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assess the ability of ambulance staff to achieve successful outcomes using existing training.

All the patients included in the study were emergency cases—that is, either 999 calls or cases classed as an emergency by a general practitioner—and all had “hands on” assessment by ambulance and medical staff. To suggest that this prospectively performed study was a “table top theoretical exercise” is therefore far from the truth.

All of the patients admitted to a resuscitation area were assessed in detail, not merely the 396 who died. The patients in resuscitation areas constituted 6% of all the emergency cases studied in Edinburgh and 4-3% of the Glasgow cases. These figures are similar to those reported for accident and emergency departments elsewhere in Britain.

Though “abundant evidence in favour of extended ambulance skills” exists in the United States, the situation in Britain is very different. Drs Baskett and Sleet claim that “hard data” are available from centres that have had years of experience with ambulancemen trained to perform a range of skills. We do not know of studies of this kind that compare basic and advanced ambulance skills, and we note that Drs Baskett and Sleet do not give references for such results.

As we indicated in our paper, the benefits of advanced training will be seen mainly in patients requiring cardiopulmonary resuscitation. We do not dispute the role of early defibrillation for ventricular fibrillation, and we agree with Mr William Rutherford (28 February, p 578) that there is a strong case for concentrating resources in this area. In the absence of cardiopulmonary resuscitation by a bystander, however, the limiting factor is the time the ambulance service takes to respond. We refute the comment that “the journey... leave something to be desired.” The time referred to as “journey time” is in fact represents the time from the initial 999 call to arrival in hospital and not the response time of the ambulance service.

In no way denigrated the fact that “only 54%” lives might have been saved; this figure represented the maximum possible benefit, and to suggest that over 2500 lives could be saved in Britain every year is an inappropriate interpretation of our results. As the authors indicate, we took no account of the effect of extended training on mortality. We would be delighted to have a scientific and reproducible assessment for morbidity in patients before they reach hospital.

JAMES D URQUHART
Information Services Division, Commedics Ltd, Edinburgh EH5 3QK

Tennis elbow: conservative, surgical, and manipulative treatment

SIR,—There is a very simple cure for many patients with tennis elbow, which is little known and which is only briefly hinted at by Mr Thomas G Wadsworth (7 March, p 621).

Some years ago, when I played a great deal of tennis, I developed the typical lateral elbow in my right arm. This steadily worsened and was relieved for a day or two only after cortisone injections by an orthopaedic colleague. Rest gave no more than temporary relief, and I began to think that I should stop playing tennis. I mentioned this intention when operating at a cottage hospital one day. A general practitioner in the theatre, Dr M R Sheridan, bluntly responded: “Rubbish! Go to Briggs’s in Wood Green high street and get yourself a raquet with a bigger handle.” I took the doctor’s advice and went to Briggs’s shop as soon as I finished operating and bought a new raquet with a handle 3-75 cm larger in circumference than my existing one.

A day or two later I played three sets of tennis with Dr Sheridan. On taking my first service, I said: “I shall never be able to serve with this large handle.” My medical partner retorted: “Shut up! You’ll be alright by the end of the first set.” He was absolutely right. Within half an hour I had adjusted my grip and never had any recurrence of trouble in the next 30 years. Lateral elbow pain is also often caused by gripping too small handles on shears and other garden tools. This can be prevented by building up the handles to the requisite thickness, and I have helped many sufferers to cure themselves in this way.

The mechanism of relief is simply explained if the position of the wrist when the hand is gripping objects of different thicknesses is studied. The smaller the circumference of the object held, the less the degree of dorsiflexion of the wrist. As progressively thicker objects are held, dorsiflexion increases, reducing the tension on the forearm extensor muscle origins. It seems that with a
tight hand grip the wrist is straighter, increasing the tension at the common extensor origin and in the extensor radialis brevis. I have no doubt that the other factors referred to by Mr Wadsworth can be contributory in some cases, but my experience suggests that a little attention to the size of racquet and to the handling techniques by the tennis player, with the relief and permanent cure of this tiresome condition in tennis players, gardeners, and other sufferers.

SIR REGINALD MURLEY

Radlett,
Hertfordshire WD7 1NJ

Portraits from memory: Dr E C Smith

Sir,—I thank Sir James Howie (21 February, p 501) for his portrait of the late Dr E C Smith of the medical research institute at Yaba, Lagos.

As a junior officer in the Royal Army Medical Corps, newly arrived in Nigeria, I had the privilege of meeting Dr Smith and found him to be a mine of knowledge and a tower of strength in 1942, when we were confronting so many difficult clinical and microbiological problems. His Introduction to Pathology and Bacteriology for Medical Students in the Tropics, published in 1939, became an immense help to me.

His kindness equalled his experience, and his lectures were full of clarity and good sense. As Sir James pointed out, the dangers of yellow fever and malaria were very serious in 1941-2, when the Lagos airfield at Apapa became one of the nodal links of the little known but vital transcontinental ferry service of the Royal Air Force, essential in providing a steady supply of front line aircraft for north Africa and the Middle East after the Mediterranean sea route was blocked by enemy forces.

Fighter planes (mainly Hurricanes) were shipped in crates from Britain to west Africa. Takoradi in Ghana and the Lagos airfield at Apapa in Nigeria served as main bases for the assembly and test flights of those single engine, one man planes. From Lagos these fighter planes were flown by civilian pilots of the Air Transport Auxiliary Group (Canadians, French, Polish, Yugoslavs, men well over the age of 40, and several women) from Africa in short hops, with refuelling every 400-500 miles at permanent landing strips. They flew in air caravans, consisting of six to eight planes following the leader, a light bomber with navigational facilities. The air route was across Nigeria, from Equatorial Africa, and Sudan, and then up the Nile valley to Luxor or Cairo. Several thousand planes were delivered thus in 1943-4, with very few losses.

As early as 1941 it became evident that the Lagos airbase was situated near a highly malignant coastal mangrove swamp. Up to 500 blood fed Anopheles gambiae were found daily in airmen's tents, and the weekly incidence of malaria was about 100/1000. In mid-1942 the main swamp was drained, and, as this was very successful, the work carried out by Lieutenant Colonel Alan Gilroy and his No 7 field malaria laboratory was soon extended to all swampy lands within a one mile perimeter of the airbase.

The possibility of importing yellow fever into Egypt and beyond by infected Aedes aegypti was even more worrying in the long run, as the only preventive action that could be taken was the immunisation of all those working at the base and the use of appropriate anti-mosquito measures, rather than to ease our consciences than to prevent the spread of yellow fever. Much of this work was carried out under the supervision of the Royal Army Medical Corps, but the task at smaller Nigerian airfields between Lagos and Maiduguri was enormous and beyond the available technical means or resources.

In all of the discussions and decisions agreed between the military and civilian authorities Dr E C Smith's experience, balanced views, and wide knowledge were invaluable. Though the pathology and therapy of yellow fever was his main interest, his 1942 study of mortality in Lagos was of great public health importance for the government of Nigeria.

L J BRUCE-CHWATT

Welcome Tropical Institute,
London NW1 2BQ

Points

Low serum selenium concentration and glutathione peroxidase activity in intrahepatic cholestasis of pregnancy

Drs DAVID SHENNAI and C A R BOYD (Department of Human Anatomy, University of Oxford, Oxford OX1 3QX) write: We were interested in the discovery by Professor A Kauppila and others (17 January, p 150) of the association between reduced serum concentrations of selenium and intrahepatic cholestasis of pregnancy. In addition to the pronounced reduction associated with the disease, their figure 1 showed that nearly all the control group fell significantly during the last trimester of pregnancy and that this fall reversed very quickly after delivery. In discussing this finding and the finding of Butler et al., the authors consider the possibility that increased metabolism of selenium "might be responsible for the low serum concentrations...in patients with intrahepatic cholestasis of pregnancy." They do not comment further on the possible reasons for the fall in plasma selenium concentration during normal pregnancy. The first (discussed by Butler et al.) is the haemodilution effect of pregnancy, and the second is placental transport of selenium. A pathway for the membrane transport of selenium (in the form of selenate) is present in the brush border of the human placenta.1,2 The findings of Professor Kauppila and colleagues in normal pregnancy, together with their observation that twin pregnancy is a risk factor for intrahepatic cholestasis, may be related to the physiology of placental transport of this essential trace element.


Hyperpigmentation of skin in patients with AIDS

Dr ROBERTO ESPOSITO and others (University of Milan, Italy) write: To the many dermatological manifestations in patients with the acquired immune deficiency syndrome (AIDS) the following syndromes described by Dr M M Walker and coworkers (3 January, p 29) we would add diffuse brown hypermelanosis of the skin. Among the 120 cases of AIDS followed up for so far at the clinic of infectious diseases in Milan we have seen six men (three homosexuals and three drug abusers) who, in the most advanced stage of the disease, showed a generalised brown darkness of both exposed and unexposed areas of the body. In all cases skin biopsies showed an increase in epidermal melanin. In addition to hyperpigmentation other clinical signs of adrenocortical deficiency (weakness, weight loss, abdominal pain, hypotension) developed progressively. Concentrations of serum sodium, chloride, and bicarbonate were reduced considerably. Urinary steroid excretion and plasma cortisol concentration were at the lower end of the normal range, while stimulation tests with adrenocorticotropic hormone showed a response characteristic of primary adrenal insufficiency. All the patients died within three months of the development of the dermatological signs. Necropsy was performed in four cases and showed general atrophy of the adrenal gland with infec tious disease or neoplasia. Hypofunction of the adrenal cortex seems to be a fairly common manifestation of full blown AIDS, and the progressive darkening of skin is its earliest and most striking symptom.

Is “Less than the Week” really a lesson?

Dr PETER SANDERCOC (Department of Neurology, Walton Hospital, Liverpool L9 1AE) writes: I was very disappointed to read the recent lesson of the Week entitled “The brain abscess. An extradural gas shadow by Drs Kui Chung Lee, J P McCann, and D P Nicholls” (7 February, p 365). Having presumably weighed up the risks and benefits, they undertook a lumbar puncture in a patient with impaired consciousness and focal neurological signs. Mercifully, though the patient had a cerebral abscess, transient herniation did not occur. I am surprised that Drs Lee, McCann, and Nicholls did not mention the hazards of lumbar puncture in patients with focal neurological signs. The lesson was described in a previous lesson of the Week and in the extensive correspondence that followed.1 While I accept that perfection may be difficult to achieve in everyday clinical practice, the authors might have referred to the hazards and emphasised this very important lesson.


Continued medical education must not be an optional extra

Dr PAUL PLESLEY (Cheltenham Postgraduate Medical Centre, Cheltenham GL53 7AG) writes: Dr T P C Schofield suggests that finance is a major problem for continued medical education (28 February, p 326). In the present financial climate, with course organisers’ pay demands being effectively rejected and clinical audit unpaid, extra cash cannot be expected from government sources. The section 63 budget could be reorganised, however, to reward group leaders. The government would still get something (increased standards of care and effectiveness in practice) for nothing, but this is the price of professionalism.

Comprehensive care of patients with head injuries

Dr Ian MckINLAY (Royal Manchester Children’s Hospital, Manchester M27 1HA) writes: Dr Gordon Brocklehurst and colleagues (7 February, p 345) described a comprehensive admissions policy but not comprehensive care. No details are given of their rehabilitation service, and patient outcome is scarcely dealt with. Oddy et al. have indicated the extremely long term psychological consequences of residual disability and the impact on family and social adjustment, closely associated with cognitive impairment and personality change. Comprehensive care must address these issues as well as emergency neurosurgery.


Royal Free disease: risk of suicide

Dr P D WHITE (Department of Psychological Medicine, St Bartholomew’s Hospital, London EC1A 7BE) writes: I am concerned that the case report, with the mention of “myalgic encephalomyelitis” may be considered to be suffering from either an “organic” postural disease or a psychosomatic disorder (7 February, p 327). If myalgic encephalomyelitis is regarded as purely “organic” then any psychiatric illness (whether primary, secondary or in a more complex interaction) may not be