After nine days on this dose a test was made and the result was "serum lithium: nil detected."—I am, etc.,

J. G. WEIR

London W.1

Compensation for Personal Injury

SIR,—Many orthopaedic surgeons will welcome the Government's decision to set up a Royal Commission on compensation for personal injury (*B.M.J.*, 30 December, p. 802) and will hope for a modification of the present legal arrangements, which so often serve to prevent or delay a patient's recovery. Now once an injured person believes he is suffering as a result of someone else's negligence and that he is accordingly entitled to hope for financial compensation a severe blow is struck at his will to recover. Without such a will the efforts of his medical and other advisers are largely stultified and considerable exaggeration and prolongation of the disability often follow. I am not writing of deliberate malingering for financial gain, which is relatively uncommon and usually easily recognized when attempted, but of a subconscious compensation neurosis which all too readily develops in the months following an injury, often in patients who have shown great courage and determination in the early stages of their treatment. Such a man becomes a neurotic burden to himself and to all concerned with his welfare, a situation which often seems directly attributable to the delays and uncertainties of the present legal procedures.

The principle of compensation for the effects of another's negligence is a fair one, but its implementation needs drastic revision. Entitlement to compensation, if not automatic, needs to be decided at a very early stage so that the patient is relieved of the anxiety brought on by uncertainty. The extent of the special damages attributable to his injury similarly needs prompt recommendation, possibly based on a tariff and administered by a special branch of the judicial system. If the special damages were payable promptly, but only on the completion of medical treatment they would form a positive inducement to recovery instead of a golden millstone around the neck of the unfortunate beneficiary.—I am, etc.,

A. J. HARROLD

London W.1

Cutaneous Sarcoidosis in Venepuncture Sites

SIR,—In the interesting cases of sarcoidosis collected by Dr. B. W. Hancock (23 December, p. 706) some of the granulomas developed where venepuncture had been performed for blood donation. Might not an intracutaneous injection of saline (or of the patient's blood) therefore be as effective in diagnosing early sarcoidosis as an injection of Kveim homogenate? Erythema nodosum is often visible and painful evidence of subcutaneous sarcoid granulomas. The skin lesions are distributed dependently in the legs, and rarely also in the forearms. The hydrostatic pressure may locally damage the overlying skin so that it is temporarily vulnerable to minimal trauma. The subcutaneous granulomas themselves, however, are painless. In a similar sort of way beryllium dust may perhaps have an adjuvant effect,

so that otherwise silent cases of sarcoidosis are sometimes unmasked. It is probably significant that in some industrial cases of chronic berylliosis the patient simply lived in the vicinity of the factory but never worked there at all.—I am, etc.,

GERALD MACGREGOR

Chilworth, Surrey

Severe Hyponatraemia in Hyperlipaemic Diabetic Ketosis

SIR,—In their interesting case report (23 December, p. 709) Dr. J. A. Bell and others point out the drawback of assessing plasma water concentration by the technique of evaporation to dryness in hyperlipaemic diabetic ketosis.

The plasma water content may be more readily obtained by measurement of plasma osmolality and then repeating the measurement after dilution of plasma by an equal volume of unionized water. Then plasma water (%) = $\frac{\text{osmolality of dilute plasma} \times 100}{(\text{plasma osmolality} - \text{osmolality of dilute plasma})}$.

Electrolyte concentrations in the water phase may then be easily calculated.—I am, etc.,

J. M. RAWLES

Department of Medicine,
University of Aberdeen

Skin Reaction to Isopropyl Alcohol

SIR,—Recently a patient was admitted for radiotherapy who had a bad eczematous reaction in the skin of both cubital fossae which had been ascribed to Elastoplast allergy. She had developed a deep venous thrombosis postoperatively and had been treated with a drip infusion of heparin. Elastoplast had subsequently been placed on her arms.

After admission blood was taken for prothrombin time estimation and a similar eczematous reaction developed on the back of the hand at the site of venepuncture. This could not have been due to Elastoplast, as this had not been used, but it was noticed that the fingers which had held a Medi-swab (saturated with 70% isopropyl alcohol) on the puncture site were also eczematous. A crude but effective skin testing system was set up and pieces of Elastoplast, cotton-wool, a Medi-swab, a Medi-swab whose isopropyl alcohol had been allowed to evaporate, and a needle were all applied to the skin. The area under the Medi-swab became very red and itchy while the other areas were unaffected.

This suggests that some people can be allergic to simple substances like isopropyl alcohol. This is now almost universally used to clean skin before venepuncture and this type of reaction may be quite common. It is also possible that some cases of "Elastoplast allergy" are in fact due to some other, simpler, substances like isopropyl alcohol.—I am, etc.,

ANGUS MCINNES

Western General Hospital,
Edinburgh

Drugs in Infertility

SIR,—Your expert's recent "Today's Drugs" article (21 October, p. 167) and subsequent letters from Dr. G. I. M. Swyer (18 November, p. 425) and Professor I. D. Cooke (30

December, p. 794) were interesting, and call for a small added comment.

It is all too common to find that the male partner in a subfertile marriage has been overlooked until his wife has had considerable preliminary investigation. In the Bristol male subfertility clinics investigation of approximately 300 men a year rarely reveals a fully fertile husband. Clomiphene may well be the only drug yet available with a possibility of stimulating spermatogenesis, but it is extremely difficult to prove—or refute—its efficacy and correct dose, and its applications may not yet be determined.¹ I fully agree with Dr. Swyer and Professor Cooke that mesterolone is a disappointingly weak androgen, which possibly accounts for its claimed lack of inhibition of gonadotrophin. It is difficult to understand how it can possibly stimulate spermatogenesis in males already producing adequate endogenous testosterone, and in order to produce normal levels of testosterone in hypogonadal males, sufficient to result in penile development it is necessary to give 200 mg daily for one to two years, and such patients are likely to be subfertile anyway.

Undoubtedly clomiphene has been a major factor in the successful treatment of anovulation, and Dr. Swyer's statement that ovulation occurs 8-12 days after a course has been substantiated by our experience of successful pregnancy on four occasions after therapeutic donor insemination; 200 mg clomiphene had been given daily for five days and insemination was carried out seven days later, on day 16 of the cycle.—I am, etc.,

G. L. FOSS

United Bristol Hospital

¹ Foss, G. L., Tindall, V. R., and Birkett, J. P., *Journal of Reproduction and Fertility*, 1973, 32, 167.

Psychiatric Day Care

SIR,—The article by Dr. D. H. Gath and others (13 January, p. 94) is indeed timely (though I suspect too late) in pointing out, *inter alia*, that a large proportion of day hospital patients have long-term needs which might be difficult to meet in the district general hospital units. Their findings support the view that a large proportion of the total psychiatric day population is made up of patients with chronic disorders of poor prognosis who maintain a high rate of daily attendance over a long period of time and have become long-term day patients as a direct result of the closure of mental hospital beds. With the rundown and eventual closure of these hospitals it is certain that the numbers of such patients in the community will multiply.

The hospital in which I work is located within an industrial county borough area and it serves a population of 330,000 persons. It has its own outpatient department and has recently been provided with a custom-built day unit to which is attached an industrial therapy unit. There are 30 beds in a detached unit intended for short-stay patients and another 60 intended for short/medium-stay disturbed patients within the traditional mental hospital itself. There are, of course, long-stay and psychogeriatric wards as well. In fact, under various pressure all these short/medium-stay beds tend to be used for the admission and readmission of patients with all types of psychiatric disorder regardless of age and

mental state. The overall average age of 45% of all inpatients exceeds 65 years.

This hospital is now functioning on about 1.0 beds per 1,000 of the population served, and this figure has been achieved over the past 12 years by high turnover of short-stay beds, rigid control of geriatric admissions, but above all by the cutback in readmissions resulting from the support of discharged chronic psychotics and other recently discharged mentally ill persons with continuing social problems through the day unit. Over this period we have lost some 200 longer-stay patients but have built up a day patient force of almost the same number, though the individuals are not identical.

For each of the past five years we have found that, on average, we have finally accepted the obligation to take back into our long-stay wards on a permanent basis from 11 to 13 patients, all of whom were no longer capable of being supported within the community reinforced by the facilities of the day unit. Most of these people have a life expectancy of 30 years and all have at one time or another received every known and appropriate treatment. It will be at least 15 years before any of each small cohort is removed by death; there will thus be a steady accumulation of these patients.

The inescapable fact is that certain chronic psychotic patients ultimately become unacceptable in the community by reason of appearance, oddities, and vagaries of behaviour or because of frankly psychotic mental content. These patients, if they are not to become the appalling spectacles which haunt the London parks, undergrounds, and main-line stations, do require the kindly, understanding, and indeed free atmosphere of a long-stay psychiatric ward (which can be quite small and homely) where their needs are recognized and where each can be treated as an individual. Where then will they go when we have closed down the "asylum" which they require? The district general hospitals certainly won't, and will not be able to, deal with them; present indications are that they will also still be unacceptable to the ordinary residents of social welfare accommodation unless these authorities establish numerous little asylums, which would probably be non-viable.—I am, etc.,

MARTIN CUTHBERT

St. Luke's Hospital,
Middlesbrough, Teesside

Intramuscular Injection and Coagulation Defects

SIR,—I was extremely interested to read the letters from Dr. P. M. Jones (24 June, p. 770) and Dr. T. Dyk (30 December, p. 795) on the danger of intramuscular injections in patients with coagulation defects.

I have studied haematoma formation in chronic uraemic patients with bleeding tendency due to a uraemic haemostatic defect of the platelets. In these patients with normal platelet counts and prolonged Ivy bleeding time (over 10-15 min) large intragluteal haematomas never developed after intramuscular injections, and only prolonged oozing could be observed. During haemodialysis, however, intramuscular injections were always associated with excessive haematoma formation because of the heparin administration.

In my experience the danger of intramuscular injections is insignificant not

only in thrombocytopenic states, but in uraemic toxin-induced thrombocytopathy as well.—I am, etc.,

S. BERKESSY

County Hospital,
Miskolc, Hungary

Intestinal Pseudo-obstruction

SIR,—I deplore the term "intestinal pseudo-obstruction" and am surprised that it should be used in a leading article (13 January, p. 64); it is misleading and encourages the surgeon to ignore the underlying cause of the obstruction.

Intestinal obstruction may be acute, sub-acute, or chronic, the last two being incomplete obstructions. It may be due to a variety of causes, but the syndrome remains the same, depending on the level of the lesion and the degree of obstruction. The great majority of patients with obstruction will come to laparotomy, and if no macroscopic lesion is found may well be labelled as pseudo-obstruction and the underlying pathology ignored.

Patients are either completely or partially obstructed or not obstructed; there is no such condition as pseudo-obstruction. Do patients from whom a normal appendix is removed have pseudo-appendicitis or do we look for an alternative explanation for their symptoms?—I am, etc.,

JULIAN NEELY

Crawley, Sussex

Administration of T.A.B.

SIR,—While welcoming your intention to publish a series of articles on "A New Look at Infectious Diseases," I find it unfortunate that in the first of these (13 January, p. 98) Dr. A. M. Geddes should suggest that the prevention of enteric fever should be by "two intradermal injections of 0.1 ml" of T.A.B. The Standing Medical Advisory Committee for the Central Health Services Council as recently as July 1972 in the booklet *Immunisation against Infectious Disease*¹ have clearly set out (p. 15) that currently accepted practice in this field is to give T.A.B. by subcutaneous injection, the first dose being 0.5 ml and the second 1 ml injection. As the Committee point out, 0.1 ml given by the intradermal route "may be too small a dose to confer adequate protection" and "it is inadvisable to attempt to administer a large volume by this route." They also state that "painful reactions have been reported following the administration of both . . . T.A.B. and typhoid vaccine by the intradermal route."

I am sure these comments would command general acceptance and I should be interested to learn on what grounds Dr. Geddes recommends only intradermal T.A.B.—I am, etc.,

ANGUS MCGREGOR

Department of Community Health
Southampton

¹ Department of Health and Social Security. *Immunisation Against Infectious Disease*. London, D.H.S.S., 1972.

Clinical Freedom in the N.H.S.

SIR,—We have received a welcome document from Dr. Derek Stevenson, Secretary of the B.M.A., giving us assurances that the Council of the Association has been active

in pressing for certain amendments to safeguard the position of doctors under the N.H.S. Reorganization Bill, due to come into effect in April 1974. (See *Supplement*, 3 February, p. 29.)

On the subject of clinical freedom, the Secretary points out that "the official report on management" states that consultants and general practitioners must have clinical autonomy so that they can be fully responsible for the treatment they prescribe for their patients." While the term "treatment" may be interpreted here in its widest sense, it should not be forgotten that over 10% of all consultants in the N.H.S. (for example, radiologists, pathologists, and clinical physiologists) do not in point of fact prescribe treatment for patients, for they are wholly and responsibly engaged in carrying out specialist diagnostic procedures upon them. Certain of these diagnostic procedures may not, in themselves, be entirely without risk to the patient of subsequent morbidity.

In order to define the position of all groups of consultants in regard to clinical freedom without ambiguity, I should like to suggest an important amendment, namely, that "consultants and general practitioners must have clinical autonomy so that they can be fully responsible for the treatment they prescribe, and for such diagnostic procedures on patients as they may be required to undertake or supervise."—I am, etc.,

K. A. EXLEY

Leeds

¹ Department of Health and Social Security. *Management Arrangements for the Reorganized National Health Service*. London, H.M.S.O., 1972.

G.M.C. Inquiry

SIR,—The Secretary of State for Social Services has announced his intention, in conjunction with the Lord President of the Council and the Secretaries of State for Scotland, for Wales, and for Northern Ireland, of setting up a committee of inquiry into the regulation of the medical profession, with the following terms of reference:

"To consider what changes need to be made in the existing provisions for the regulation of the medical profession; what functions should be assigned to the body charged with the responsibility for its regulation; and how that body should be constituted to enable it to discharge its functions most effectively: and to make recommendations."

The Council of the British Medical Association has referred the task of preparing evidence for the committee of inquiry to a special working party which consists of two panels. Panel A will deal with a wide range of matters covered by the terms of reference of the inquiry. Panel B will deal with the specific matter of disciplinary machinery.

The two panels have now met and have jointly decided to seek the views of branches and divisions and of the major committees of the Association on matters coming within the terms of reference of the committee of inquiry, and a letter of invitation has been sent to those concerned. The panels are also ready to consider comments from individuals, and the purpose of this letter is to invite any member of the Association who wishes to do so to submit his views in writing to the Secretary of the Association to reach him at B.M.A. House not later than Monday 19 March 1973. Any communications received after that date will be