

but no obstructing lesion or other abnormality were found. He had an uneventful recovery.

Acute pseudo-obstruction of the large bowel is a recognised, potentially fatal, clinical syndrome.¹ The mechanism is unknown, but the condition may be associated with serious pathology inside or outside the abdomen.¹⁻³ Our experience suggests that pulmonary thromboembolism may lead to this condition.

- 1 Addison NV. Pseudo-obstruction of the large bowel. *J R Soc Med* 1983;76:252-5.
- 2 Stephens FO. The syndrome of intestinal pseudo-obstruction. *Br Med J* 1962;3:1248-50.
- 3 Bardsley D. Pseudo-obstruction of the large bowel. *Br J Surg* 1974;61:963-9.

Dangers of adding insulin to intravenous infusion bags

Dr E MARK TALBOT (St Paul's Eye Hospital, Liverpool L3 9PF) writes: In reply to Dr Mark J Curtis and Dr Mervyn Singer (13 October, p 1007) my first of several recommendations (15 September, p 678) was not to use syringes with short fixed needles at all. This was based on a finding that 16 out of 30 did not successfully penetrate the inner seal despite forceful, determined, and repeated effort. The inadequacy of the addition is that often the needle length cannot reach the inner seal, and thus I doubt whether the bayonet manoeuvre described will help, nor does it overcome the loss of injection into the dead space after successful penetration, should the fight with the infusion bag be relaxed.

I urge doctors who care for patients with diabetes to educate their juniors about this regular danger and demand a supply of appropriate syringes and needles for reliable addition of insulin and better control of their patients. Furthermore, I would advise manufacturers and suppliers of fixed needles of inadequate length—less than 16 mm—to provide a warning on the boxes: *Not to be used for making additions to infusion bags.*

Cardiac arrhythmias during rewarming of patients with accidental hypothermia

Dr A L POZNIAK (Department of Medicine, Middlesex Hospital, London W1N 8AA) and Dr A HAMMOND (Whipps Cross Hospital, London) write: Dr Andrew C Rankin and Dr Alan P Rae (6 October, p 874) suggest that in hypothermia asystole is the primary arrhythmia, ventricular fibrillation being precipitated by external factors. We have used an intraoesophageal extracardiac pacing wire in an 83 year old woman who presented with hypothermia, a low idioventricular rhythm, and an unrecordable blood pressure. The paced ventricular rate was set at 50/min, which was followed by an increase in systolic blood pressure to 80 mm Hg. No arrhythmia was precipitated during this procedure. On rewarming the patient sinus rhythm returned at a normal heart rate and the pacing wire was removed. This method of cardiac pacing is less invasive and may be less arrhythmogenic than intracardiac pacing in hypothermia.

Damage to postgraduate education from withdrawal of section 63

Dr JOHN K PATERSON (vice president and honorary secretary, Bristol Association of Manipulative Medicine, London W1M 7AB) writes: The long term effect of the withdrawal of reimbursement of travelling expenses and subsistence allowances has proved catastrophic in many areas of postgraduate education. In common with most courses run by agencies not under the control of regional postgraduate deans, the figures for the courses that this association has run for more than 20 years have dropped alarmingly in the past year, and indeed this year we have had to cancel the basic series owing to lack of support.

This is a sad blow, and we are conscious that

we are by no means alone. We are also aware that such courses are not generally available. Furthermore, there is increasing interest in therapies not commonly taught, and it is important that they are taught by experienced tutors. We now have a cadre of tutors "at a loose end."

I suggest that any of your readers who are interested in medical manipulation contact me, with a view to investigating holding provincial courses around the United Kingdom.

Anticholinergic intoxication syndrome: potentiation by ethanol

Dr G P PULLEN (Littlemore Hospital, Littlemore, Oxford OX4 4XN) writes: Dr I Drummond and Dr K Wilson, in describing a toxic confusional state in a 33 year old man after ingesting orphenadrine (13 October, p 964), emphasise the importance of the patient having drunk three pints of beer. He had, however, consumed 420 mg of orphenadrine; experience suggests that surprisingly small doses of anticholinergics may lead to toxic states.¹ Shariatmadari² reported a case of a 23 year old man who deliberately abused orphenadrine and suffered from an epileptic fit after taking 600 mg.² As a believer in the "law of parsimony" I suggest, therefore, that Drs Drummond and Wilson's patient should be seen simply as a case of anticholinergic overdose.

That such a severe confusional state followed the ingestion of a comparatively small dose of orphenadrine is further evidence of the need for caution in prescribing anticholinergics.¹ Orphenadrine's potential for abuse seems to make Norgescic (orphenadrine citrate 35 mg and paracetamol 450 mg) a hazardous preparation.

- 1 Pullen GP, Best NR, Maguire J. Anticholinergic drug abuse: A common problem? *Br Med J* 1984;289:612-3.
- 2 Shariatmadari ME. Orphenadrine dependence. *Br Med J* 1975;3:iii:486.

Hyperbaric oxygen in treatment of carbon monoxide poisoning

Dr SATISH KUMAR (Department of Renal Medicine, KRUF Institute, Royal Infirmary, Cardiff CF2 1SZ) writes: Dr Avishai Ziser and colleagues (13 October, p 960) advocate the routine use of hyperbaric oxygen in the treatment of carbon monoxide poisoning without giving evidence for its superiority over conventional oxygen treatment. Late neuropsychiatric sequelae are certainly recognised after carbon monoxide poisoning,¹ but there is no evidence that these are prevented by hyperbaric oxygen. The results of at least one study have shown that neurological sequelae develop in 50% of patients with severe carbon monoxide poisoning despite intensive treatment with hyperbaric oxygen.²

I think that we should wait for more evidence supporting the advantage of hyperbaric oxygen over conventional 100% oxygen before using this expensive and possibly dangerous treatment routinely.

- 1 Smith JS, Brandon S. Morbidity from acute carbon monoxide poisoning at three year follow up. *Br Med J* 1973;3:318-21.
- 2 Sawada Y, Takahashi M, Ohashi N, et al. Computerised tomography as an indication of long term outcome after acute carbon monoxide poisoning. *Lancet* 1980;ii:783-4.

Accumulation of midazolam in patients receiving mechanical ventilation

Dr A J RAMPTON (Department of Anaesthesia, University College Hospital, London WC1E 6AU) writes: Midazolam is being used more and more to sedate patients in intensive care units (29 September, p 799). At this hospital it has been administered both by infusion¹ (0.025-0.1 mg/kg/h in dilute solution) and as repeated bolus doses. The occurrence of convulsions in one patient when the infusion was withdrawn may have been

due to the same mechanism that can cause fits when diazepam is withdrawn.

A 51 year old man, weighing only 46 kg, had had a prolonged stay on the intensive care unit due to recurrent episodes of respiratory failure after a pneumonectomy. He became distressed while being ventilated, with little relief from infusions of diamorphine or Althesin (then still in use) in doses much greater than those normally required. He was subsequently started on a midazolam infusion, again requiring higher than normal doses, and when withdrawn he had two short lived generalised convulsions. Concentrations of arterial blood gases, serum electrolytes, and serum calcium were normal. No other neurological abnormalities were detected, computed tomography of the head was normal, and he is alive and well eight months later.

In other patients midazolam has been useful, causing little cardiovascular or respiratory depression, with prompt return of alertness even after a high cumulative dosage.

- 1 Lauen PM, Stoeckel H, Schwilden H. Ein pharmakokintisch begründetes Infusionsmodell für Midazolam. *Anaesthesist* 1982;31:15-20.

Stoved in fractures

Mr J A CHALMERS (Whitbourne, Worcester WR6 5RT) writes: I read with interest Dr Andre G de Clercq's letter (13 October, p 1007) describing the reduction of a depressed skull fracture using a vacuum cup, in this case in babies or small children. The first application of this principle in children was described by Hildamus in 1632, but in 1655 Ambroise Paré reported the use of "a cupping glass with a great flame" applied to a depressed fracture of the skull "Withall commanding the patient to force his breath up as powerfully as he can keeping the mouth and nose shut." How far this manoeuvre contributed to the success of the intervention is doubtful, but once again it seems that there is no new thing under the sun.

Anaesthetists and anesthesiologists

Dr STEPHEN MATHER (Sir Humphry Davy Department of Anaesthesia, Bristol Royal Infirmary, Bristol BS2 8HW) writes: The answer that Dr B J Freedman (13 October, p 993) gives to the question on the differences between the British and American use of anaesthetist and anesthesiologist implies that candidates might still obtain a consultant post without the FFARCS (fellowship of the faculty of anaesthetists of the Royal College of Surgeons) diploma and that the FFARCS "seems to be displacing the DA [diploma of anaesthetics] as a requirement for senior posts."

The classified advertisements in the *BMJ* show that a candidate for a post as senior registrar must have the FFARCS diploma or its equivalent (FFARCS, FFARCS Ireland). Thus any advisory appointments committee would be unlikely to recommend the appointment of a candidate with only the current DA. From February 1985 the DA and FFARCS diplomas will have been reorganised into an integrated examination, comprising three examination sittings. Obtaining the DA will now satisfy part of the requirements for the FFARCS England diploma.

Correction

Risks of intrauterine contraceptive devices

We regret that an error occurred in the letter by Dr Helen L D Duguid and others (22 September, p 767). The first sentence of the second paragraph, which began "There is no evidence that . . ." should read: "There is now evidence that *Actinomyces israelii* can be cultured or identified by immunofluorescence techniques in cervical and vaginal samples taken from women who are not using an intrauterine contraceptive device."