Points

Management of gastrointestinal bleeding

Mr J S KIRKHAM (St James' Hospital, London SW12 8HW) writes: I was interested to read Surgeon Lieutenant-Commander J G Williams's letter (10 October, p 987) about the management of gastrointestinal bleeding, and agree entirely with your comment. I would take exception, however, to his last sentence, which implies that an "alcoholic binge" may lead to an upper gastrointestinal haemorrhage and that this does not require investigation. It is our experience that when alcoholic excess leads to a massive bleed there is usually a chronic underlying cause, and I would suggest that these patients most certainly should be investigated.

Biphasic sulphinpyrazone-warfarin interaction

Drs A GIROLAMI, L SCHIVAZAPPA, F FABRIS, and M L RANDI (Medical School, Padova, Italy) write: We have read with interest the paper on the biphasic interaction between sulphinpyrazone and warfarin observed by Professor Giuseppe G Nenci and others (25 April, p 1361) in one patient. We have recently studied the same relationship in a group of cardiac patients after prosthetic heart valve surgery and a paper on the subject is about to be published. We have noticed a constant potentiation of the coumarin effect by sulphinpyrazone. However, we have never noticed an inhibitory effect of warfarin, even during a prolonged observation (five to six months). In every patient the dosage of warfarin, after the addition of sulphinpyrazone (800 mg/day), had to be decreased by approximately half to maintain the same level of anticoagulation (patient:normal ratio of about 2 on the basis of a rabbit brain preparation). In no instance did we observe the need for an increase in warfarin medication. The significance of these findings is enhanced by the fact that the study was double blind and that before the key of the study was opened we had no explanation for the difficulties we were encountering in maintaining a stable anticoagulation in some of the patients. In view of our results, it is unlikely that the explanation for the inhibitory effect of sulphinpyrazone reported by Professor Nenci and others involved an established metabolic pathway—namely, an increased hepatic metabolism of warfarin. If that were so we should have observed the phenomenon in our patients. Possibly a peculiar individual response or failure to take the medication (or both) is involved. Diet is important, as recognised by the authors. In the paper it is not specified whether the patient was still hospitalised at the time of the study. In our experience frequent adjustment, usually an increase, of warfarin dosage is needed after patients are discharged from the hospital. This is probably associated with the higher lipid content of the average diet than of the standard hospital diet. . . .

Human trypanosomiasis in Africa

Dr N McD Davidson (Medical Unit, Eastern General Hospital, Edinburgh EH6 7LN) writes: Dr J R Foulkes (31 October, p 1172) provides a timely reminder of the scourge of human sleeping sickness in Africa. . . . By 1980 a very serious outbreak of trypanosomiasis was well under way in the area of Uganda north-east of Lake Victoria in north Busoga. There were huge numbers of patients being treated, and in that district alone over 1000 new cases were being seen monthly. Staff, diagnostic facilities, and drugs were desperately inadequate to cope with the epidemic. Although international help has been sought, it will be a long time before the outbreak can be controlled under present conditions in Uganda.

Management of patients with bilateral amputations

Mr RAYMOND HELSBY (Goodleigh, Nr Barnstaple, Devon EX32 7NB) writes: In my retirement in the peace of North Devon I read with interest the letter from the rehabilitation studies unit at Edinburgh on the management of patients with bilateral amputations (31 October, p 1184). In particular, I was interested that the problems *will* be studied "with the skills of a multiprofessional team." In 1972[1] Miss Collette Welch (a nurse) and I described how, to improve the situation of the bilateral amputee and to provide better service, multidisciplinary fortnightly meetings attended by all hospital staff involved in the care of the elderly amputee had been instituted at the Liverpool Royal Infirmary. . . . From our experience, we said, we were able to anticipate most of the problems with which our patients had to cope, and act accordingly. *Plus ça change.* . . .

[1] Welch DC, Helsby R. *Nursing Times* 1972;**68**:743-4.

Drugs and cost consciousness

Dr ANTHONY J S NICHOLLS (North Harrow, Middx HA2 7RF) writes: . . . It is surely beyond doubt that the overwhelming majority of conditions for which a general practitioner prescribes drugs can be treated with cheap generic preparations rather than the latest, most expensive preparation, the literature for which deluges every doctor in the country. It occurs to me that the public might be educated to ask whether expensive preparations are really necessary for their condition if they were charged a proportion of the cost up to a certain agreed level rather than having a flat item charge as at present. In this way the patient would directly benefit from cost consciousness on the part of the profession.

Diving is dangerous for diabetics

Dr M R KILN (Casualty Department, Guy's Hospital, London SE1 9RT) writes: The letter from Dr John D King (3 October, p 918) entitled "Diving is dangerous for diabetics" . . . does not, I feel, give an accurate view of the dangers for a diabetic of underwater diving. There are at present 11 diabetics who belong to the British Sub-Aqua Club, . . . which has reviewed each one in the last two years, with a special medical report from each of their consultants. If a diabetic is to be allowed to dive he must have tip top control . . . as he is at a slight risk while diving. The diver quoted in this letter, who had a pre-existing neuropathy, would not be allowed to drive. . . . The 11 diabetics allowed to dive in the UK are all very experienced divers, they are all extremely fit, and they are perfectionists in their control. I would feel that under these circumstances divers who smoke, drink, and perhaps even dive under the effect of a hypnotic taken the previous night are at a greater risk than these fit diabetics. . . .

Assessment of insomnia

Professor DOUGLAS GORDON (Harrow, Middx HA1 3PZ) writes: Every nurse and doctor knows that patients grossly exaggerate the proportion of the night that they have been awake. When therefore my wife and I had our sleep rhythms completely disrupted by living under the glide path to London Airport we resisted the temptation to become drug dependent. When the normal rhythms did not return after a move to the silent skies of Harrow, the first step was to install a luminous clock. This proved that a "sleepless" night was one in which one was awake for perhaps an hour in all. The invention of the clock radio with the easily read LED display provided the answer to the problem. We now have one each with a single earphone that is highly directional so that, even if it comes adrift during the night, it does not present an irritant to one's spouse. The problem has now been inverted. I am more likely to complain that I missed an instalment of a Dorothy Sayers play in the small hours or Alistair Cooke's "Letter from America" at dawn than of being awake for half an hour when there was no suitable programme. The easily read clock proves conclusively how little time is really lost from insomnia. The threat to discontinue the BBC's World Service is to be strongly condemned and I hope that the author of your leading article on insomnia, Professor Ian Oswald (3 October, p 874), will add his voice to mine. The saving in barbiturates should meet the cost of making the World Service audible throughout the country. . . .

Corrections

Paget's disease of bone

Three errors occurred in this letter by Professor C Nagant de Deuchaisnes and others (17 October, p 1055). In line 14 of the third paragraph the dose of $1,25(OH)_2D_3$ should have read "0·50-0·75 μg/24 h," not mg/kg/24 h. At the end of the fourth paragraph the normal mineralisation front should have been $>70\%$, not $\pm 70\%$. In the last sentence the phrase "this and related compounds" in the fourth line refers to 3-amino-1-hydroxypropylidene-1,1-diphosphonate (APD), not disodium etidronate. We apologise for the second and third errors.

Improved pain relief after thoractomy

An error occurred in this letter by Dr E N S Fry (31 October, p 1185). The infusion of buprenophine mentioned in line 10 should have read 25 μg/h, not 250 μg/h.

Asthma—expiratory dyspnoea?

We regret that the name of one of the authors was accidently omitted from this letter by Dr R D Stark (24 October, p 1121). Mr J A Lewis, FIS, should also have been included as an author.