peak plasma insulin value was reached 15 minutes after glucose injection.

These findings lead us to conclude that intravenous administration of hypertonic solutions such as glucose 40%, but probably also radiocontrast media, may cause a fall of blood pressure in the elderly, probably through direct vasodilatation. Secondly, the endogenous insulin response to glucose 40% given intravenously elicited no effect on blood pressure in the elderly.

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1 Jansen RWMM, Hofnagels WHL. Influence of oral and intravenous glucose loading on blood pressure in normotensive and hypertensive elderly subjects. Lancet 1986; ii: 672-3. (in press)

Health and nutrition of Ethiopian refugees in emergency camps

Sir,—Dr Paul Shears and colleagues draw attention to the high mortality among Ethiopian refugees arriving in the Sudan in 1985 (1 August, p 314). The mortality remained high despite the relief programme in the area and was observed in a number of camps with differing standards of relief services.

The main determinant of mortality was the extremely poor nutritional state of the population on arrival. Severely malnourished people of all ages may be kept alive for some time by the efforts of relief agencies, but they often fail to improve nutritionally because of impaired gastrointestinal and metabolic functions and finally succumb to infection weeks later. Reactivation of infections with refeeding was not specifically recognised but might have contributed to the delayed mortality in that confused environment.1 2

The authors do not regard water supplies as a major problem. As one who was working in the area at that time, I know that in many of the camps the water supply was the weak link in the provision of early services in the emergency. Both the quality and, more importantly, the quantity of water were inadequate.

There was another factor which probably added to the high mortality. Non-governmental agencies appeared at times to be more concerned with interagency rivalry and the pursuit of rigid ideology than the welfare of the refugees. On one occasion three agencies were asked to provide medical services for a large group of new arrivals in very poor condition. None of these agencies wanted to be left behind in "curative medicine." 3 As a result, during the first critical weeks, when many of the population were acutely ill, the curative services provided were quite inadequate and many died of treatable conditions. Agencies concerned in disaster relief programmes must make the welfare of the victims their prime concern rather than their own prestige or ideology.

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Regular Review: Somatostatin

Sir,—We would like to comment on the statement made by Professors S R Bloom and J M Polak (1 August, p 287) about the use of somatostatin in controlling variceal haemorrhage. They state that "the initial reports were good but have not been confirmed, and the long acting analogue is of doubtful usefulness in treating either bleeding peptic ulcer or bleeding varices." Though studies of the efficacy of somatostatin in controlling haemorrhage from peptic ulceration have produced conflicting results, this is not the case with bleeding oesophageal varices. Thus control of bleeding was achieved in 47 of the 62 episodes of variceal haemorrhage treated with somatostatin in the three published randomised controlled clinical trials, a success rate of 74%.1 2 Such an outcome compares favourably with that achieved with vasopressin, which in the 13 randomised control trials reported to date has controlled bleeding in 122 out of 238 (51%) episodes of bleeding.3 Moreover, no major complications have been associated with the use of somatostatin to control variceal haemorrhage, in contrast to vasopressin, which, at the dosages used to control variceal haemorrhage, may produce serious, and sometimes fatal, side effects in about 15-25% of patients. Therefore at present the evidence suggests that somatostatin is safer and more effective than vasopressin for the control of acute variceal haemorrhage.

There is little doubt that injection sclerotherapy is currently the treatment of choice for the control of variceal haemorrhage being controlled in about 85-95% of patients presenting for treatment. The facilities for injection sclerotherapy, however, are not always available at the admitting hospital, and there may be no one present with the skill to inject a patient's bleeding varix. Consequently, there is a need for a stop gap treatment that is safe and effective and can be instituted rapidly without the need for special skills. As balloon tamponade of the oesophagus may be associated with a prohibitively high complication rate and requires skilled use, we believe that such circumstances necessitate a safe pharmacological agent to control bleeding. Evidence suggests that somatostatin is effective for this purpose. Clearly, however, further prospective randomised trials are required to confirm the role of somatostatin, and possibly its analogues, in controlling acute variceal haemorrhage.

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Abuse of fresh frozen plasma

Sir,—I agree wholeheartedly with Dr Jennifer Jones about the abuse of fresh frozen plasma (1 August, p 287), but she does not discuss its use in the special care baby unit, where it has been recommended for premature infants who are at risk from intraventricular haemorrhage and who commonly have a haemostatic defect which may contribute to their death.4 5 Over two years we identified 21 premature infants (gestational age 29 weeks, range 25-32 weeks) with abnormal clotting on the first day of life (international normalised ratio greater than 2.0, kaolin-platelet clotting time ratio greater than 2.0). Fifteen babies with abnormal clotting received fresh frozen plasma in a dose of 10 ml/kg and had a repeat clotting sample tested within 24 hours. In all the clotting ratios were normal. The mean reduction in international normalised ratio was 0.7 (range 0.2-1.5) and mean reduction in kaolin-clotting time ratio was 1.6 (range 0.6-4.5). During the period of study seven babies were found at necropsy to have substantial intraventricular haemorrhage. Of these two babies with abnormal clotting (international normalised ratio 1.9 and 3.2, clotting time ratio 6.0 and 6.0) had received fresh frozen plasma while five babies with normal clotting ratios had not received fresh frozen plasma. Thus, although we are confident that we can correct the haemostatic defect with fresh frozen plasma, we have no evidence that this can save lives.

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Rapid resolution of signs of primary intracerebral haemorrhage in computed tomograms of the brain

Sir,—I cannot agree with the uncritical dismissal by Dr MS Dennis and colleagues of magnetic resonance imaging in the investigation of stroke (8 August, p 379). They are also mistaken in their belief that it is the T1 relaxation time which distinguishes subacute haemorrhage from infarction and cite early work which did not compare haemorrhage and infarction but dealt with a small heterogeneous collection of intracranial haemorrhages imaged at different times on a low resolution prototype 0-170 tesla resistive system.

Numerous clinical studies have documented the superiority of magnetic resonance imaging over computed tomography in detecting cerebral infarcts.1 2 These changes in ischaemic brain are shown earlier on magnetic resonance imaging than computed tomography,3 because small increases in tissue water insufficient to change x-ray attenuation coefficients are shown by a prolongation of the magnetic relaxation time. This gives a typical isointense signal on a T1 weighted image and an isointense or hypointense signal on a T2 weighted image.

Although more noticeable on high field than on
Acute stress erosions: can they be prevented?

Sir,—We agree with Drs Gillian C Hanson and B G Gazzard (8 August, p 348) that the use of antacids and H₂ receptor antagonists should be restricted to patients who are at serious risk of haemorrhage secondary to stress erosions. We also agree that there is increasing evidence that antacids may be more efficacious than H₂ receptor antagonists. Antacids are, however, without their own side effects in critically ill patients, including hypermagnesaemia, hyperaluminaemia, metabolic alkalosis, diarrhoea, and constipation, and some impose a large sodium load. Furthermore, regular use is more time-consuming than the service for consumers, which must be able to see the effects of all professional groups, even doctors.

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Sir,—The Joint Consultants Committee is worried about Project 2000 (1 August, p 342); perhaps we can clarify some of the misunderstandings about it. Student status for nurses has been advocated since the Lancet report in the 1930s¹ and means that students would not be counted as part of the workforce; it does not mean they would have no clinical experience.

The high wage we have at present is because students are left to cope on the wards without adequate supervision or preparation. Sisters cannot give the supervision they would wish owing to the shorter working week, high patient turnover, and the change in the sister’s role.² A sister may have as many as 42 contacts to a ward and consequently a variety of patients requiring very different nursing care. Student status would enable students to learn the theory followed by appropriate supervised practice, and they would continue to have early contact with patients.

Nurses who already have student status — those following degree courses — have a low wastage rate and stay in nursing longer than others.³ Trainee nurses following the general registration programme are in school for only about 28 weeks during the three years. Such little theoretical input has no academic credibility and is insufficient to provide the nurse with the knowledge and understanding required today and in the future.

Project 2000 proposes a greater number of the in number of qualified nurses, which should mean that standards of care will improve. Any educational improvement is costly, and the profession would not want this at the expense of patient care. It requires central funding and a major investment now if we are to have a properly educated workforce to meet the needs of patients in the future. The status quo is not an option.

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References

How to signpost your hospital

Sir,—I enjoyed Dr Hugh Baron’s paper on how to signpost your hospital (22 August, p 482), and many hospitals could benefit from his advice. I would, however, take issue on two points.

He states that a sans serif rather than a serif typeface was chosen for motorway signs despite the Road Research Laboratory having shown no significant differences between the two. The fact is that a sans serif face was chosen because road signs had always been in sans serif type and there seemed to be no merit in changing a good example of one for a good example of the other. What the Road Research Laboratory did show was that it was the size and spacing of letters that were important, not whether they had serifs or not, and that at speed upper and lower case on a dark background were easier to read than signs all in capital letters. They also showed that the legend should as far as possible fill all the available space on the board.¹

Secondly, I am surprised that he totally ignores market research from the world of advertising. Ogilvie showed that, while a serif typeface is easier to read on the printed page, a sans serif face is easier to read at a glance—and a glance is all that a m

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