equated with physiological activity that would cause a twofold increase in noradrenaline release it is roughly equivalent to a patient standing for five minutes after lying down for ten. It is not reasonable to compare this situation with a catecholamine cardiomyopathy induced by very large doses of β -receptor agonists in animals or, as is sometimes seen, in patients with pheochromocytoma.

There is one other interesting implication, which was pointed out recently by Dr Rangno at a meeting in the Hague. The small degree of receptor hypersensitivity after withdrawal can be blocked by a very small dose of a β -receptor blocking agent. Thus a graded reduction in dose of the β -adrenergic blocker is not required; but a sudden reduction to a very small dose—that is, propranolol 10–20 mg/day—should be quite safe so long as this dose is continued for about two weeks before it is finally stopped.

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¹ Nattel, S, Rangno, R E, and Van Loon, G, *Circulation*, 1979, **59**, 1158.

² Ross, P J, Lewis, M J, and Henderson, A H, *British Medical Journal*, 1975, **1**, 875.

Vitamin B₁₂: an area of darkness

SIR,—We agree with Dr C W Picard (6 October, p 867) that there were some who doubted the predominant role of cyanocobalamin in metabolism as early as the 1950s. Nevertheless, for many years it was very widely assumed that cyanocobalamin was the main form of vitamin B₁₂ in the body, and we do not think our review falsified the general picture.

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Life-threatening arrhythmias and intravenous cimetidine

SIR,—In a recent paper (29 September, p 768) Dr J Cohen and others described the serious cardiovascular complications that occur during treatment with intravenous cimetidine. I would like to suggest that hyoscine butylbromide (Buscopan) can prevent these arrhythmias.

Hyoscine butylbromide has been shown to suppress the oculocardiac reflex during operations for correction of squint.¹ During a current study designed to show that it has as effective though briefer chronotropic and inotropic actions on the heart during general anaesthesia as intravenous atropine, it was noticed that hyoscine butylbromide has an antiarrhythmic action. Not only did it not cause arrhythmias as atropine can but it restored sinus rhythm for periods of up to one hour to hearts affected by arrhythmias associated with pancuronium and halothane. Among the 44 cases so far studied hyoscine butylbromide restored normal cardiac rhythm in two cases of nodal bradycardia and hypotension, in three cases of multiple ventricular extrasystoles, and in one case of auriculo-ventricular dissociation within one minute of intravenous injection.

Like Dr Cohen, I can only speculate about an evident temporal association; unlike him I cannot offer even one hypothesis to explain

my observations. However, the similarity between the arrhythmias following intravenous cimetidine and those associated with the oculocardiac reflex—that is, bradycardia with hypotension, a trioventricular dissociation, and asystolic cardiac arrest—suggests that a drug that can control one would also control the other.

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¹ Fry, E N S, and Hall-Parker, B J P, *British Journal of Ophthalmology*, 1975, **59**, 525.

Day-bed units

SIR,—We were interested to read the report "Operations for hernia and varicose veins in a day-bed unit" from Mr C V Ruckley (22 September, p 712) and we would support his enthusiasm for short-stay care. One could, however, be misled by the title into assuming that the majority of varicose veins were being treated by day care, but analysis of their data shows a small decline in such management over the last five years.

The authors are correct in stating that "it would not be right to claim efficiency in health care without taking account of the views of patients." We carried out a survey in 1978 of the Hammersmith Hospital experience in day surgery for varicose veins in which we sought the patient's opinion.¹ This showed that patients did not like day-care vein surgery when more than one incision was necessary. An increased number of general practitioner call-outs, unacceptable analgesia consumption, etc, accompanied multiple skin incisions and our practice was modified accordingly—especially the ending of the long saphenous strip on a day-care basis.

If one accepts that the success of a varicose vein operation can be directly related to the extent of surgery then day-care surgery will often provide inadequate treatment alone.

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¹ Clyne, C A C, and Jamieson, C W, *British Journal of Surgery*, 1978, **65**, 194.

SIR,—I was interested in the experiences of Dr J B Rainey and Mr C V Ruckley in the Edinburgh day-bed unit (22 September, p 714). I recently spent 18 months as an obstetric and gynaecological resident in Canada, where day beds are widely used. All our patients having minor gynaecological procedures and laparoscopies were admitted as day patients unless medically unsuitable.

Admittedly we did not have a waiting list problem, most patients being admitted within a month. When the decision that surgery was indicated was made in the clinic the patient's medical status was assessed, with examination of respiratory and cardiovascular systems and routine blood tests. When the patient arrived in the gynaecological day ward routine observations were made by the sister and she was seen by the doctor only when she arrived in theatre and again prior to discharge.

This system not only eased the bed situation

but also avoided the need for junior doctors to hurriedly request and re-examine several patients each morning before rushing off to theatre. I feel that with our ever-increasing waiting lists and work load day beds should be used wherever facilities permit.

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Smoking and acclimatisation to altitude

SIR,—Dr N MacLean's suggestion (29 September, p 799) that to starve Olympic athletes of oxygen by controlled smoking and so "acclimatise" them in the same way that altitude training does is ingenious but does not really follow from his observations of mountain sickness in himself and fellow climbers. Acute mountain sickness cannot be caused solely by induced alveolar hypoxia; if it were, asthmatics would exhibit the symptoms during prolonged attacks (which they don't) and the condition occurring at altitude would be alleviated by oxygen (which it isn't).¹

From my own observations of some hundreds of sea-level residents ascending to and living at 3000–4200 m in the Andes, I can say that smoking habits have no effect on susceptibility to mountain sickness. Neither would one expect them to have any effect, as they are overwhelmed by other, more important factors such as exertion and, not least, a huge individual variation in response. Whether artificial "acclimatisation by smoking" followed by abstinence prior to athletic endeavour could improve total aerobic capacity at sea level (or high altitude) in the medium term is quite another question, albeit of theoretical interest.

Whatever the answer (and there must be less deleterious ways of incurring reversible hypoxia—daily suffocation with a pair of running shorts, for example), acute mountain sickness has a more complex aetiology than suggested and the likelihood of its development in an individual is no guide to his future acclimatisation and physical performance at high altitude.

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¹ Ward, M, *Mountain Medicine: A Clinical Study of Cold and High Altitude*, p 266. London, Crosby, Lockwood, Staples, 1975.

Wanted: a new wound dressing

SIR,—We would agree with your leading article (22 September, p 689) that wound dressings in common use are less than ideal, and welcome the attention drawn to Turner's comprehensive review.¹ We would also agree with the properties suggested as necessary for an ideal dressing, but are surprised that no mention is made of the use of the silicone foam elastomers, which fully meet these requirements in relation to granulating wounds.

This material, developed as a wound dressing in Cardiff, is contour forming, soft, resilient, absorbent and non-adherent. We first reported the use of silastic foam dressing Q7-9100 (Dow Corning Ltd) in 1974^{2,3} and experience in this department now covers over 1000 patients treated for a wide variety of types of granulating wounds, including pilonidal sinus, infected abdominal wounds, sacral pressure sores, and anal and perineal wounds, skin graft donor sites, and varicose ulcers.