may represent an absence of vascular response to ketanserin at the latter site but could be due to technical problems of using this method to assess circulation in sclerodermatous skin. The results of ketanserin treatment for ulceration in scleroderma appear to be less favourable than the results in treating Raynaud's phenomenon.

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1 Dowd GSE, Linge K, Bentley G. Measurement of transcutaneous oxygen pressure in normal and ischaemic skin. *J Bone Joint Surg* 1983;**65B**:79-83.

Blood pressure follow up with nurse practitioner assessment and microprocessor based data retrieval

SIR,—In the concluding paragraph of their article on blood pressure follow up by nurse practitioners (1 September, p 537) Dr P C Rubin and others suggest that such work is repeated in other settings. I and my colleagues have done this in four general practices in a study (in press) which measures the effects not only on systolic and diastolic pressures but also on smoking, weight loss, drug consumption, patient attendance, and acceptability to doctors and patients. It also attempts to measure the contribution that the micro-computer makes to the work.

But there is another important issue raised in their last question and in our and other studies. General practitioners regard continuity of care and the comprehensive nature of the problems as a keystone. With the development of many clinics—often staged by others interested in hypertension, diabetes, paediatric surveillance, and many other areas of work—where goes this continuity? What is the trade off in the balance between increased effectiveness and efficiency in a limited area of care with the total care of the whole person? Can we design patterns of work which meet both these requirements?

I believe these to be other important topics for study in our attempts to provide high quality primary care.

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Treating fissure in ano in outpatients: what dose of local anaesthetic?

SIR,—Dr Steen Lindkaer Jensen and others (1 September, p 529) state that their operations were performed under local anaesthesia by deep injection of 25-30 ml 2% lignocaine (Xylocaine) without noradrenaline on each side of the anal canal. If we infer correctly this equates to a total dose of between 1000 and 1200 mg of lignocaine and substantially exceeds the maximum recommended dose of 200 mg for local anaesthesia.

They also state that patients were allowed home 30 minutes after their operation. If outpatient surgery is performed using such large doses of lignocaine it is important to emphasise that the patient should not drive a motor vehicle for some time afterwards. The recommended period of abstinence from

driving after an injection of 200 mg of lignocaine is one to one and a half hours.

We think that the difficulties in achieving adequate anaesthesia for lateral subcutaneous sphincterotomy and anal dilatation, without giving potentially toxic doses of lignocaine, make this technique unsuitable for routine use on outpatients.

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SIR,—The report of Dr Steen Lindkaer Jensen and others on treating fissure in ano recommends a dose of lignocaine far in excess of that usually regarded as safe. Their dose of "25 to 30 ml of 2% lignocaine without noradrenaline on each side" is probably about 14 mg/kg in an average adult. This is twice the safe dose with a vasoconstrictor and almost five times the safe dose without. Surely the figure is a misprint?

If not I take issue with their last statement that the procedure is done "easily and safely." Both brief skilful general anaesthesia and sacral epidural (caudal) anaesthesia are acceptable for day care patients, and there is no need to employ a technique which is less than perfect to avoid these alternatives.

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*** Dr Jensen and others reply below.—ED, *BMJ*.

SIR,—Dr Diggory and Dr Simkin, and Dr Skinner, have made an important comment. We state that local anaesthesia was performed by deep injection of 25-30 ml 2% lignocaine (Xylocaine) without noradrenaline on each side of the anal canal. This dose is indeed far above the recommended dose of 200 mg for local anaesthesia.

A misprint has, however, occurred in the paper, which we unfortunately overlooked. We used 25-30 ml lignocaine with noradrenaline (12.5-15 ml on each side of the anal canal). Furthermore, no patients were allowed to drive a motor vehicle after the operation—they were all transported home.

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Are there any absolute medical contraindications to the progestogen only oral contraceptive?

SIR,—I agree entirely with Dr Linda Beeley's answer to the above question (1 September, p 545), but I want to add two further contraindications.

The progestogen only pill is absolutely contraindicated between evacuation of a hydatidiform mole and the return to normality of gonadotrophin values in the urine (confirmed in the serum). Professor K D Bagshawe's team has shown that the use of the combined pill at this time more than doubles the risk of invasive mole or choriocarcinoma requiring drug treatment.¹ Subsequent research at the same centre

has confirmed this association, and there is no evidence that the progestogen content is unimportant (as has been suggested in Canada²). Indeed, the reverse may be true (Joan Dent, personal communication). Prudence dictates that the progestogen only pill is absolutely contraindicated until human chorionic gonadotrophin activities are undetectable in serum—that is, less than 2 IU/l. Fortunately this occurs in most women within four or five weeks.

The second absolute contraindication in my view must be past ectopic pregnancy. The association between ectopic pregnancy and the progestogen only pill is well established.³ It is not certain whether the pill causes the condition or merely fails to prevent its manifestation in a woman with tubal damage from past pelvic infection. Whatever the mechanism the implications are the same—a woman possessed of only one tube should not use either the progestogen only pill or an intrauterine device but should choose a method which is as effective in preventing tubal as intrauterine pregnancies. The best choice will lie between a male or female barrier and the combined pill.

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- 1 Stone M, Dent J, Kardana A, Bagshawe KD. Relationship of oral contraception to development of trophoblastic tumour after evacuation of a hydatidiform mole. *Br J Obstet Gynaecol* 1976;**83**:913-6.
- 2 Ho Yuen B, Burch P. Relationship of oral contraceptives and the intrauterine contraceptive devices to the regression of concentrations of the beta subunit of human chorionic gonadotropin and invasive complications after molar pregnancy. *Am J Obstet Gynecol* 1983;**145**:214-7.
- 3 Liukko P, Erkkola R, Laaks O. Ectopic pregnancies during use of low-dose progestogens for oral contraception. *Contraception* 1977;**16**:575-80.

Donor ureteric calculus presenting as acute rejection in a renal transplant recipient

SIR,—Urinary tract lithiasis in patients who have received kidney transplants is a well known complication which has been reported in as many as 10% of patients.¹ Dr P K Donnelly and others (30 June, p 1961) describe a patient whose stones presented problems soon after transplantation. They think that the stone was probably present in the donor ureter at the time of transplantation.

We have observed stones in 15 of our 558 patients who have received transplants; in seven the stones presented within 45 days. Not one of these patients or their donors (nine cadavers and six living donors) had evidence of stones before or at the time of transplantation. In six cases stones were spontaneously passed or diagnosed in the bladder, and clinical symptoms were mild and non-specific or non-existent. The remaining patient was admitted to our unit 45 days after transplantation because of a sudden increase in serum creatinine concentration, fever, oliguria, and graft tenderness. Ultrasound examinations showed urinary tract dilatation, and pyelography showed a large radiolucent stone.

In these patients factors such as hyperparathyroidism, hypophosphataemia, hyperphosphataemia, hypercalciuria, urinary tract infection, and reduced ureteric motility are often present and may favour the development and enlargement of stones. Thus the early appearance of stones is not enough to prove that a stone was present in the donor.

In our series nine patients developed further