consultants if they were in that part of the world anyway. It amazed us to find how many "travelling experts" came within a few hundred miles of our remote mission hospital in Kurdistan. (6) For the few who for any reason (such as revolution) return after a longer period, the authorities might consider creating personal part-time supernumerary posts of limited duration. This would be infinitely preferable to a succession of locum posts, or prolonged period of unemployment, with no eligibility for state benefits because of previous absence from the UK, often on a salary too low to save capital or maintain UK National Insurance contributions.

Doctors who are more junior would be well advised to look for supervised posts—for example, in the universities of developing countries or in larger Christian hospitals with experienced senior staff, so that responsible reports of their work would be provided. At this stage a shorter period of a year or so could be useful to the overseas community.

Finally, those individuals who work in developing countries may have something worth while to offer the NHS on return. They value highly the privileges of working in our NHS. In addition to their extensive clinical experience, they have experience in decision making and responsibility under difficult circumstances which may give them a more mature viewpoint in consultant practice; there should be scope for those who have gained a broader experience of medicine from contact with different spectra of diseases and alternative schemes of health care. Since no "ideal" training for consultant practice has yet been devised or identified, these points provide a valid argument at least for considering such work for retrospective recognition by joint higher training committees.

Those who choose to work in developing countries are likely to have a high sense of vocation in their careers, and, although expecting no preferential treatment, they should not be penalised. They have in fact much to contribute to the NHS, which was after all conceived as a service to the community.

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Mission hospital medicine

SIR,—Following Dr Anne Savage's article (14 July, p 111) there have been a number of letters expressing interest in medical missions and the desire for an office of information of such opportunities abroad (4 August, p 335 and 11 August, p 388). Both the Medical Missionary Association and the Christian Medical Fellowship have for years provided such advice, the former through their quarterly magazine *Saving Health*, which includes an analysis of advertised needs of the many British missionary agencies. The CMF maintains individual correspondence and liaison with Christian medical associations of the Third World through which (and including missionary and government agencies) over 300 members of the CMF are currently serving. Also, Dr Peter Green of the MMA is the official BMA representative for British missionaries.

We would be happy to advise any who want to help overseas missions. Varied opportunities and needs abound. However, it should be noted that most mission hospitals request expatriates who are at least in sympathy with the ideals of serving in the name and spirit of Jesus Christ, the significance of which is not readily apparent in privileged Britain. We would gently, modestly, and in all sincerity plead for expatriates to "give up" (you won't,

you'll gain!) a few years or make an open-ended commitment to serve abroad, and to go not primarily seeking "interest" or "experience" but to understand the real needs of the situation and adapt oneself to meeting those needs. Besides, there is a growing resentment in the Third World against those whose contribution is so obviously geared to personal ambition or specialty. As one national superintendent put it, "Let them make such mistakes on their own people before they practise on us."

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SIR,—My experience of mission hospital medicine was in a hospital specialising in eye surgery in the Bihar area of North India and my lasting impression is of the tremendous amount of high quality work that was done with the minimum of staff and equipment. The experience has also made me, like Dr C J Burns-Cox (11 August, p 388), critical of the waste and pomposity prevalent in the NHS and I am sure that a spell doing clinical medicine or surgery in a poor country would be of value for anybody intending to work in clinical medicine, though it might be of even greater value for potential community medicine specialists.

In contrast to the BTU (been to an underdeveloped area), the BTA (been to North America) has always been considered to be an advantage to a career in the NHS. Nevertheless, the fear of losing a place on the NHS career ladder meant that no senior registrar from my teaching hospital was interested in following me for a year as staff anaesthetist in a Toronto teaching hospital. Dr C J Chandler (p 389) should therefore not be too surprised at the lack of interest in the BTAf.

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SIR,—The two recent letters by Drs C J Burns-Cox and C J Chandler (11 August, p 388) on mission hospital medicine reinforced the call by Dr Anne Savage (14 July, p 111) for a central register both to refill vacated Third-world posts and to find the returning doctor a rung on the ladder back home.

Neither mentions one other very important function of such a registry. It must have up-to-date information on the political and economic climate of the country involved. Although few doctors are likely to go to Uganda at the present time, there was a time when Makerere University was a hive of research for adventurous registrars, and let us hope it will be again. About three years ago I asked a BMA spokesman about the advisability of going to a particular Third-world country. Although it was a well-known area, he could neither tell me anything positive nor put me in touch with any doctor who had recently been there. All he could say was, "Australia and Canada are always a safe bet." Now, only three years later, both those countries are overdoctored.

It is a sad fact that there was never a time when Schweitzerian philosophy and medicine were more apt than now, and never a time

when they were less likely to be carried out. The "wind of change" has become a tornado, and let no doctor think he is immune. Such a registry therefore must have realistic information about the country or State to which it is recommending the enthusiastic doctor. If it does not, rather than graduate BTAf, he may join the even more distinguished band of NHS (never heard of since) doctors.

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Clioquinol and related drugs

SIR,—All of us were foreign (that is, non-Japanese) participants in the International Conference Against Drug-Induced Sufferings, held in Kyoto 13-18 April 1979. We find the evidence overwhelming that medicines containing certain hydroxyquinoline compounds, such as clioquinol, can cause serious and irreversible injury to the nervous system. We urge those manufacturers who are still selling these products either to provide clear evidence that there are benefits which justify the risks or to withdraw them. In our opinion, the reassessment of these drugs is an urgent task for national drug regulatory authorities and international organisations.

LENNART BERGGREN (Sweden)	ÅKE LILJESTRAND (Sweden)
LARS ERIK BÖTTIGER (Sweden)	N D W LIONEL (Sri Lanka)
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Metronidazole in the aetiology of pseudomembranous colitis

SIR,—It has been suggested that metronidazole alone may be implicated in the aetiology of antibiotic-associated pseudomembranous colitis following the report by Dr A Kappas and others (18 March 1978, p 675) that a single patient developed pseudomembranous colitis after having metronidazole. As metronidazole alone has little influence on faecal microflora we questioned whether this patient received any other antibacterial agents. A detailed study of the notes revealed that the patient was given lincomycin in addition. The prescription sheet was missing from the notes and the information that this person received lincomycin became evident only as a result of careful scrutiny of the nursing records.

We apologise for this error and we would emphasise that the paper in question was concerned with the diagnosis of pseudomembranous colitis and not with a detailed investigation of its aetiology. We feel that it is most important to point out this error since we know of no patient reported so far in the

literature who has developed pseudomembranous colitis after having metronidazole alone.

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Iatrogenic collapse

SIR,—Your leading article on iatrogenic collapse (18 August, p 408) pointed out that the Joint Committee on Contraception recommended that at the insertion of intrauterine contraceptive devices an artificial airway such as the Brook should be close at hand. The wisdom of this advice must be questioned.

A vasovagal attack in someone already lying on her back with her legs raised is very unlikely to lead to respiratory arrest. Where this does occur the most probable cause is ventricular asystole. Atropine given *before* the procedure would help to protect the heart from such a catastrophe. On the other hand, a transient hypotensive loss of consciousness does occasionally occur when the patient stands or sits up too soon. Anyone without anaesthetic experience who tries just before recovery to insert a Guedel or "doctor version" Brook airway will at best give the patient an unpleasant experience or at worst cause vomiting, laryngeal spasm, and iatrogenic death. At a recent meeting of the Gloucestershire anaesthetic division it was unanimously agreed that IUCDs and Brook airways should be kept well apart.

In any case, patients who require an IUCD form a rather selected group. Almost by definition they do not have the rotten teeth or alcoholic halitosis which reinforce a doctor's or nurse's social inhibitions about mouth-to-mouth resuscitation. For those who feel an artificial airway to be indispensable, the shorter first-aid version of the Brook or a simple face mask would be safer than the longer Brook—and just as effective, because under the age of 45 cervical arthrosis and toothlessness are relatively rare. There are not many other conditions seen in a coil clinic which would give the longer Brook or the Guedel airway a decisive advantage over the face mask.

P K SCHUTTE

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SIR,—Your leading article (18 August, p 408) refers to the "iatrogenic faint" that may follow minor manipulative procedures such as the insertion of intrauterine contraceptive devices.

I would suggest that a number of these are due to acapnia. The nervous patient who is anticipating an unpleasant experience, perhaps over a long waiting period, involuntarily overbreathes; the effect may be compounded by additional factors such as a hot, stuffy room and the nervousness may result in a fasting patient—causing a lowered blood glucose with attendant increased irritability of the central nervous system. The attack is precipitated by a sudden increase in hyperventilation following the painful stimulus of an injection or the insertion of the IUCD.

There are several features that help to distinguish this from other "faints." The loss of consciousness is accompanied first by tonic (carpopedal spasm due to the accompanying hypocalcaemia) and then clonic contractions. The recovery is rapid following the head

down and feet up manoeuvre, although the patient may complain for several minutes about cramp-like pains in the arms and legs.

The differential diagnosis is important. It occurs in an otherwise healthy patient. No treatment, other than simple first-aid, is required. The bradycardia is not due to vagal inhibition caused by dilatation of the cervix. Lastly, a mistaken diagnosis of covert epilepsy may be made.

The prophylactic remedy may be to "beware the pale, sweaty patient with the dilated pupils."

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Prevention of pulmonary embolism

SIR,—Like Professor Charles Wells (14 July, p 129), we have prevented deep-vein thrombosis (DVT) and pulmonary embolism (PE) in a ward which previously had a high incidence; hence there is no doubt that it can be done.¹ The critical part of Professor Wells's letter, other than his determination to succeed, is: "... supported by dedicated sisters and nurses."

DVT and PE are most uncommon in home surroundings, and the issue is not complex, as Dr R H Fell states in his letter (14 July, p 129). The medical profession still confuses the difficulty of obtaining a result with its value. We do not see DVT and PE in children's hospitals because children will not "lie to attention" for inspection by matron or anyone else. Our problem is to make adults behave like children, or as they do at home, on admission to hospital. We found that when adults were told to behave in this way only about half did so. Doctors must believe that any case of DVT or PE is a failure on their part. However dedicated the doctor may be, he is helpless without the support of a dedicated nursing staff; nurses are the only skilled observers present all the time.

Patients have either a low or a high risk of DVT and PE. For low-risk cases the administration of anticoagulants of any kind is evidence of ignorance. We failed to eliminate DVT and PE completely because doctors failed to play their part with high-risk cases: while they are taught at medical school that the subject is difficult, this will continue.

The human is the only animal able to lie like a log in bed with the weight of the leg compressing the veins in the leg muscles. Whenever I have visited a friend in any hospital I have observed him or her lying like this and found on questioning that the danger was quite unknown.

The Royal College of Obstetricians and Gynaecologists held a scientific meeting on the problem of DVT and PE in 1964. When opening the meeting the president stated that, with the mastery of the problem of deaths from puerperal sepsis and toxæmia, the previously uncommon causes of maternal deaths were now the common ones; notable among these is PE, which then caused 14% of the deaths. Later a visitor from Singapore stated that he had never seen a death from PE; the need for beds in the hospital was so great that the mother was not put into bed until shortly before the baby was born, and she was discharged as soon as all was in order.

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Domiciliary obstetrics

SIR,—I found the reminiscences of Professor J K Russell (11 August, p 377) on his experience with the Newcastle obstetric flying squad pleasantly nostalgic, as they must have been to many other senior obstetricians. Our organisation in Birmingham differed slightly, in that we did not take an anaesthetist and we seldom travelled intentionally to second stage problems, although the occasional undiagnosed second twin was removed manually with the placenta and usually proved to be unexpectedly well.

We learnt an important obstetric lesson which may be forgotten in these days of sophisticated institutional midwifery. By far the commonest life-saving procedure on the flying squad in those days was the manual removal of the placenta from a shocked and exsanguinated woman. I had been instructed, when I came into obstetrics at the end of the war, to resuscitate with transfusion before removing the placenta. I soon discovered, as many others must have done, that that represented a waste of blood and time, so that we adopted the policy of removal before transfusion. In some desperate cases this had been forced on me by the slow rate of flow of the blood drip, even when a vein had been exposed and a cannula tied in. (There were no nice needle cannulas in those days.) I soon learnt, what astonished me when first it happened, that blood which dripped slowly and reluctantly into the arm of the shocked woman would accelerate into a rapid flow within seconds of the placenta being removed. This led to the dictum: "No woman is too ill for manual removal and no one must die with the placenta inside."

I do not know whether the severe shock suffered by many of these patients with an "hour-glass" constriction of the uterus and a placenta half in and half out was due to humoral or neurogenic factors, but it was not caused solely by loss of blood. Nor do I know for certain why it is so rare today. The old habit of expressing the placenta and reluctance to use oxytocics at the end of the second stage were probably responsible. It led to two principles of which only one is still valid. We taught that no patient should ever be moved with her placenta retained, something that modern experience has shown to be no longer true in all cases. But we also taught that every obstetrician should be able in an emergency to remove a placenta without waiting for an anaesthetist and that is as true today as ever it was, although in Britain the occasion may not so often arise.

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Induction of labour using prostaglandin E₂ pessaries

SIR,—I read with interest both Mr A W Banks's and Mr C J Hutchins's useful remarks (4 August, p 332) concerning induction of labour using prostaglandin (PGE₂) pessaries.¹ Ultrasound examination has been shown to be the most accurate method of "dating" a pregnancy² and this is a routine procedure at 16 weeks' gestation at Queen Charlotte's Hospital. In our reported series many patients were scanned serially both before and after this time, depending on their obstetric problem. With this information a small proportion of