controlled studies of heparin treatment versus supportive treatment, but a review of the available literature strongly suggests that in most published series heparin has been of value in the treatment of the haemolytic-uraemic syndrome.

The use of thrombolytic therapy in the haemolytic-uraemic syndrome cannot be assessed simply by selecting those patients who have failed to respond to conventional therapy over prolonged periods or who present after some weeks of treatment at another institution. Such patients are obviously a selected group in whom improvement or cure from any form of therapy is most unlikely. Furthermore, the efficacy of thrombolytic therapy cannot be assessed only on the basis of reduction of mortality during the acute phase of the disease. In this sense it is particularly relevant that 52% of the children described by Gianantonio et al. had a high incidence of renal abnormalities, and we have observed similar findings (see table). The reduction of long-term sequelae of the haemolytic-uraemic syndrome reported by Monnens et al. and by Powell and Ekert1 is a strong indication for the use of thrombolytic therapy in this disease. There seems little to be gained from conservative management during the acute phase of the illness when probably half of the children may end up with renal injury.

Four lines of evidence have been used to indicate that the haemolytic-uraemic syndrome is the clinical counterpart of the Schwartzman reaction, in which repeated subminimal triggers produce a hypercoagulable state with fibrin deposition. These are: (1) occurrence of impaired renal function and a haemorrhagic tendency in both circumstances; (2) fragmentation of red cells and thrombocytopenia in both circumstances; (3) fibrin deposition in the renal arterioles and glomerular capsules with partial or complete cortical necrosis; and (4) response to anticoagulants. It is clear from experimental work that the Schwartzman reaction can be prevented by heparin if it is given early. Likewise, thrombolytic therapy can prevent the Schwartzman reaction if given within four hours of the provocative injection of the triggering agent. Thus the selection of patients for anticoagulant and thrombolytic therapy on the basis of failed response to conservative treatment will ensure that very few, if any, will obtain benefit from this form of treatment. I am, etc.,

E. Ekert
Royal Children's Hospital Research Foundation, Victoria, Australia


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<table>
<thead>
<tr>
<th>Treatment</th>
<th>Total No. of Cases</th>
<th>Deaths during Acute Illness</th>
<th>Chronic Renal Failure at Follow-up**</th>
<th>Normal at Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic only +</td>
<td>22</td>
<td>9</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Heparin for less than 3 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heparin for 3 or more days</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Symptomatic, heparin and aspirin, and/or dipyrindamide</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

*Patients in all treatment groups received dialisys and blood transfusion as necessary. Review of medical record showed no shrinking differences in therapy among treatment groups other than the use of heparin, streptokinase, and antithrombin agents.

**Shown by presence of hypertension and/or raised serum urea or creatine at least three months after acute illness.

E.C.T. and Cardiac Arrhythmia

SIR,—I would be grateful for space to support Dr. P. J. Ward’s letter (26 October, p. 229), particularly his last paragraph.

In my experience it is not reasonable to think in terms of a “mortality rate.” I have administered thousands of convulsive treatments by chemical, inhalant, and electrical induction and the worst accident so far was a broken dental plate. I always leave dentures in place when there are odd teeth which need to be supported during treatment—they are removed immediately afterwards.) This technique has proceeded from “straight” E.C.T. to treatments with anaesthetics alone and then with decamethonium (C10), gallamine, and suxamethonium. Dr. Ward mentions that tranquillizers, antidepressants, and barbiturates do not have obvious inhibitory effects on the induced convulsion, but in the course of my study of inhalation induction with flurethyl my colleagues Drs. A. Watson and Jean Harrison established that diazepam does have a marked inhibitory effect and that thiopentone inhibits to a greater degree than methahexatone; nevertheless, I prefer thiopentone and to ensure that the patient sleeps long enough to permit restoration of orientation on waking. I also prefer to use calibrated apparatus to establish the minimum discharge necessary for therapeutic response. With so many unwanted side effects and interactions of treatment the simpler the better. E.C.T. is one therapeutic weapon the administration of which is not very well taught.—I am, etc.,

London W.1.

L. Rose

Consultant Contract

SIR,—The Bath District Medical Committee feels deep concern at the policy which is currently being put forward by the Department of Health and Social Security in their recent report on the development of community hospitals.

The Bath Health District is perhaps unique in having 22 local hospitals in the towns which surround the City of Bath, and those working for the district have a special knowledge of the benefit of such an arrangement. The majority of the consultants from the district general hospital in Bath regularly visit these local hospitals. As a result there is a very close relationship between the consultant and family practitioner and mutual understanding of each other’s problems and the patient’s needs. This leads to better treatment of the patient.

In particular, the committee felt that if all surgery, obstetric, and other acute work was to be carried out in the district general hospital, then community hospitals would be left to care mainly for geriatric patients, and staff, particularly nursing staff, would have their range of work restricted, which would result in greatly diminishing interest and morale. This will be detrimental to the recruitment of nursing staff. It would seem that unless the Department’s proposals are modified the service offered at present by our local hospitals could well deteriorate.—We are, etc.,

HOWELL JOHN
Chairman
JOHN E. U. MOXON
Vice-chairman
JOHN G. MEADOWS
Secretary,
Bath District Medical Committee


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[Note: The document contains various references and appendices, but for the purpose of this transcription, we will focus on the main content.]