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.

The classical caesarean section would avoid both of these problems, although it is associated with more postoperative morbidity and makes a repeat caesarean section very likely. For these reasons it is not applicable to every patient in progressive preterm labour with a breech presentation, but it is perhaps worthy of consideration in some cases.

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Eyes run on light

SIR,—Mr M J Gilkes (23 June, p 1681) quoted numerous references pointing out a lacuna in the articles recently published under my name. He could understandably have been on the brink of using the term "black hole," which is as I understand it a disaster area in the universe that is inexplicable in normal scientific terms. He also referred to the fact that common sense is so often ignored because it is self-evident. Self-evidence can also be a black hole in all our judgments on visual impairment.

Common sense tells some people that weak eyes are strengthened by glasses or protected by them from becoming weaker, but others take the contrary common sense view that eyes are weakened by glasses and should be made to work without support from such crutches.

Common sense tells us that we have to conserve our eyesight like savings and that it can be used up like a bank account: that it can be preserved if we don't use artificial light, the wrong glasses, or perhaps any glasses, and don't read because of the strain. Common sense also tells us that use of a skill improves it, like sewing, skiing, or sailing. Common sense, which we all run on, is a primitive thread in all social, intellectual, and scientific patterns. Neither science in such a dilemma about black holes, based on analysis of fact, nor common sense confused by its reliance on contradictory self-evidence, is an ultimate authority.

The conclusion is that because neither science nor common sense can answer our questions consistently people might well resort to revelation.

Mr Gilkes has revealed a simple truth which should cast a light even in the confused and tortuous warrens of our general and primitive ignorance about basic visual processes.

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Rate of change of haemoglobin A₁ in diabetic patients

SIR,—We read with interest the reports of the change in concentration of glycosylated haemoglobin (HbA₁) occurring in newly diagnosed diabetic patients following treatment (14 April, p 979, and 7 July, p 19). Our own observations support the view of Leslie and others that "conclusions about diabetic control drawn from a single HbA₁ estimation should be treated with caution," and that "a single HbA₁ estimation may relate to a shorter period of hyperglycaemia than has been suggested."

The figure shows the concentration of

Changes in serum concentrations of glycosylated HbA₁ with treatment in eight newly diagnosed diabetics.

HbA₁ (measured by Fluckiger's method¹ modified to read absolute values against fructose standards as mg fructose/g Hb) in eight newly diagnosed diabetic patients (five men and three women aged 49 to 74 years; two requiring treatment with insulin, three chlorpropamide, and three diet alone) before and at weekly intervals after treatment. Control of the diabetes was assessed by measuring the 24-hour urinary glucose excretion and the blood glucose concentration two hours postprandially. Like Fraser's group and others,² we found a significant fall in HbA₁ four weeks after starting treatment, by which time the 24-hour urinary glucose had fallen to an insignificant amount (less than 10 mmols) in all patients. Thereafter the concentration of HbA₁ continued to fall more slowly, to either within or just above the upper limit of the normal range (mean value for normal subjects ± 2 SDs = 1.9 ± 0.68) after approximately eight weeks' treatment.

Consideration of these monthly measurements alone, however, obscures much individual variation. Thus, although the concentration of HbA₁ fell in the first week of treatment in seven patients, it rose in one, and in three others it rose again two, four, and five weeks after starting treatment, despite a continuing overall fall in glycosuria and blood glucose concentration. We are confident that these fluctuations are real and not due to methodological errors, since duplicate estimations performed by column chromatography (Biorad Kits) showed similar changes. Moreover, other more detailed studies involving daily estimation of HbA₁ in inpatients (to be published elsewhere) confirm and extend these findings.

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Edinburgh EH4 2XU¹ Fluckiger, R, and Winterhalter, K H, *FEBS Letter*, 1976, 71, 356.
² Ditzel, J, and Kjaergaard, J-J, *British Medical Journal*, 1978, 1, 741.

Handbook of Medical Ethics

SIR,—I welcome both the Central Ethical Committee of the BMA's initiative in producing a new draft edition of the *Handbook of Medical Ethics* and the resolution of the Representative Body to instruct the Council to review the handbook on an annual basis. The profession would do well, however, to pursue Dr D L Gullick's point (7 July, p 71) and ask the Council of the BMA to establish the purpose and the meaning of the document

for the benefit of its members and non-members alike.

To me, it would be acceptable for the handbook to be ascribed the status of a code of practice to which the BMA asks but does not oblige its members to conform and which its representatives, but not necessarily individual members, uphold in negotiations with other bodies. It would be unacceptable for the GMC or any other body to use the document as standard for disciplinary measures.

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Half-way houses

SIR,—Under the heading of Any Questions? (5 May, p 1190) your correspondent refers to the use of half-way houses in geriatrics. The original concept of these was put forward by me in a public lecture during May 1949, and the idea was taken up by King Edward's Hospital Fund during the following year.

At that time many elderly so called chronic sick had been kept in hospital for very long periods, sometimes several years. When they were rehabilitated in geriatric units they proved difficult to discharge. Many of them were frightened of the world outside and very averse to leaving the wards which had been their refuge for such a long time. We needed some place where they could continue their physical and mental rehabilitation under skilled supervision, while the social workers sought a suitable destination for them. It was desirable to have a building away from hospital premises in which they could learn to live normal lives once more. Hence the scheme for a half-way house, under the umbrella of the parent geriatric unit and its staff, to train the old folk for independent existence.

In my original half-way house Westmoor (associated with St John's Hospital, Battersea) out of the first group of admissions, two patients had been in hospital for ten years, one five years, and another three years before transfer. Later we had a woman who had stayed 15 years as a patient. All of these were discharged in the end usually to part 3 accommodation. Eventually our annual turnover rose from 25 beds to a level of 200, thus freeing beds at the parent hospital at an unprecedented rate. The services of physiotherapists and occupational therapists enabled us to overcome the dread of discharge so common in our patients, while the co-operation of municipal welfare authorities facilitated transfer to suitable hostels or sheltered accommodation.

It is essential to use a half-way house for rehabilitation and convalescence only. If any patient fails to respond, he should be returned to the parent unit and replaced by another. Otherwise the place merely becomes a dump for the chronic sick. Diseases which have been dealt with at Westmoor include osteoarthritis, rheumatoid arthritis, various fractures, cerebral infarcts, ischaemic heart disease, varicose ulcers, chronic bronchitis, malnutrition, and mild grades of senile dementia, among others. So it will be seen that a half-way house is not a substitute for simple discharge of a fully recovered patient, but a specialised unit for those whose return to the community would otherwise be doubtful.

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