BRITISH MEDICAL JOURNAL

SATURDAY 18 OCTOBER 1986

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SUPPLEMENT

NO 6553 BRITISH MEDICAL JOURNAL 1986 VOLUME 293 971-1044
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 293 (6553) 971-1044 (1986)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Halothane and the liver

SIR,—The recent statement by the Committee on Safety of Medicines on halothane and the liver and its recommendation that the minimum interval between halothane anaesthetics be extended from 28 days to three months[1] concern us because we fear that some may see them as a signal that the use of halothane in routine practice should be substantially reduced or abandoned. On present evidence such a change in anaesthetic practice would not only be without justification but might be harmful to patients.

Epidemiological studies over 25 years have failed to yield firm evidence on the factors predisposing to halothane hepatitis. All have concluded that the condition is rare: the incidence is estimated to be 1/10 000 to 1/35 000 halothane anaesthetics. The possible role of repeated exposure to the drug has been recognised at least since the report of Walton *et al* in 1976.[2] Nevertheless, cases have occurred after single exposures and after exposure intervals longer than 28 days or even three months. Special attention has been focused on unexplained fever and severe nausea and vomiting after halothane as possible indicators of a likely future adverse reaction to the drug. The diagnosis is made only by excluding other likely causes of hepatitis—a difficult task in the complex conditions of the postoperative period, especially after multiple operations, a circumstance which may make for over-reporting of halothane hepatitis to the CSM.

We recognise that the CSM has a duty to monitor reports of adverse reactions to halothane and to offer guidance on the basis of its findings. The CSM cannot indicate the totality of the risk associated with particular drugs and techniques.

For almost 30 years halothane has enjoyed a reputation as a reliable and usually safe anaesthetic. It is more potent than enflurane or isoflurane and less irritant to the respiratory tract than isoflurane. These properties may confer an important advantage when there is a need to deepen the level of anaesthesia quickly, given that the maximum output of most vaporisers is 5% (vol/vol) nominal. Inability to control the level of anaesthesia effectively is always an immediate threat to a patient's life if regurgitation or airway obstruction supervenes. Such problems are not, of course, normally reported to the CSM.

On the present evidence we believe that it is desirable for there to be a choice of volatile anaesthetics: halothane, enflurane, and isoflurane. That choice should be a clinical decision, exercised responsibly with due regard to the patient's anaesthetic history and with careful recording of untoward effects, whatever the drugs used.

Finally, it has been suggested that halothane liver injury will be increasingly likely to attract actions for litigation (28 June, p 1691; 2 August, p 335), although, to our knowledge, no case has been pursued successfully as a civil action in the United Kingdom. An anaesthetist who departed from the CSM recommendations on the interval between halothane anaesthetics, having carefully considered the options and the patient's condition and recorded appropriate reasons for the choice of halothane, would not, in our opinion, be acting negligently. A more rigorous view than that would be expensive and nonsense. On the basis of its statement we believe that the CSM would concur with that view.

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1 Committee on Safety of Medicines. Halothane hepatotoxicity. *Current Problems 18* 1986;Sept:1-2.
2 Walton B, Simpson BR, Strunin L, Doniach D, Perrin J, Appleyard AJ. Unexplained hepatitis following halothane. *Br Med J* 1976;i:1171-6.

Is there an ideal body weight?

SIR,—Professor R J Jarrett (23 August, p 493) rediscovered that the risk of premature death is not a simple direct function of relative body weight. Apparently that fact, well established from various prospective studies, is not yet common knowledge in the medical profession, let alone the general public. This deficiency prevails in all "developed" countries; in the least developed countries the popular view is the reverse: obesity is prized as a sign of "health." A brief review of the facts is overdue.

Professor Jarrett attributes to me information about the role of the late Dr Louis Dublin and the Metropolitan Life Insurance Company in creating body weight standards.[1] Labelled "ideal weight" in 1943, the Metropolitan tables, revised in 1959 and more modestly termed "desirable weight," covered three "frame" types—small, medium,