Antiobiotic Policy

SIR,—Resistant bacterial strains do emerge following the topical use of antibiotics, and outbreaks of infection by resistant organisms in a general surgical ward as a result of this have been recorded.1 The fact that sensitization to cephaloridine may occur is recognized by the manufacturers even if not by Mr. A. V. Pollock and Miss Mary Evans (16 August, p. 436). It has been stated that agents used for topical prophylaxis should not select resistant variants;2 yet resistance to the cephalosporins emerges in habituation experiments3 and in one clinical study resistance developed in four out of 25 patients treated with cephaloridine between the 5th and 15th days of therapy.4 The results of the open study in which cephaloridine was compared with povidoneiodine as prophylaxis against postoperative wound infection5 require careful appraisal. These Care II 

Treatment of Breast Cancer

SIR,—In your leading article “Screening for Breast Cancer” (9 August, p. 338) you justifiably pessimistic in recording the results of treatment of breast cancer when you state that “it is now evident that purely local treatment by surgery or radiotherapy rarely cures the disease.” Should this nihilistic position regarding breast cancer receive too much publicity among our patients it will lead to unnecessary anxiety. While I agree with you that in most patients occult dissemination of the cancer, long before a lump in the breast has been discovered, it should also be pointed out that when the cancer is confined to the breast, or to the breast and low axillary nodes, then mastectomy with axillary dissection is curative. Daland and Haagensen2 have both demonstrated survival rates of more than 60% 10 years after such treatment; in both series the survival rate after this time parallels that of the normal population. Less than 5% of patients with untreated breast cancer will survive five years.1 I will continue to perform mastectomy on all those patients who do not have signs of incurability until the group of patients without occult spread of the disease can be precisely defined. And that day, I fear, is a long way off.—I am, etc.,

J. L. CRAVEN
University Department of Surgery, Llandough Hospital, near Penarth, Glam.

Death during Dental Anaesthesia

SIR.—Dr. A. S. Mody (23 August, p. 488) describes yet another apparently inexplicable fatality associated with dental anaesthesia derived from an "on-demand" gas machine. The use of "on-demand" anaesthetic machines poses a number of problems, not the least of which is how to ventilate the patient with oxygen positively should the need arise. A popular solution is to plug a reservoir bag into the anaesthetic circuit. However, this may have disastrous consequences if the blow-off pressure of the patient's expiratory valve exceeds the gas delivery pressure. Almost complete rebreathing will occur in and out of the reservoir bag, with eventual severe hypercarbia and hypoxia in the patient. If, in addition, the halothane vaporizer has been positioned downstream from the reservoir bag very high concentrations of vapour will be treated by the patient. Thus with coexisting hypercarbia, hypoxia, deep anaesthesia, and possibly high blood catecholamine levels due to depressive fear the stage is set for ventilatory, vibrational, which seems a more likely cause for these fatalities than the vasovagal syncope so often cited.

If the "on-demand" anaesthetic machine is used an independent means of positively ventilating the patient with oxygen should be available. Even better, the use of a continuous-flow machine of the Boyle type would avoid the dangers I have described.—I am, etc.,

J. D. HILL
Epping, Essex

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