happen in practice. If the GP had the day off, his own patients would be unable to consult him—thereby decreasing continuity of care. Dr Hobday suggests that if his idea was implemented a singlehanded practitioner with an average list size would deprive only 13 patients of a personal visit. This is correct only if the GP "on the road" all night works normally the following day.

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SIR,—Dr Paul J Hobday's account of the general practitioners' night workload in Maidstone makes interesting reading, particularly for those who may advocate a salaried service. He may be right to say that change is inevitable but not I hope a change which leads to 93 general practitioners being on call at night only once every six weeks.

The figures from which he draws his conclusions differ considerably from previous studies. I believe that there are two simple reasons for this. Firstly, although there may be no seasonal variation in the Kent family practitioner committee figures, this does not mean that the figures for three months' visits can be extrapolated with any accuracy to give an annual figure. My own figures for night calls during 1983 illustrate the point: January 6; February 6; March 6; April 3; May 1; June 8; July 6; August 2; September 5; October 8; November 3; December 9. Thus while the total was 63 extrapolation of any of the 10 consecutive three month periods would give figures ranging from 40 to 80 visits a year. Secondly, the inadequacy of the sampling is further borne out by the fact that the sample studied constituted 13% of Kent's general practitioners yet they performed only 7% of the county's night visits.

Having arrived at the figure of 6.2 night visits for each 1000 patients a year, Dr Hobday cannot say when studying a range of 32 practices covering groups of one to six doctors that "one general practitioner will do one night visit roughly every eight nights on duty." With an average list of 2099 the night visit rate for each doctor is 13 a year or one in every 28 days. For a singlehanded practitioner this means one in 28 days on duty, while for a partner in a six doctor practice it means one in 4½ days on duty. Such a call out rate should not cause bad tempers next day to the detriment of the doctor's work.

Furthermore, the quoted night visit rate of 3.3 for the total of practices under study hardly constitutes a case for the on call general practitioner being "on the road" all night—for even at that rate there will be variations between perhaps 0 and 6. This leads me to challenge the statement that having several general practitioners available for each visit required is "extremely inefficient." Would it not be far more inefficient to have one doctor "on the road" each night impatiently waiting for the next call to come in?

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SIR,—Dr Paul J Hobday's survey of out of hours calls in Kent shows that a service based on two general practitioners covering a whole district at night would not be overwhelmed by seasonal or day to day variations, although Ridsdill-Smith's study did show a higher rate of units in October and December.¹ Indeed, given an average number of calls of 3.3 a

night and assuming a Poisson distribution to apply, eight calls would be expected to occur on only one night in 100.

Dr Hobday states, however, that "these figures show inefficient use of expensive and highly trained medical manpower." One might wonder how the new system would actually reduce costs since general practitioners' remuneration for out of hours calls is linked to arrangement being made for the provision of the service no matter who actually provides it. Furthermore, each general practitioner will do the same number of units per year, and it might be argued that the occasional night visit in an area one knows might cause less disruption than a busier night once every six weeks working in an unfamiliar area.

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β blockers and verapamil: a cautionary tale

SIR,—Dr S J Hutchison and others (15 September, p 659) provide a timely reminder of the untoward effects that can occur when the calcium antagonist verapamil is used in combination with a β adrenoceptor blocker.¹⁻³ In addition to a mutual potentiation of effects, particularly on cardiac conduction and contractility (pharmacodynamic interaction), verapamil undergoes rapid and extensive first pass hepatic metabolism, raising the possibility of a pharmacokinetic interaction with lipid soluble β adrenoceptor blockers—for example, propranolol, oxprenolol, and metoprolol—which undergo similar biotransformation.

Theoretically the water soluble β adrenoceptor blocker atenolol may be a safer choice, but in our study of 15 patients with angina pectoris we found considerable morbidity with this combination: four patients experienced profound lethargy; one developed frank left ventricular failure; and four had important bradyarrhythmias (symptomatic in two) documented by 24 hour ambulatory monitoring.⁴ Mean plasma atenolol and verapamil concentrations were unchanged from those during monotherapy, suggesting a pharmacodynamic interaction (unpublished data). Interestingly in hypertensive patients we found a much lower incidence of electrophysiological or haemodynamic side effects during combination treatment with propranolol and verapamil.⁵ While we agree that this very effective combination can be potentially hazardous in certain patients, it may be that it is better tolerated in patients with hypertension. It remains to be determined whether this reflects a difference between the patient groups in, for example, cardiac reserve or simply a lesser degree of β blockade in the hypertensive patients studied.

None the less, this combination can cause appreciable deterioration in cardiac performance in patients with normal or near normal left ventricular function.² In general, it is not possible without invasive electrophysiological study to assess the integrity of cardiac pacemaker tissue. This is particularly important in patients with coronary heart disease in whom latent dysfunction may be present.

We think that verapamil should be used in

combination with a β adrenoceptor blocker only under the close supervision of a hospital clinic, doses should be individually titrated (particularly the dose of β adrenoceptor blocker), and fixed dose combinations should be avoided. The eventual role of this potentially useful combination awaits the publication of further controlled studies with varying dose regimens and employing β adrenoceptor blockers with differing ancillary properties.

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Appropriate technology: equipment for the gastroenterologist

SIR,—I agree with Mr John Nicholls's emphasis (1 September, p 549) on the value of endoscopy in the Third World.¹ I disagree, however, with what he writes about laparoscopy: "[laparoscopy] demands experience and you also need expensive apparatus and a supply of carbon dioxide gas." I believe that laparoscopy is cheap, safe, easy, and an excellent technique for the diagnosis of diseases of the liver and peritoneum in developing countries. The capital cost of laparoscopy is much less than for gastroscopy, and with a cheap adapter you can use the same light source. The equipment can also be shared with gynaecologists, which further reduces cost, and is robust and can be easily sterilised; and laparoscopy can be done in the endoscopy room without using theatre time. In most cases the alternative to laparoscopy is laparotomy, which entails at least a week in hospital, whereas after laparoscopy the patient stays only overnight. The technique of laparoscopy is easily learned and is easier to master than gastroscopy.² Furthermore, it is safe: Berci combined several series to reach a total of 111 713 patients and found a mortality rate of only 0.07%.³

The supply of carbon dioxide is not a problem as it is produced by plants producing oxygen which are available in most cities. A cylinder of 1000 cc capacity can easily be used for over 15 laparoscopies.

Laparoscopy is valuable in diagnosing many liver conditions (especially hepatomas where guided biopsies can be obtained) and can be used even when coagulation defects do not permit liver biopsy since bleeding at a laparoscopy puncture site is controllable. It is also valuable in diagnosing tuberculous peritonitis, which is a common problem in most developing countries: laparoscopically guided biopsy of the peritoneum is positive in at least three

quarters of patients with tuberculous peritonitis.⁴

My own experience in the Sudan of over 60 laparoscopies done over 18 months is rewarding. I found it an extremely useful and cost effective procedure, which must be mastered by every gastroenterologist practising in a developing country.

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Multiple myeloma on the Fylde coast

SIR,—Dr E G Jessop and Dr S D Horsley (14 July, p 84) have shown that diagnostic bias does not account for the observed excess of myeloma in south Cumbria. The Blackpool, Wyre, and Fylde health authority is responsible for about 300 000 people, in three county districts (fig), and we have calculated expected numbers for the incidence of myeloma on the basis of national cancer registration rates and compared these with the number of observed cases for 1979-83 (table).

The overall observed incidence (79 cases) is close to expectation (79.8 cases), although there is a considerable north/south variation. This pattern is not repeated for the distribution of our cases of chronic lymphatic leukaemia, another B cell disorder with a similar age distribution. There is no obvious explanation

County districts of Blackpool, Wyre, and Fylde.

for the pattern of myeloma incidence, which may be a chance finding or may reflect different aetiological risks in the northern and southern districts. The Sellafield nuclear power station is some 40 miles from the north Fylde coast, and we are aware of recent suggestions that this may have some aetiological role, but any confident interpretation of aetiological factors is premature.

We have also found that the annual number of cases has increased steadily over the past five years, and our incidence figures will need regular review. In fact in the 14 months ending 29 February 1984 33 new cases have been diagnosed.

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Unrecognised psychiatric illness in medical patients

SIR,—Having worked in the neurological unit studied by Dr Keith W Bridges and Professor David P Goldberg (15 September, p 656), I was naturally interested in their paper. Although not a member of the department at the time of the study, I suspect that Dr Bridges and Professor Goldberg overestimate the percentage of unrecognised psychiatric morbidity. All physicians realise that symptoms of depression and anxiety are common in hospital inpatients. The fact that no explicit reference to such conditions is made in the notes does not necessarily mean that it has gone unrecognised. The authors comment that they have no knowledge of how best to manage their patients, but it would be interesting to know how often, in their opinion, the psychiatric morbidity was underestimated to a serious extent. (For example, how often would they have felt that prescription of an antidepressant was appropriate rather than simple supportive treatment?)

Dr Bridges and Professor Goldberg have drawn attention to the major difficulty of managing a patient rather than an illness—a concept which still receives more prominence in theory than in practice. There remains a tradition of full physical investigation before deciding that symptoms are “functional.” Dr Bridges and Professor Goldberg point out the error in this approach.

The organisation of most busy neurology units is based on the need to investigate large numbers of patients efficiently and quickly. Sir John Nabarro recognises that a great deal

will depend on the dedication and interest of the registrar. Unfortunately, junior doctors intending to specialise in hospital medicine are not encouraged to gain experience in psychiatry or general practice. Certainly, there are now few easy opportunities to acquire such experience. This applies even in neurology, where there are very few senior house officer or registrar posts giving exposure to psychiatry. The converse is also true: psychiatrists in training have little exposure to general medicine. The inevitable and unfortunate result is lack of contact between physicians and psychiatrists, in both training and career posts. Neither group receives adequate training in the skills of the other, and there is a consequent failure to deal with the patient who has the temerity to “overlap.”

How can this problem be resolved? There is no easy answer. Much depends on the individual physician, his inclinations, and the time he has at his disposal. None the less, there are things which should be done. Two of the most important defects mentioned by Dr Bridges and Professor Goldberg concern the lack of privacy and the difficulties inherent in a traditional medical ward round. The DHSS should be encouraged to study the costs and benefits of providing better interview facilities on general medical wards. This sort of expenditure is unlikely to be welcomed by district treasurers but would be appreciated by doctors and patients alike.

Sir John Nabarro recognises the need for more consultants but does not think the country can afford it. Even in our present straitened circumstances this seems a poor excuse, and I feel sure that if the political will were there the funds would be forthcoming.

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SIR,—I was privileged as a student to be taught by young Dr John Nabarro. Naturally I learnt a lot of medicine, but in those days we acquired no useful psychiatry. Today it is very different. When students graduate they know how to take a psychiatric history and examine the mental state of the patients they will look after as housemen. They are conversant with psychological problems. Not necessarily so, their consultants. I doubt therefore Sir John's assertion (15 September, p 635) that “an even better history would probably be taken by the consultant.”

Nowadays there are many more housemen so each should have less specialised medical or surgical work to do. The preregistration year is an extension of basic medical education, to fit young doctors for the generalities of medical practice. It is a pity if, as Sir John asserts

Incidence of multiple myeloma in the Blackpool, Wyre, and Fylde health authority, 1979-83

	Fylde			Blackpool			Wyre			Total		
	Expected cases†	Observed cases	Standardised registration ratio‡	Expected cases†	Observed cases	Standardised registration ratio‡	Expected cases†	Observed cases	Standardised registration ratio‡	Expected cases†	Observed cases	Standardised registration ratio‡
Men	8.2	6	75	18.4	15	82	12.1	21*	174	38.7	42	109
Women	9.1	3*	35	20.0	15	75	12.0	19	158	41.1	37	90
Total	17.3	9*	52	38.4	30	78	24.1	40**	166	79.8	79	99

* $p < 0.05$ (two-tailed tests).

** $p < 0.01$.

† Calculated on the basis of cancer registration rates for England and Wales, 1977-80. Population estimates from the county reports of the 1981 census for England and Wales.

‡ Standardised registration ratio = observed cases/expected cases $\times 100$.