will fail as a result of a bureaucratic approach. This will leave them with a statutory duty to train GPs, but no one prepared to carry it out. There are many who have the ability and interest to train young doctors for general practice and who have high standards, but have enough common sense not to be bound by inflexible rules.

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Doubtful epilepsy in childhood

SIR,—An important point not covered in your leading article (7 July, p 1) is the question of anticonvulsant therapy in doubtful cases of epilepsy.

Many clinicians face the dilemma of whether to institute a trial of anticonvulsants for a doubtful case of epilepsy. It is tempting to do this when the patient continues to return with unabated attacks. Although there are exceptions to every rule, it is probably best to advise against a trial of anticonvulsant therapy. Time tends to reveal the nature of attacks and I have never yet been convinced of any benefit to be derived from prescribing anticonvulsants on a trial basis when the diagnosis of epilepsy is uncertain. Having seen a number of adolescents who have had the diagnosis of epilepsy incorrectly applied and received anticonvulsants for several years, I would make a plea for avoiding this particular line of management.

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Drug-induced oesophageal injury

SIR,—May I add compound codeine, aspirin, and phenacetin tablets to the list of drugs causing oesophageal injury, as reviewed by Mr F J Collins and others (23 June, p 1673)?

A 54-year-old woman was admitted to hospital following a haematemesis. She had been well until the evening of admission, when she had suffered an acute headache for which she swallowed two compound codeine, aspirin, and phenacetin tablets. She took the tablets broken in half with a glass of water. She admitted subsequently that she felt the tablets stick in the upper gullet. Half an hour later she vomited, initially food but later blood. Physical examination was unremarkable, but early endoscopy revealed an annular irregularity of the oesophageal mucosa extending from 22 to 27 cm from the teeth. The lesion was not bleeding, but an adherent clot was noted. Biopsies from the edge of this lesion showed inflammatory changes only. The rest of the oesophagus, stomach, and duodenum were normal. She was treated conservatively and a repeat endoscopy 10 days later showed marked healing with epithelialisation but friable mucosa and easy contact bleeding. Two months later the lesion had completely healed.

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Photocoagulation and diabetic retinopathy

SIR,—We fully agree with Mr B L Hercules and Dr I I Gayed (23 June, p 1710) and Dr

G P Walsh (7 July, p 48) that treatment of proliferative diabetic retinopathy when new vessels arise from the optic disc is urgent. Treatment is easiest, least time consuming, and most successful when it is given in the early stages.

Dr Walsh's suggestion that patients with eye complaints should go to their GP with dilated pupils is not, however, a satisfactory solution. Firstly, how are the patients to know they will need to dilate their pupils, and who will give them dilating drops prior to attending surgery? Secondly, recognition of early disc vessels is by no means always easy. Doctors working in diabetic clinics should be trained to recognise sight-threatening lesions. Thirdly, and most important of all, patients with proliferative retinopathy have commonly normal vision and no symptoms until their first vitreous haemorrhage. By this time treatment is often difficult, time consuming, and not always successful.

Patients at risk of developing new vessels should be screened regularly by adequately trained people so that treatment can be early.

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Seat-belt Bill before Parliament

SIR,—Mr Neil Carmichael's private member's Bill that proposes to make the wearing of seat belts compulsory will be coming before the houses of Parliament in the near future. This is the single most practical measure to reduce the number of deaths and serious injuries on our roads. It has been estimated that the present death rate of about 8000 a year could be cut by about 1000.

We hope that all doctors will write to and lobby their MPs and do all they can to make sure that this Bill becomes law.

K C EASTON
Chairman
D C RAWLINS
Honorary secretary
H M BAIRD
Vice-chairman
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Honorary treasurer

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SIR,—May I make a plea through your columns to all doctors to write to their MP, with a copy to Mr Neil Carmichael MP, urging support for his Bill to make the wearing of car seat belts compulsory? I no doubt must be left about the views of the medical profession on this issue.

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¹ *Lancet*, 1979, **1**, 1415.

Diagnosis of allergy to insect stings

SIR,—In Any Questions (19 May, p 1334) it is stated that specific IgE tests (the radio allerge sorbent test (RAST)) are not performed in routine laboratories.

We have been supplying Phadebas RAST reagents to routine laboratories for five years and they are currently in use in at least 25

NHS hospital laboratories, one supraregional assay service laboratory, and various research labs which also perform routine service to some extent. In addition, we operate a routine testing service in collaboration with the RAST allergy unit at Benenden Chest Hospital in Kent.

RAST for both wasp and bee stings plus 60 other allergens is thus routinely available.

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Unfit for holiday

SIR,—May I use your columns to appeal, as a GP in a holiday resort, to my colleagues in the "donor" areas to take greater care in the advice they give their patients when asked, "Am I fit to go on holiday?"

In the past even days I have seen:

(1) A 37-week primigravida who presented in the second stage of labour giving a history of being discharged from a consultant obstetric unit three days before, having been an inpatient for 10 days with a diagnosis of hypertension.

(2) A 12-week-pregnant multipara with a history of two normal confinements and three spontaneous abortions who had been in a professorial obstetric unit as an inpatient because of bleeding in the present pregnancy, who presented with heavy blood loss and products of conception in the vagina six days after discharge from hospital.

(3) An 82-year-old man presenting in left ventricular failure who had no idea why he should have continued to take "the water tablets" even while on holiday.

All three told me that they had been specifically told by their doctors that they were fit to go on holiday, which involved a 90 mile journey, two travelling by private car and one by coach. I think further comment is unnecessary.

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Disposable syringes for insulin injection

SIR,—The article by Dr A Greenough and others (2 June, p 1467) is of great importance in the management of diabetics in the developing countries, as most diabetics find it financially difficult to purchase glass syringes for insulin injections.

I have gone some steps further than the authors in that nearly all diabetics requiring insulin in the diabetic clinic of this hospital are taught to use the ordinary 2 ml or 2½ ml disposable syringes with 10 marks in 1 ml for their injections. These plastic syringes with needles, which cost 12 kobo (about 0.09p), besides being a lot cheaper than the British standard 1619 plastic syringes with needles, which cost 21 kobo (about 0.16p), are more readily available. The slight disadvantage is that finer adjustments in insulin doses may be difficult with the higher strengths of insulin. However, since we mainly use the U-40 insulins, a mark on the syringe is therefore equal to 4 units of insulin, and half the mark is 2 units. I am therefore not looking forward to any proposed plan to change all insulin strengths to U-100 insulins.

I have found that the diabetics use on average a plastic syringe a month, changing

the needles as frequently as they get blunt. As most diabetics in Nigeria do not have fridges, I just tell them to replace the syringe with the attached needle in the packet and put it, as well as their insulin, in a clean container or pot that is properly covered. The pot is then stored in a hole in the ground, dug as deep as one's hand can reach. Since 1974, when I started running the diabetic clinic in this hospital, I have carefully observed the insulin-requiring diabetics without coming across any case of infection with this technique. As the authors noted, the advantages to the patients are considerable. This is even more so in a developing country like Nigeria, where most diabetics are responsible for the cost of their treatment.

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Raised HCG in hyperemesis gravidarum

SIR,—We read with interest the paper by Dr Antti Kaupila and others (23 June, p 1670) on their finding of raised levels of serum human chorionic gonadotrophin (HCG) concentrations in hyperemesis gravidarum.

We have also measured β -subunit HCG by a specific radioimmunoassay in 12 women with hyperemesis gravidarum and 12 control patients matched for gravidity and gestational age. Although the mean value of β -HCG was higher in the hyperemetic patients (36.2 IU/ml as against 24.5 IU/ml for controls), the difference was not significant using the paired Student's *t* test.

We have recently reported¹ altered thyroid function in hyperemesis gravidarum and are preparing for publication our findings of a possible relationship between chemical hyperthyroidism and high levels of β -HCG in some patients with hyperemesis gravidarum.

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¹ O'Moore, R R, et al, in *Proceedings of 3rd European Congress of Clinical Chemistry*, ed V Marks and D Williams, *Annals of Clinical Biochemistry* (suppl). London, British Medical Association, 1979.

Labetalol in severe tetanus

SIR,—We read with interest the case report by Dr J W Dundee and Dr W F K Morrow (28 April, p 1121) on the use of labetalol in severe tetanus and deem it necessary to make some comments.

While vasomotor instability in severe tetanus may be an uncommon phenomenon in the UK, this is certainly not the case in the respiratory unit at King Edward VIII Hospital. Of the 30 to 40 adult cases of tetanus seen annually at our unit, 15 to 20 cases are severe enough to need controlled ventilation and of these 60% develop vasomotor instability, which usually manifests as tachycardia, labile blood pressure, cold peripheries, and marked sweating. A possible explanation for high incidence of this complication is that many of our patients have had no immunisation whatsoever prior to the onset of the disease.

We have used intermittent injections of labetalol in our tetanus patients with very

high blood pressures and found it to be effective in some, though not all, patients.

Regarding management, we were surprised at the use of tubocurarine in their patient, who experienced problems with decurarisation. We stopped using curare some years ago and instead use alcuronium, which in our experience is very effective in controlling spasms and furthermore does not pose the problem of residual curarisation which occurs with prolonged use of tubocurarine. Hence this obviates the need for decurarisation and the problems associated with it.

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Why does the Committee on Safety of Medicines do what it does?

SIR,—The DHSS has now banned methapyrilene on the grounds that it can cause liver tumours in rats if given 25 to 30 times the normal human dose throughout the animal's normal life span. We can no doubt get along quite well without one of the many anti-histamines just as we can manage without cyclamates, but I feel we are entitled to ask the DHSS or rather its Committee on Safety of Medicines to answer a few questions.

(1) What is the maximum dose that can be used to produce cancer in an animal before the committee will regard such amounts as too ridiculous to have any relevance to humans? Is it 25 to 30 times the human dose daily for life as in methapyrilene or 80 times as in cyclamates, or is there no limit as in the USA?

(2) Why are cyclamates and methapyrilene banned but not saccharin or nitrites, which are under just as much suspicion?

(3) Is it only cancer that the committee is worried about when a drug is given in such huge quantities over a long period? If any substance given in this manner caused disease or death should it not also be banned? This would include most drugs in the pharmacopoeia, even salt.

(4) Has the committee no reasonable standards of its own or are we in future to have the absurd requirements of the American Food and Drugs Act imposed upon us? If so we may well find ourselves like them deprived of useful drugs like chromoglycate for years at a time.

I call upon the Committee on Safety of Medicines to answer these questions. It is not good enough to be given a papa knows best edict. We have a right to ask why he thinks he knows best, before being subjected to American law.

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Adolescent idiopathic scoliosis

SIR,—The leading article on adolescent idiopathic scoliosis (June 2, p 1446) stressed the importance of early recognition and prompt treatment without explaining why the disease must be treated early. Many medical people still believe that scoliosis is merely a cosmetic problem, but this is not so. Cardiorespiratory insufficiency secondary to thoracic deformity has been recognised for a long time, and recently the socioeconomic and psychological effects of scoliosis have been studied as well.¹⁻³

We interviewed and examined 55 adults with

untreated scoliosis who were first seen as children in Quebec hospitals 10 to 45 years previously.⁴ Two-thirds had back pain, one patient in four was disabled by it, and 20 patients were temporarily or permanently unemployed. Two-thirds of the women and one-third of the men were not married, which is more than twice the national average, most had sedentary hobbies, and two-thirds of all patients were selfconscious of their appearance, some avoiding sunbathing, swimming, and other activities that involved undressing in public.

A separate group of 152 adults with untreated scoliosis consulted us mainly for back pain. Most were improved by non-operative treatment, but 36 required Harrington instrumentation and posterior fusion. The surgical indications were disabling back pain not controlled by conservative measures, progression of the curve, or increasing respiratory distress. The complication rate was higher, and the results of surgery were not as good as they were in a similar group of adolescents, confirming the findings of other authors.^{5,6} Besides this, the prolonged convalescence of the adult created socioeconomic problems which did not occur among the adolescents.

We concluded that untreated scoliosis affects the quality of life and is a disabling disease in the adult. Because of the problems associated with surgery in the adult, scoliosis should be treated definitively before the end of the period of growth.

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¹ Collis, D K, and Ponseti, I V, *Journal of Bone and Joint Surgery*, 1969, **51A**, 425.

² Nachemson, A, *Acta Orthopædica Scandinavica*, 1968, **39**, 466.

³ Peyer, J, *Zeitschrift für Orthopädie und ihre Grenzgebiete*, 1975, **113**, 577.

⁴ Fowles, J V, et al, *Clinical Orthopedics and Related Research*, 1978, **134**, 212.

⁵ Dawson, E G, Caron, A, and Moe, J H, *Journal of Bone and Joint Surgery*, 1973, **55A**, 437.

⁶ Ponder, R C, et al, *Journal of Bone and Joint Surgery*, **57A**, 797.

The premature breech

SIR,—It is certainly true that the management of the premature breech presents a major problem to the obstetrician, and your leading article (30 June, p 1747) debates some of the factors which influence the decision to deliver vaginally or abdominally. Neither this article nor the study of Karp and others¹ states which type of caesarean section is being considered, though the reader will assume it to be the lower segment operation.

I would like to point out that the lower segment caesarean section can itself be hazardous to the fetus, and to suggest that the classical caesarean section be considered. When a premature breech is delivered electively by lower segment caesarean section the incision in the often ill-formed lower segment contracts so that the head is in danger of rapid compression and decompression or even entrapment. The situation is little different from the compression and decompression and entrapment by the cervix in a vaginal delivery: only the bony pelvis is bypassed, and this is normally relatively capacious when the fetus is premature. A second problem is that when a premature breech is delivered by emergency lower segment caesarean section for cord prolapse, or fetal distress, after being allowed to labour, the breech is often very low in the pelvis, making disengagement both difficult and dangerous.