and will only see cases referred from other consultants. As a result there is considerable detachment of the neurological services as far as general practitioners are concerned.

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SIR,—Dr Anthony Hopkins (9 June, p 1733) has drawn attention to the progressive isolation of neurologists that has followed the decision to stop advertising for physicians "with an interest." Another consequence is that a registrar who moves into the specialty and remains for more than a year is likely to have difficulty in getting back into the mainstream of clinical medicine. Nevertheless, it takes about three years of concentrated clinical experience for a post-membership trainee to become competent in clinical neurology. One of the difficulties for physicians with an interest who had less training was that they attracted progressively more neurological cases and had neither the experience nor the facilities to deal with them.

The location of beds is important. Beds in a general hospital are always in demand for emergencies, and patients needing inpatient investigation tend to be kept waiting or squeezed out. When the beds are in a small hospital which does not take emergencies the patients are isolated from facilities for investigation.

While there may be a case for physicians with adequate training doing part time neurology, there is surely an even greater need for neurologists to deal with emergencies in their own specialty. To do this they must have beds in the general hospital for cases of stroke, status epilepticus, subarachnoid haemorrhage, and other acute conditions. In this they can usefully collaborate with neurosurgeons as well as other physicians. Cases of this type form a considerable component of medical emergencies, and a neurologist would be better used in this way than in managing cases that properly belong to other specialists.

Neurological symptoms account for about a fifth of medical outpatients. The neurologist is in the best position to select those who require special tests, but this means seeing many patients who do not require investigation at all.

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SIR,—We have reviewed the diagnoses of 265 patients admitted to a general medical ward, which does not admit cardiac patients, from 19 March to 14 June 1984. Patients being observed after drug overdoses accounted for 71 admissions. Of the remainder 57 (30%) were neurological admissions. The reasons for admission were: epilepsy (17), investigation of headache (13), stroke (11), subarachnoid haemorrhage (5), multiple sclerosis (3), transient ischaemic attack (2), cerebral neoplasm (2), and miscellaneous (3).

These figures exclude acute admissions to our geriatric medical unit, although a survey of all such admissions during 1982 showed that a similar proportion of patients (188 out of 613 (31%)) had active neurological problems on admission. There were more cases of strokes—101 (54% of the neurological cases).

Obviously not all of these patients require assessment by a neurologist. The hospital has excellent neurological backup: a consultant neurologist has monthly clinics, seeing both outpatients and inpatients, and we have access to regional neurosurgical opinion. We feel, however, that the general medical workload would support a physician with an interest in neurology.

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Hidden dangers of sliced bread

SIR,—I was pleased to read Mr N J Bundred's article concerning the dangers of ingested bread wrapper clips, but I think he understates the dangers. I have been interested in bread clips since November 1983 when I performed emergency right hemicolectomy for an ileocolic intussusception. A bread clip was firmly attached to the bowel wall at the apex of the intussusception. The patient, who had presented in a very unkempt state, was a respiratory cripple and unfortunately died of respiratory failure six weeks after surgery.

I thought his death was partly due to the need for surgery immediately after the ingestion of the bread clip. I contacted the Federation of Master Bakers, which informed me that after a letter in the *Lancet* it had set up a committee to look into ways of making clips safer.¹ It later said that the problem must be rare as it had heard of no other cases, despite the sale of at least 10m clips each day.

I thought the problem was more extensive than this but I was surprised to find two further cases at Swindon. One, a 60 year old woman who later died, was first operated on in June 1982 for an unexplained intra-abdominal abscess. This operation was complicated by the development of small bowel fistulas. At a second laparotomy a bread clip was found lying free in the peritoneal cavity. The fistulas, however, persisted and pancreatitis supervened. The patient died after a protracted illness of four months. The second case was a 49 year old woman who presented with dysphagia and had a clip removed from the middle third of the oesophagus endoscopically. Her recovery was uneventful.

The lodging of clips in the oesophagus is, however, not without danger. I have been informed of a case where the clip caused dysphagia and a barium swallow suggested a carcinoma. At thoracotomy, after excision of the oesophageal mass (later found to be inflammatory), a mediastinal abscess was found containing a bread clip which had presumably eroded through the oesophageal wall. The patient unfortunately died later of complications of the major surgery.

These clips represent avoidable danger to life, and I hope that in reporting these three fatal cases I can influence the Federation of Master Bakers. Perhaps simply enlarging the clips would be sufficient to prevent their accidental ingestion?

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¹ Rivron RP, Jones DRB. A hazard of modern life. *Lancet* 1983;iii:334.

Conservative management of pregnancy in diabetic women

SIR,—Both Dr J Murphy and others (21 April, p 1203) and Dr John M Stronge and Dr M I Drury (19 May, p 1539) advocate conservative management of pregnancy in diabetic women and quote excellent results. While it is true that the widespread use of home glucose monitoring and stricter attention to diabetic control in pregnancy now make it unnecessary to admit most diabetic women to hospital, it is important to recognise that even very close control of diabetes does not achieve the even pattern of blood glucose concentrations seen in the non-diabetic pregnant woman. Furthermore, it does not guarantee that pregnancy complications will not develop or that the fetus will be unaffected.

The delivery of a baby typically affected by diabetes at the end of a pregnancy in which the diabetes is impeccably controlled is well described¹ and accords with our own experience. Fetal macrosomy (> 90th centile) was present in 30% of 100 women whose diabetes was well controlled at King's College Hospital from 1982 to 1984, indicating that the fetus had been affected by the maternal diabetes in spite of good control. Why one woman with well controlled disease gives birth to a macrosomic baby and another apparently similar woman has a normal sized baby is not clear. It would seem that a macrosomia factor operates in some pregnancies where the diabetes is well controlled.

Developing macrosomia can be detected by serial ultrasound scanning, and we believe it is prudent to consider delivery before full term in these women, generally at or about 38 weeks. To allow a macrosomic fetus to continue to grow disproportionately even larger in the last two weeks of pregnancy is to invite a difficult delivery and perhaps to risk an unexplained late intrauterine death. The need is to individualise management, which in our hands has produced a reasonably low perinatal mortality rate of 3.2% in 463 consecutive diabetic pregnancies (1971-83).

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¹ Knight G, Worth RC, Ward JD. Macrosomy despite a well controlled diabetic pregnancy. *Lancet* 1983;iii:1431.

Breaking bad news

SIR,—Dr Robert Buckman (26 May, p 1597) made some valid points, especially concerning the fears that some doctors have of performing badly and creating a problem that they cannot handle while bad news is being broken. I take issue, however, with his conclusions that teaching of such skills would need only minor alteration in the curriculum and that such a skill can be taught.

There have been many studies looking at the reactions of patients to bad news, and although Dr Buckman quotes his own experience many studies have pointed to the fact that doctors are appallingly bad at giving bad news. Much of this blame is, of course, related to the news itself rather than the performance of the doctor. The teaching about physical disease is based on each disease having at least something