 Withdrawal of Rifamide

SIR,—May we echo the views of Professor J. D. Williams (6 July, p. 44) that the withdrawal of rifamide (Rifocin-M (Lepetit)) would be a retrogressive step. This drug attains exceptionally high levels in the biliary tree and has been described as "the only specific antibiotic" for cholecystitis,1 and its loss would leave a considerable gap in the antibiotic armamentarium. 5-Fluorocytosine is another infrequently used but equally specific drug. This compound was supplied free by Hoffman La Roche (a company which has come under heavy criticism from other quarters) to hospitals on request for many years.

Though we realize the commercial considerations in a free-enterprise drug industry, we believe Lepetit Pharmaceuticals Ltd will reconsider the withdrawal of rifocin-M or make it available on personal request.—We are, etc.,
D. S. Reeves R. Wise
Department of Pathology, Southmead Hospital, Bristol

1 Struthford, B. C., and Dixon, S., Medical Journal of Australia, 1966, 1, 1.

Inversion of the Appendix

SIR,—Incidental removal of the appendix is of undoubted prophylactic value and it is right that the technique should be as safe as possible. Some time ago I reviewed in some detail the methods of management of the appendix stump.2 There are three accept-able methods—amputation leaving a projecting stump, "burial" of the ligated stump with a retaining purse-string structure, and inversion of the ligated stump with retention by a purse-string suture. There is little to choose between these methods for the "cold" case but "burial" seems as safe as any; if this ever causes a small intramural abscess it is too small to be serious.

Inversion of the whole appendix after detachment of the meso-appendix is now advocated by Mr. F. S. Tait (29 June, p. 726). Even though in a large series he has not, so far, performed any, I wonder if this proposal is wise. After Edebohls introduced this technique in 1895 there were reports of bleeding from the inverted appendix and of sarcoma of the appendix. Mr. G. H. Dickson (18 May, p. 385) has added lately the additional complication of re-emergence of the appendix with ileal obstruction by adhesions.

I fear that if total inversion is generally adopted there will be a crop of obstructions by intussusception. Spontaneous inversion of the appendix, a rare but well-documented condition, is well known to cause caecal intussusception. It seems wise to create knowingly a situation which may give rise to such a dangerous complication.

In passing I would put forward the plea that surgeons should inform their patients more precisely when they remove the appendi-cinx in the course of an abdominal exploration. Too often one is faced in emergency with the situation where one may suspect that the appendix has been removed, particu-larly during a gynaecological procedure, but the patient has not the faintest idea of the answer.—I am, etc.,

Liverpool

John Shepherd


Anoxic-ischaemic Brain Injury

SIR,—In your leading article on this subject (13 July, p. 73) you say that the common clinical impression is that consciousness is lost after about six seconds of total arrest of cerebral circulation. I would say that it is a gross deal less than this. It is a time interval which is difficult to measure objectively, especially as the term "loss of consciousness" is not a precise one. A fairly accurate estimate can be made if it is possible to watch the patient and to take a continuous electrocardiogram at the time of a cardiac arrest. Such an opportunity will rarely occur, but I had the chance to do this on one occasion, and on two others when ventilricular standstill was provoked by carotid sinus pressure.3 In all three patients it seemed certain that consciousness was lost immediately or, say, within one second of the stopping of the ventricle. After a few seconds signs of epilepsy appeared, and this was something that could be measured more or less exactly. This and other sudden and clonic contractions of the limbs could be timed by their effects on the electro-cardiogram, and this varied from five to eight seconds after the ventricle stopped beating.—I am, etc.,

Harold Cookson

Lynchet, Malverns, Worcs.

1 Cookson, H., British Heart Journal, 1952, 14, 350.

Sterilization of Fibrescopes

SIR,—Your leading article on fibreoptics (20 July, p. 131) made interesting reading and encouraged a potential patient to expect faster and less traumatic diagnostic procedures when his time comes. However, as chairman of the Central Sterilizing Club, my heart sank at the prospect of yet more unsterilizable and even more expensive instruments becoming available. The only really satisfactory procedure for sterilization is autoclaving; others are, say, low-temperature steam and formic-acetic, ethylene oxide, and liquid chemicals in descending order of usefulness. To make matters worse many instruments are now so expensive that no one dare lend us one to test in case of damage.

May I plead for manufacturers and designers to remember the problem and to state clearly what methods, if any, can be used? If anyone has actually found a satisfactory way of dealing with specific instruments I would be grateful to hear about it so that the information can be made available to those who need it.—I am, etc.,

J. C. Kelsey

Deputy Director, Public Health Laboratory Service

Colindale Hospital, London N.W.9


Call to Arms

SIR,—It has now, I think, been made quite clear that the profession as a whole has been short-changed by the Review Body and indeed that the "wise men" themselves are not too happy about their findings. The time has come, therefore, to forget any internal differences that we may have and turn solidly to the support of the B.M.A. in the policy that it proposes—namely, graduated sanctions culminating, if necessary, in mass resignation.

My only fear regarding the B.M.A. is that it will "chicken-out" as it has been known to do in the past, but a massive show of support should minimize this risk and strong language is the only thing that this Government understands. Doctors should always remember that they are not only running a medical practice but also running a business and that a profit is desirable at the end of a year's work. No energy should be wasted on trying to set up an alternative health service. Should resignation come, then the patient must be expected to pay as was the case prior to N.H.S. It is true to say that no patient must be allowed to suffer physical hardship, but a squeeze on their pockets would help a great deal towards having our demands met and the N.H.S. reinstated.

Young doctors with mortgages etc. and old doctors with an eye on their pension should not worry about resignation—strong action and the fight will be short-lived. Support the B.M.A. and we shall win.—I am, etc.,

J. Miller Attenk

Dundee

Rescuing the N.H.S.

SIR,—There is no doubt that the Health Service is in a desperate state in many areas, there chronically underpaid and scarce staff face ward closures, lengthening waiting lists and deteriorating standards of care. On top of this, recent disputes have often proved crippling to all workers in the service.

The B.M.A. belief that what is needed is an immediate injection of £500m. is an