distribution of consultant and other medical services throughout the country. Would it not be better to distribute the extra consultants and resources to those districts that have a disproportionately low level of consultant provision and yet can be seen to use their consultants efficiently? Kenneth Clarke stated on television that the "size of the GP list is probably the best indicator of workload," and the same could be said for consultants: catchment population per whole time equivalent consultant surgeon is probably the best indication of surgical workload.

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Slicing up authors
Sir,—We found the news item "Publication: duplicate, salami, meat extender—all redundant, distasteful." Redundant publication is a legitimate point of debate but criticisms that potentially impugn authors' professional integrity, even by implication, should be made with great caution. Authors' redress is limited to the right of reply, and in this instance, this courtesy was not extended to Saad et al. Instead, readers were directed to their reply published in the New England Journal of Medicine, presumably on the basis that to publish their letter in the BMJ would have clagged "the literature and databases with the same material," wasted time of the editors and secretaries, and excluded "more deserving authors who play by the rules." Medical journals should adhere to the journalistic standards expected of the serious press. Sensational headlines are usually inappropriate. It should be recognised that, however unjustified, "... mud usually sticks." Impugning by implication the reputation of these authors was unwarranted. Your reviewers acknowledged that the two articles in the New England Journal of Medicine were largely identical, and their active principles carried the same warning that "diltiazem should be avoided and nifedipine or nicardipine preferred," the implication being that concurrent treatment with one of these calcium channel blockers is safer. While it may be true that concurrent use can be valuable and usually uneventful, the combination of β blockers and nifedipine also sometimes causes problems. There is a report of two patients of angina taking diltiazem or pranoprolol who developed cardiac failure when additionally given 10 mg nifedipine three times daily. The signs of failure disappeared when the nifedipine was withdrawn. Cardiac failure has also been described in two other patients taking atenolol who were given nifedipine and in another patient taking propranolol whose hypotension became so severe and prolonged that it may have been a factor which led to fatal myocardial infarction. These reports are few compared with those describing the advantages of concurrent use, but they clearly illustrate that the use of nifedipine is also sometimes not uneventful.

Drug Points
Are β blockers and nifedipine safe?
Dr HAN HSTOCKLEY (Department of Physiology and Pharmacology, Queen's Medical Centre, Nottingham NG7 2UH) writes: Drs A Hassell and J E Creamer suggest, after describing two patients of theirs taking β blockers who showed profound bradycardia when given diltiazem, that "diltiazem should be avoided and nifedipine or nicardipine preferred," the implication being that concurrent treatment with one of these calcium channel blockers is safer.

While it may be true that concurrent use can be valuable and usually uneventful, the combination of β blockers and nifedipine also sometimes causes problems. There is a report of two patients of angina taking diltiazem or pranoprolol who developed cardiac failure when additionally given 10 mg nifedipine three times daily. The signs of failure disappeared when the nifedipine was withdrawn. Cardiac failure has also been described in two other patients taking atenolol who were given nifedipine and in another patient taking propranolol whose hypotension became so severe and prolonged that it may have been a factor which led to fatal myocardial infarction. These reports are few compared with those describing the advantages of concurrent use, but they clearly illustrate that the use of nifedipine is also sometimes not uneventful.

Clearly, reports of adverse reactions like those described by Drs Hassell and Creamer should be published and become known, but it is equally important that a well rounded picture of the adverse reactions should be presented so that "safer" substances which also carry a risk, however small, are not suggested without such qualification being added.


Acute epiglottitis and Chloraseptic
Drs SHU-LEONG HO and K HOLLINRAKE (Department of Medicine, Walsgrave Hospital, Coventry CV2 2DS) write: We describe the development of acute epiglottitis, resulting in a life threatening airway obstruction, after the use of Chloraseptic (phenol) throat spray. It is advertised as a remedy for instant relief for sore throat.

A 7-year-old Afro-Caribbean woman was admitted in cardiorespiratory arrest. Resuscitation was started. She regained a full volume pulse less than half a minute after external cardiac massage was started. The electrocardiographic monitor confirmed the return of circulation. We suspected phenol toxicity and chlorimine poisoning. The patient was intubated pronounced oedema and oedema of her epiglottis and larynx, causing airway obstruction, were noted. There was no skin lesion. Blood cultures and laryngeal swabs were taken. Artifactual blood gases showed severe metabolic acidosis with pH 6.86, carbon dioxide pressure 17.4 kPa, and oxygen pressure 5.1 kPa. She was ventilated for 48 hours. Her temperature was 37.5°C and a chest x-ray showed consolidation in her right lung, thought to be right sided aspiration pneumonia. Antibiotics and dexamethasone were started. On extubation examination of her epiglottis and larynx showed that the inflammation had settled. Recovery was uneventful.

She had complained of a sore throat and runny nose two weeks before admission. She bought a Vicks Chloraseptic throat spray and sprayed it five times as prescribed on the bottle. She then felt a burning sensation of her throat after 1 minute forwards became acutely dyspnoeic. She lost consciousness in the ambulance. In 1983 she had undergone microlaryngoscopy for laryngeal nodules, which had not troubled her since. She had a six-year history of asthma and COPD, and had been receiving nifedipine for the past year for hypertension. There was no previous exposure to Chloraseptic spray or any history of atopic reactions.

On admission her haemoglobin was 179 g/l, white cell count 15.8 x 10⁹/l, neutrophils 10.9 x 10⁹/l, lymphocytes 3.45 x 10⁹/l, and eosinophils 0.4 x 10³/l; a sickle cell test was negative. Blood culture and laryngeal swabs showed that antibiotics were started. Sputum specimens taken after she was extubated showed no growth. Viral studies, including chlamydia, coxiella, and mycoplasma, showed no rise in titer. Her IgG titre was 301 (reference range 900-200 IU/l). Complement studies were normal: C1 inhibitor concentration was 0.27 g/l (normal range 0.18-0.30), C3 1.19 g/l (0.75-1.75), and C4 0.32 g/l (0.14-0.54). Five days after she was extubated a repeat chest radiograph showed clear lung fields.

The Chloraseptic liquid used in the throat spray contains as its active ingredient phenol and sodium phenolate equivalent to total phenol 1.4%, with sodium borate, menthol, and phenol, and glycerol. It has also been used as a gargle. Phenol is bactericidal in concentrations of 0.02-1%, bactericidal to some micro-organisms in concentrations as low as 0.04% and to all above 1.6%, and fungicidal in concentrations above 1.3%. It is not sporicidal. Concentrations above 0.5% cause a depolarising local anaesthesia. Its activity is greatly reduced or abolished in alcohol, glycerol, or alkaline solution. When moderate concentrations of phenol are applied to the skin or mucous membranes over the surface becomes white and opaque owing to the denaturation of tissue proteins. Oral ingestion can result in mucocutaneous and gastrointestinal corrosion.

The Committee on Safety of Medicines has received only nine reports of adverse reactions to single constituent preparations containing phenol. Chloraseptic is the only one available in the United Kingdom. Both diltiazem and nifedipine include anginoina (one), erythromycin base (two), glottis (one), and contact dermatitis (two). We think that this woman suffered a life threatening adverse effect from the Chloraseptic throat spray, although we are uncertain whether it was an anaphylactic type reaction or a direct toxic effect.