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LEADING ARTICLES

- Anorexia page 639 Towards an Artificial Liver page 640 Experts and Child Abuse
page 641 Choice of Contraceptives 642 Metabolism and Infarction page 643
Lichen Planus—Some Progress page 643 Women's Athletics page 644

PAPERS AND ORIGINALS

- Treatment of Post-Herpetic Neuralgia by Prolonged Electric Stimulation P. W. NATHAN, P. D. WALL..... 645
Vitamin D and Myocardial Infarction VICTOR LINDEN..... 647
Blood Levels and Management of Lithium Treatment JOHN L. CRAMMER, RACHEL M. ROSSER, GRAHAM CRANE..... 650
Nephrotic Syndrome in Chronic Lymphocytic Leukaemia J. R. E. DATHAN, M. F. HEYWORTH, A. G. MACIVER..... 655
Renal Insensitivity to Frusemide Caused by Chronic Anticonvulsant Therapy SUHAIL AHMAD..... 657
Familial Trends in Low Birth Weight FRANK JOHNSTONE, LESLEY INGLIS..... 659
Blood Muramidase Activity in Colorectal Cancer E. H. COOPER, R. TURNER, L. STEELE, J. C. GOLIGHER..... 662
Case of Glomerulonephritis Associated with Acute Toxoplasmosis
B. E. GINSBURG, J. WASSERMAN, GUNNEL HULDT, A. BERGSTRAND..... 664

MEDICAL PRACTICE

- 134 Battered Children: A Medical and Psychological Study SELWYN M. SMITH, RUTH HANSON..... 666
School Health Education in Sweden G. D. RIPLEY..... 670
Clinical Medicine and Research in Britain P. MEYER..... 673
Makerere Medical School: 50th Anniversary W. D. FOSTER..... 675
In Vivo Tests of Thyroid Function C. W. H. HAVARD, MARGOT BOSS..... 678
Any Questions? 681
Personal View S. BRADSHAW..... 682

CORRESPONDENCE—List of Contents..... 683

OBITUARY NOTICES 691

BOOK REVIEWS 693

NEWS AND NOTES

- Epidemiology—Toxoplasmosis 695
Medicolegal—Injuries to Unborn Children..... 695
N.H.S. Finances: T.U.C. Debates..... 697
Medical News—Institute for Hearing Research..... 698

CORRESPONDENCE

Correspondents are asked to be brief

Danger of Saline Emetics in First-aid for Poisoning C. J. C. Roberts, M.R.C.P., and M. J. Noakes, M.B.	683	Tapeworms and Isolation F. J. Wright, F.R.C.P.	685	TSH Level and Thyroid Function G. Antony, M.D.	688
Safety and Fibreoptic Bronchoscopy P. Hugh-Jones, F.R.C.P.	683	Hypertension and Myocardial Infarction D. M. D. Lambert, M.R.C.G.P.	685	Myeloblastic Transformation B. T. Colvin, M.R.C.P., and others	688
Place of Diagnostic Radiology in Medicine A. S. Bligh, F.F.R.	684	Chickenpox from Herpes Zoster P. J. Wilkinson, M.B., and others	686	Screening for Rickets S. A. Haider, M.R.C.P.GLAS.	688
Dangers of Oxytocin-induced Labour to Fetuses G. V. P. Chamberlain, F.R.C.O.G.	684	Alkaline Phosphatase Levels in Epileptic Subjects D. J. F. Rowe, PH.D.	686	Treatment of C.N.S. Involvement in Systemic Lupus Erythematosus Y. Levo, M.D.	689
Complications of Carbenoxolone Therapy I. D. Heath, M.R.C.P.; D. O. Gibbons, M.R.C.P.	684	Larrey and Debridement D. H. Patey, F.R.C.S.	686	Disruption of the Family L. C. Hurst, M.R.C.PSYCH.	689
Beta-adrenergic Blocking Agents in Patients with Renal Failure D. J. Warren, M.R.C.P., and others	685	Infections in Asplenic Adults E. Ask-Upmark, M.D.	687	B-Lymphocytes as Target Cells for E.B. Virus Transformation F. Mizuno, and others	689
Malabsorption in Overland Travellers to India A. M. Tomkins, M.R.C.P., and W. P. James, M.D.	685	Amitriptyline Poisoning in Childhood T. L. Chambers, M.R.C.P., D.C.H., and A. D. Kindley, M.B.	687	Emergency Bed Service C. D. Walker, M.B.	689
Wartime Penicillin Sir Ian Fraser, F.R.C.S.	685	Lawn Mower Injuries R. G. Thompson, M.R.C.S., and I. A. Harper, M.R.C.PATH.	687	Meeting the Need for Doctors T. S-B. Kelly, F.R.C.S., and S. D. V. Weller, F.R.C.P.	689
		Alliterative Anxiety about Arsenic S. K. Goolamali, M.R.C.P.	687	Doctors' Pay S. Mehta, F.F.A.R.C.S., and others; A. R. Rogers, M.B.	690
		Pontomedullary Listeriosis in Renal Allograft Recipient A. G. Samuel-Gibbon, B.M., and others	687	G.M.C. By-election G. N. Jamieson, M.B.; M. M. Hasan, M.B.	690

Danger of Saline Emetics in First-aid for Poisoning

SIR,—Your leading article entitled "First-aid for Poisoning" (26 January, p. 130) states that the case for the use of most first-aid methods of inducing vomiting is "scientifically thin." It points out that the effect of taking an emetic made up with two tablespoonfuls of salt in a tumbler of tepid water is unpredictable.

We have recently reported the case of a 26-year-old woman, who died after the administration of an emetic containing 150 g of sodium chloride (6 dessertspoonfuls) in the first-aid treatment of a relatively minor overdose of an aspirin-containing analgesic.¹ The main features of her illness were severe metabolic acidosis and a cerebral disorder giving rise to generalized myoclonus and repeated convulsions with hyperpyrexia. Others have reported similar cases.^{2,3} Ward⁴ has warned that saline emetics may precipitate pulmonary oedema. Since our case occurred two further unpublished cases of

coma apparently caused by saline emetics have been brought to our attention.

There is evidence then that the administration of large amounts of salt to induce emesis is accompanied by considerable danger. The danger is enhanced by the widely held belief that this common household remedy is completely safe regardless of dosage. We would recommend that first-aid books which carry recipes for salt emetics should also warn against overdose.—We are, etc.,

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¹ Roberts, C. J. C., and Noakes, M. J., *Postgraduate Medical Journal*, 1974, 50, 513.

² Laurence, B. H., and Hopkins, B. E., *Medical Journal of Australia*, 1969, 1, 1301.

³ Robertson, W. Q., *Journal of Pediatrics*, 1971, 79, 877.

⁴ Ward, D. J., *British Medical Journal*, 1963, 2, 432.

Safety and Fibreoptic Bronchoscopy

SIR,—A leading article which may help to increase the safety of any diagnostic procedure is indeed welcome. Unfortunately, it seems to me that your leading article (31 August, p. 542) on fibreoptic bronchoscopy omits important information and is consequently misleading.

It rightly implies in the first paragraph that Dr. Ikeda's introduction of the flexible instrument in 1968¹ opened up new horizons for the endoscopist; and for the chest physician or surgeon there is at last a chance of diagnosing much more lung cancer at a curable stage. So it is important not

to suggest that it is a dangerous procedure unless that is a fact.

A point not mentioned in your article is that it is imperative to have adequate experience in the use of a rigid bronchoscope before using a flexible instrument. The latter has not replaced rigid bronchoscopy. The first step, both diagnostically and for safety, is to decide which instrument to use on which patient or whether to combine them, and by what route the flexible instrument, if used, shall be introduced. A flexible bronchoscope can be passed through the nose, the mouth, a rigid

bronchoscope, an endotracheal tube, or a tracheostomy tube, and either local or general anaesthesia can be used with any of these routes.

The transnasal route requires a minimum of topical anaesthesia if a suitable intranasal tube is used. I found no difficulty in inserting a flexible bronchoscope into my own trachea, seeing my own carina, and then talking in a Donald Duck sort of way. It is the ideal route for outpatients and bedside bronchoscopy and satisfactory in about 80% of patients—the rest either have too narrow nasal airways or too sharp a bend in their nose for it to be comfortable or even practicable. Your article mentions neither the technique of Smiddy *et al.*² nor that of Marvin Sackner and his co-workers.^{3,4} These last are important references.

But for prolonged search and careful inspection of the tree to third or fourth generation bronchi and taking scrapings, brushings, and biopsy in the search for early cancer the flexible instrument is best passed through a cuffed endotracheal tube with an attachment at the proximal end giving a T-junction for ventilating the patient and a diaphragm with a central hole in it to support the fibreoptic bronchoscope in the centre of the airway. I learnt this technique from the practice used in the Mayo Clinic-Johns Hopkins programme for the early diagnosis of lung cancer.⁵ This technique is to safety in fibreoptic work through an endotracheal tube what the Hart technique is to rigid bronchoscopy.⁶ It is remarkable to me that this work, perhaps the most extensive in the U.S.A., is not even mentioned in your article. I have used this technique,⁷ slightly modified, since I visited Dr. Marsh at the Johns Hopkins Hospital. Our concurrent mass spectrometer sampling of expired gases