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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

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.

Oral narcotic mixtures

SIR,—In his leading article Dr E R Hillier (10 September, p 701) emphasises the cheapness, efficacy, and safety of oral narcotic mixtures and asks why they are not used more. He was referring mainly to relief of pain in adults with neoplastic disease, but I would like to extend his arguments to the care of children—not only in regard to terminal pain (which is rare in paediatric practice) but also to the far more common varieties of pain and fear associated with the general care of children in hospital. These include preoperative and postoperative pain, burns, fractures, and the pain of "minor" procedures such as dressings and suturing. In all of these, oral morphine is often the treatment of choice, but is seldom given for a variety of reasons. Common errors include: (*a*) failure to use a narcotic drug at all, usually because of essentially irrational fears of addiction or respiratory depression; (*b*) preference for the parenteral route when the oral would suffice. In practice "parenteral" usually means the traumatic intramuscular route rather than the intravenous, because of the widespread retreat of our nursing colleagues from giving drugs into intravenous lines, and (*c*) lack of generosity regarding dosage or frequency of administration. In practice the narcotic drug used is often pethidine and the dosage used is often less than half of that required, mainly due to the influence of the *Paediatric Vade Mecum*, which persists in giving an upper limit of 50 mg of pethidine for an adult. Inadequate frequency is usually the result of prescribing analgesia on an "as required" basis, whereby the effect of the previous dose is allowed to wear off and the child has to experience real pain again before he is allowed a further dose, which is contrary to all the principles of pain relief.

The end result of all these tendencies is that children are suffering unnecessary severe pain, fear, and possible emotional damage which is often detrimental to their medical management. All these defects in the control of pain seem to be deeply ingrained in our medical and nursing traditions. Professor Rhodes (10 September, p 747) speaks with feeling of his postoperative sufferings and makes a plea for us all to re-evaluate our practices. Surely here is a challenge to all involved in undergraduate and postgraduate teaching.

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SIR,—I applaud and support Dr Hillier's plea for the more widespread use of monocomponent oral opiates in terminal cancer, but I am surprised that he made no mention of tablets of diamorphine or slow release morphine. We find these have considerable advantages because of their simplicity, safety, and security, and we reserve opiate solutions for the very few patients who are unable, or unwilling, to take tablets.

We also find there is a small place for oxycodone suppositories. One firm appears to have the monopoly of their manufacture, and they are not always freely available, but they can provide an acceptable substitute for injections.

BRUCE SYMONDS

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SIR,—I was pleased to see that you had given prominence to the important subject of pain control in the patient with terminal malignant disease and in particular the emphasis on simple narcotic mixtures.

I think, however, that Dr Hillier's information is misleading in two respects. The potency of morphine to diamorphine is normally taken as 1·5:1, and the shelf life of morphine in chloroform water is very much longer than one month. On the other hand, diamorphine salts rapidly hydrolyse in solution and may lose 10% of their efficacy in 10 days, and therefore diamorphine solutions should be used well within one month. It might also be worth pointing out that in addition to the general caution in the use of narcotic analgesics opiate toxicity in the elderly is a known risk and therefore patients aged over 70 should be started on a smaller dose.

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Weever fish sting: the last word

SIR,—Since there appears to be quite an interest in the problem of weever fish stings (6 August, p 406, and 20 August, p 559) perhaps your readers would be interested in some of its history. The venom of this fish, like that of the stingray and scorpion fishes (which included the lion fishes and the stone fishes), is an unstable protein. Weever fish venom is composed of several peptides, a protein of high molecular weight (among others), a kinin or kinin like substance, and possibly serotonin, adrenaline, noradrenaline,