "Drugs Causing Weight Gain" (2 February, p. 168) mentions lithium carbonate taken over months in the prophylaxis of manic-depressive disorders. Patients on this treatment stay on lithium for years and the long-term considerations could be stressed. It has been shown that generally the weight gain with prophylactic lithium occurs in the first six months, and after this initial increase the weight remains constant for many years.¹ There is also some, rather limited, evidence that this initial increase in weight represents solid weight rather than water and that it is probably a reversal of weight loss during recurrent psychiatric illnesses.² Lithium, in a few cases, at the beginning of treatment may cause increased drinking due to thirst. It is helpful to advise patients against drinks containing sugar.³ One of the important factors causing patients, particularly women, to stop taking their lithium is a fear of an excessive increase in weight. Such a lapse in treatment is not so likely if the pattern of an initial gain to be followed by stabilization at a somewhat higher weight is explained to the patient and their relatives.

From a practical point of view when prescribing prophylactic lithium your advice about physical checks, which should include regular weighing, is very desirable. A patient's initial gain in weight followed by his maintaining a constant body weight with be generally reassuring. It would be unfortunate if largely unnecessary short-term considerations by patients, their relatives, and their doctors during the first few months of prophylactic lithium caused the treatment to be stopped.—I am, etc.,

R. J. KERRY

Northern General Hospital,
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- 1 Kerry, R. J., Liebling, L. I., and Owen, G., *Acta Psychiatrica Scandinavica*, 1970, 46, 238.
- 2 Kerry, R. J., and Owen, G., *Archives of General Psychiatry*, 1968, 22, 301.
- 3 Furlong, F. W., *Canadian Psychiatric Association Journal*, 1973, 18, 75.

Attitudes to Abortion

SIR,—You have been taken to task by a number of correspondents (4 May, p. 276; 11 May, p. 329) concerning your leading article "Attitudes to Abortion" (13 April, p. 69). They are mainly concerned with only one emotive aspect of the problem. There are others.

You say that "abortion . . . is a poor substitute for contraception as a means of stopping unwanted births." This is indeed true, but so much of our work is concerned with the failures of preventive medicine and until we can eliminate the congenital defects

in the newborn, abolish the stress diseases, control all infections, deal with the cause of dental decay, and find some cause for cancer we shall have to accept a situation that is not ideal. One day, I hope, all children will be conceived with the willing consent of both parents, but meanwhile the Abortion Act of 1967 does enable the medical profession to alleviate a very great deal of mental and physical suffering and to mitigate the results of the failure of methods of contraception that are admittedly imperfect.

It is suggested by Professor H. C. McLaren (12 May, p. 329) that one termination of pregnancy every three months is all that a consultant "practising modern obstetrics, offering compassion and advice" should be doing. This statement is, with respect, that of someone living in another world. A study of some of the carefully compiled case histories of those patients presenting themselves to such organizations as the British Pregnancy Advisory Service would enable a balanced judgement to be made.—I am, etc.,

REX BINNING

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SIR,—I am sure that there are many doctors who share my great anxiety for the future of gynaecological departments and even possibly for the Royal College of Obstetricians and Gynaecologists itself if the Lane Report¹ is accepted by the Government and implemented.

For doctors generally it would mean that there could be no prospect of specializing in gynaecology for Roman Catholics or for those who hold similar views on the subject of abortion. Inside the royal colleges it could create endless divisions among Fellows and members. For nurses it would perpetuate the atmosphere we have felt since the Act has been on the statute book—a reluctance on the part of many to work in the gynaecological wards and theatres. Finally for the patients too there would be an unacceptable paradox when a woman having a threatened miscarriage or being investigated for infertility is nursed alongside one having an abortion for reasons other than strictly medical ones.

Of course one can understand the desire to use the training and expertise of the gynaecologist to ensure "safe" abortions throughout the country, in which there is said to be a majority demand for such a service. But for job satisfaction on the part of doctors and nurses and for peace in the hospitals I am absolutely convinced that beds allocated for the purpose should be separate from the gynaecological ward and staffed by those who agree with this type of practice.

In other words, I suggest a new sub-specialty—gynaecology (abortion).—I am, etc.,

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¹ Report of the Committee on the Working of the Abortion Act, Cmnd 5538. London, H.M.S.O.

SIR,—Professor H. C. McLaren (11 May, p. 329) is surely overstating his case when he tries to imply any parallel between the state atrocities of the Nazis and official recognition here of the reality of the need

for abortion and the essentially humanitarian nature of the service it provides when abortion is inevitable.

Conscience must be seen to have its positive face. The "conscience clause" cannot be regarded as merely a negative one allowing only the right of abstinence from helping the distressed. It also entitles those who are humanly concerned enough to wish to do so the right to ensure, within the law, proper medical help for those who would otherwise pass into the hands of the backstreet abortionists, with all the awful consequences of this that Professor McLaren and I, and all our generation, know very well. Hospital administrators have certainly a right on behalf of the public to stand on the side of such a positive interpretation of the "conscience clause" and for the intention of the Abortion Act as law. Trying to cripple the working of the Act seems to me almost as unworthy as profiteering from it. Those, and particularly those like Professor McLaren, who have a long and wide experience in hospital wards of the distress, damage, and not infrequently death resulting from septic abortions performed outside and who, despite it, think as he appears to do perhaps have a need to unblinker the function of conscience to give it a wider and more human sweep.

The trouble is that our natural humanity is hedged about with doctrines. Once it was thought salutary to the soul to scourge the body or to torture to death in the name of religion. We have a need still to shed all such doctrines and let the human spirit shine through. Unfortunately, the old coin is still being offered by some today as if it was valid tender without question, though very many now doubt, with reason, that it is gold. Perhaps, in our profession today we have a need to apply the touchstone more courageously and more emphatically to such coin, whoever it is presents it.—I am, etc.,

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Vaccination of Smallpox Contacts

SIR,—In reply to Dr. D. J. Bauer's letter (23 March, p. 576) we would like to stress that we stated (17 November 1973, p. 423) that "it is generally accepted that successful vaccination within up to about 48 hours after exposure will usually protect contacts against smallpox." We do not consider that there is anything absolute in the effectiveness of smallpox vaccination, and its success depends on many factors.

The efficacy of vaccination following exposure could be accurately determined only by carefully controlled studies, but these will never be done because of the known effectiveness of the procedure, which could not be withheld from any exposed person.

We have again reviewed the references quoted by Dr. Bauer but cannot reconcile his table with the published data. In his table there is no indication whether "day of primary vaccination or revaccination" relates to the day of onset of illness or to the day of contact. Only in Hanna's book¹ and the paper of Lyons and Dixon² is it possible to deduce reasonably accurate information of the day of vaccination and the day of exposure. In the data of Smith³ and Cramb⁴ the date of vaccination and the date of onset are stated and only an estimate of the day of vaccination in relation to contact can be made. Even so our analysis of the data confirms our original observation. For some reason Dr. Bauer does not include the data from