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BRITISH MEDICAL JOURNAL

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SATURDAY 22 JANUARY 1983

LEADING ARTICLES

- Campylobacter enteritis in the community** JANE SYMONDS 243
Ventilation in operating rooms P D MEERS 244
Skin replacement after burns J E LAING, P G SHAKESPEARE 245

- Artificial blood** PETER M JONES 246
Alcohol and advice to the pregnant woman
GRIFFITH EDWARDS 247

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

- Smoking, lung function, and body weight** B NEMERY, N E MOAVERO, L BRASSEUR, D C STĂNESCU 249
Acute acalculous cholecystitis complicating systemic lupus erythematosus: case report and review
CHARLES R SWANEPOEL, ANDREW FLOYD, HUGO ALLISON, GENEVIEVE M LEARMONTH, MICHAEL J D CASSIDY, MICHAEL D PASCOE 251
HLA-DR typing in identical twins with insulin-dependent diabetes: difference between concordant and discordant pairs
C JOHNSTON, D A PYKE, A G CUDWORTH, E WOLF 253
Long-term continuous intraperitoneal insulin treatment in brittle diabetes
G POZZA, D SPOTTI, P MICOSSI, M CRISTALLO, M MELANDRI, P M PIATTI, L D MONTI, A E PONTIROLI 255
Release of oxytocin and prolactin in response to suckling ALAN S MCNEILLY, IAIN C A F ROBINSON, MARY J HOUSTON, PETER W HOWIE 257
Decline in rate of death from ischaemic heart disease in the United Kingdom R F HELLER, D HAYWARD, M S T HOBBS 260
Neurological effects of recombinant human interferon HOWARD SMEDLEY, MAUREEN KATRAK, KAROL SIKORA, TERENCE WHEELER 262
Quinine-induced granulomatous hepatitis BENNY KATZ, MICHAEL WEETCH, SAIF CHOPRA 264
Simple rule for calculating normal erythrocyte sedimentation rate ANDREW MILLER, MALCOLM GREEN, DAVID ROBINSON 266
Acebutolol-induced hypersensitivity pneumonitis G M AKOUN, D P HERMAN, C M MAYAUD, J Y PERROT 266
Effects of amiodarone in thyrotoxicosis J SHELDON 267
Electrically heated gloves for intermittent digital ischaemia G E KEMPSON, D COGGON, E D ACHESON 268
The GP and the Specialist: Diabetes mellitus P J WATKINS 269
Teaching students in an Aberdeen practice F P HOWARTH 272
Problems of rural practice J McALLISTER WILLIAMS 274
Thinking About the Unthinkable: Service committee hearing ZOË KENYON 275

MEDICAL PRACTICE

- Computed tomography in the investigation of dementia** J R BRADSHAW, J L G THOMSON, M J CAMPBELL 277
Effect of genetic counselling on the prevalence of Huntington's chorea CEDRIC O CARTER, KATHLEEN A EVANS, MICHAEL BARAITSER 281
ABC of Brain Stem Death: The arguments about the EEG CHRISTOPHER PALLIS 284
Confirming the diagnosis of mild hypertension R M HARTLEY, R VELEZ, R W MORRIS, M F D'SOUZA, R F HELLER 287
Identification of adverse reactions to new drugs. II—How were 18 important adverse reactions discovered and with what delays?
GEOFFREY R VENNING 289
Letters to a Young Doctor: Community physician's tasks PHILIP RHODES 293
Any Questions? 294
Medicine and Books 295
Medicine and the Media—Contributions from D R LAURENCE, COLIN CURRIE, SUE BURKHART 300
Personal View D G MODEL 302

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FEB 18 1983

- CORRESPONDENCE—List of Contents** 303

- OBITUARY** 312

NEWS AND NOTES

- Views** 315
Medical News—RCP report on obesity 316
BMA Notices 317
One Man's Burden MICHAEL O'DONNELL 318

SUPPLEMENT

- The Week** 319
Protecting personal data WILLIAM RUSSELL 320
From the council: Doubts on World Medical Association 321
New fee structure for police surgeons 324
Data Protection Bill: BMA briefs Lords 324
Association Notices: NHS reorganisation—division titles and boundaries 324

CORRESPONDENCE

Deaths and dental anaesthetics T B Boulton, FFARCS; J M Cundy, FFARCS; Margaret L Heath, FFARCS; A S Gardiner, FFARCS; J G Bourne, FFARCS.....	Out of court settlements by defence organisations J Galway, FFARCS.....	Advertisements for doctors with particular religious beliefs G Fazal, MB, and others.....
303	307	310
Need our streets be so filthy? Clare M Hardwick.....	Research in general practice A P Presley, MRCGP.....	Doctors in occupational medicine F H Tyrer, MB.....
304	307	310
Swallowing tablets and capsules G M Ardran, FRCR.....	Shortlisting trainees H W Fladée, MRCGP.....	Containment of costs in private practice H K Basu, FRCS.....
304	308	310
A new danger associated with airgun pellet injuries W D F Smith, MRCP; H Earl.....	Death due to overdose of indoramin R Hunter, MB.....	Stephen Duckworth Appeal Fund S Duckworth.....
305	308	310
Lectin content of slimming pills D C Kilpatrick, PHD, and others.....	Alternative medicine: cost and subjective benefit in rheumatoid arthritis M D Guild, MB.....	Points Anaphylactoid reactions due to haemodialysis, haemofiltration, or membrane plasma separation (Dr R Ahmad and others); Diploma in medical practice in developing countries (H M Lipman); Are there two kinds of ward round? (K Ball); Help after a road accident (P H Spriddell); Illness of Dorothy Wordsworth (J Findlater); Zoography: the use of animal terms in medicine (L Picton Davies); BCG vaccina- tion scars (N Islam); Apical pulse rate and atrial fibrillation (M G Jacoby); Do it yourself obituaries (G Sanderson).....
305	308	311
Letters to a young doctor P Rhodes, FRCOG; D G Wilson, FRCGP.....	Examination for diploma in child health A D M Jackson, FRCP.....	Corrections Hours of work of junior hospital doctors (Berrill); Bromocriptine induced psychosis (Procter, <i>et al</i>).....
305	308	311
Ambulatory blood pressure during administration of atenolol, metoprolol, pindolol, and slow release propranolol A J Man in 't Veld, MD, and M A D H Schalekamp, MD; B N C Prichard FRCP..	Death from asthma in two regions of England G Fowler, FRCGP, and others.....	
306	308	
Cot deaths and medical communication D Loshak.....	Rugby football injuries to the cervical spine R W Porter, FRCS.....	
307	309	
Value of the Medical Defence Union M Allen, MB.....	Imprisonment of Dr Anatoly Koryagin A Wynn, FRACP.....	
307	309	
	Using computerised lists of doctors J Williamson, FRCPED.....	
	Manpower proposals D Roy, FACS.....	
	310	

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

*Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by *et al*; and the first and last page numbers of articles and chapters should be included.*

Deaths and dental anaesthetics

SIR,—May I congratulate Dr Brian Lewis on his wise, fair, and clear headed leading article (1 January, p 3)? Dr Lewis distinguishes clearly, as many unfortunately still do not, between the safe intravenous and inhalational sedative and analgesic techniques short of loss of consciousness, which are now available to operating dental surgeons, and full general anaesthesia with the loss of protective pharyngeal reflexes. He also rightly includes the so called intermediate techniques (usually intermittent methohexitone administrations) in the category of full general anaesthetics, at which a second trained medical or dental practitioner solely responsible for the anaesthetic should be present. I hope that it is unnecessary to add that neither sedative nor general anaesthetic techniques should be administered except in the presence of nurses and attendants trained to assist with such techniques.

If we could get the leaders of the medical and dental professions and the Department of Health and Social Security to accept these definitions and their implications we could go a long way towards solving the problems and increasing the safety of outpatient anaesthesia. We could go still further if (as Dr Lewis suggests) we could induce the department to stop paying for full general anaesthesia administered by the operator and, instead, to devote the money thus saved to paying an adequate fee both for the administration of full general anaesthesia by a second trained medical

or dental practitioner and to a trained operating dental practitioner for administering sedative techniques.

The implementation of the Seward report, for which both Dr Lewis and myself fervently hope, would also imply that medical or dental practitioners who seek to undertake to administer general anaesthesia or sedation should have received adequate postgraduate training in the use of these techniques.

T B BOULTON

Association of Anaesthetists of
Great Britain and Ireland,
London WC1

SIR,—Dr E B Lewis's explanation for the low mortality rate of the technique of nitrous oxide associated with hypoxia could be read as an apology. Surely we should be asking those who use this technique to prove that there is no risk of cerebral damage, and in the absence of such proof we should condemn the technique to the dustbin of anaesthetic history. Likewise we should be critical of the use of benzodiazepines in ambulant patients. Allowing anyone to drive within six hours of administration of 15 mg of intravenous diazepam shows ignorance of both the pharmacokinetics and the behavioural effects of this drug.^{1 2} Patients should be warned of the amnesic effects, not allowed home unaccompanied, and told not to drive or use potentially harmful machinery for at least 24 hours.

Interestingly the latest confidential inquiry into maternal deaths shows the extreme safety of modern anaesthesia when dealing with a healthy population. Thus in the triennium 1976-8 only two anaesthetic deaths occurred in patients undergoing suction termination of pregnancy. Yet one of those deaths occurred when after premedication with papaveretun and hyoscine hydrobromide (Omnopon-Scopolamine) 20 ml of epidural bupivacaine (Marcain) was administered followed by 10 mg of intravenous diazepam. The obstetrician-anaesthetist then undertook the termination, during which the patient aspirated stomach contents and subsequently died. It should be clear that a person performing an operation cannot also perform the essential functions of an anaesthetist—namely, to maintain respiration and circulation.

The dental operator-anaesthetist is now as anachronistic as the surgeon-anaesthetist, and Dr Lewis's contention that the Dental Estimates Board should not be paying wages for these people's sins deserves our ardent support.

J M CUNDY

Lewisham Hospital,
London SE13 6LH

¹ Baird ES, Hailey DN. Plasma levels of diazepam and its major metabolites following intramuscular administration. *Br J Anaesth* 1973;45:546.

² Cundy JM. Medical aspects of fitness to drive. *Anaesthesia* 1979;34:1056-9.