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# BRITISH MEDICAL JOURNAL

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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

## Reactions to dextran

SIR,—Professor N L Browse and his colleagues have written a very interesting account of methods they adopted to prevent postoperative pulmonary embolism (27 November, p 1281). They were very fortunate to observe no side effects from dextran (p 1283). We are writing to emphasise that side effects due to dextrans 40 and 70 require serious attention. The issue of the *BMJ* which contains the paper by Professor Browse and his associates also includes an account by Dr T G Feest (p 1300) of episodes of renal failure caused by low-molecular-weight dextrans. This year we have been dismayed by two severe reactions to dextran 70. We have therefore stopped using it routinely for the prevention of postoperative phlebotrombosis and pulmonary embolism.

**Case 1**—This patient had an alarming adverse reaction which we were sure was anaphylaxis attributable to the infusion of only a few millilitres of 6% dextran 70 (Lomodex 70, Fisons). A healthy 42-year-old nurse was anaesthetised for postnatal tubal ligations. Shortly after induction of general anaesthesia a dextran 70 infusion was started. When only a few drops of the solution had been given urticaria appeared in the arm receiving the infusion and in her face and neck, and her heart stopped. Death was averted only by rapid vigorous resuscitation.

**Case 2**—This patient also exhibited a severe reaction to a small amount of Lomodex 70 and we believe that the hypoxia occurring during prostration was responsible for acute fetal distress. A 21-year-old subfertile primigravida at term (married five years) was given dextran 70 because she had a painful swollen leg. An immediate reaction took place. Maternal pallor and hypotension was accompanied by profound fetal bradycardia and passage of meconium when amniotomy was performed.

These cases have been reported to the Committee on Safety of Medicines.

Dr R A Thompson, of the Regional

Immunological Laboratory (East Birmingham Hospital), and Dr J Brostoff (Middlesex Hospital, for Fisons Ltd) have very kindly examined sera from these patients in order to study the mechanisms underlying the anaphylaxis.

We have studied some reports about reactions induced by dextran and found no grounds for complacency. Bauer and Ostling<sup>1</sup> referred to a patient who died from circulatory arrest after a dextran reaction. Representatives of Fisons, the makers of the dextran we used, kindly supplied copies of many other reports.<sup>2-14</sup> We found these articles very disturbing. Dextran reactions may be uncommon, but we believe that they are too dangerous for us to carry on with a dextran 70 routine for the prevention of postoperative clots.

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- <sup>1</sup> Bauer, A, and Ostling, F, *Acta Anaesthesiologica Scandinavica*, 1970, **37**, suppl, p 182.
- <sup>2</sup> Bailey, G, et al, *Journal of the American Medical Association*, 1967, **200**, 889.
- <sup>3</sup> Brisman, R, Parks, L C, and Haller, J A, *Journal of the American Medical Association*, 1968, **204**, 324.
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- <sup>5</sup> Getzen, J H, and Speigle, W, *Archives of Internal Medicine*, 1963, **112**, 168.
- <sup>6</sup> Gonzalez, D, Gurdjian, E S, and Thomas, L M, *Neurology*, 1970, **20**, 1139.
- <sup>7</sup> Henley, E E, McPhaul, J J, and Albert, S N, *Medical Annals of the District of Columbia*, 1968, **27**, 21.
- <sup>8</sup> Maddi, V I, Wyso, E M, and Zinner, E N, *Angiology*, 1969, **20**, 243.
- <sup>9</sup> Maltby, J R, *British Journal of Anaesthesia*, 1968, **40**, 552.
- <sup>10</sup> Michelson, E, *New England Journal of Medicine*, 1968, **278**, 552.
- <sup>11</sup> Shephard, D A E, and Vandam, L D, *Anesthesiology*, 1964, **25**, 244.
- <sup>12</sup> Vitali, P, and Cavagnini, F, *Anestesia Rianimazione*, 1969, **10**, 339.
- <sup>13</sup> Waldhausen, E, et al, *Anaesthesist*, 1975, **24**, 129.
- <sup>14</sup> Webster, A L, Comfort, P T, and Fisher, A J G, *South African Medical Journal*, 1973, **47**, 2421.

## The NHS is dead: long live the NHS

SIR,—Dr T F Davies's open letter to Sir Alec Merrison (4 December, p 1376) is an impressive collection of inaccuracies, unsupported assertions, non sequiturs, and illiteracies. I will not comment on the illiteracies because the medicoliterary giants whose letters have recently sparked in your columns seem unable to instruct others without falling over their own feet; besides, it would take too much space.

The notion that teaching hospitals must be more efficient than peripheral hospitals is not supported by the figures quoted in Dr Davies's table. Both teaching hospitals were less successful in saving the lives of patients with myocardial infarction than three of the peripheral hospitals and no more successful than two more. The results could be the starting point for a study of the factors that make some hospitals better than others but, as they stand, prove nothing.

Primary medical care, we read, should be "a disease prevention service combined with appropriate screening programmes." Appropriate to what? I would like to see Dr Davies produce evidence that screening for anything but hypertension and pulmonary tuberculosis has affected morbidity and mortality figures. Disease prevention and health education have traditionally been the business of the medical officer of health, now the community physician, but the general practitioner repeatedly tells his fat patients to eat less and his patients with bronchitis, peptic ulcer, or angina to stop smoking cigarettes. Basic and self-evidently good advice, one would think, but while medical treatment is free people will not stop doing what they enjoy because they are told it is bad for their health.

"Fifty per cent of ill patients are seen in less than five minutes," says Dr Davies. Most of these, if they are ill at all, are suffering from minor, self-limiting diseases. The other 50% need and have more time spent on them. The first lesson learnt by an apprentice GP is that the problems he fails to solve this week will return next week and the week after that