not be work available locally in the clinical specialty in which a community physician is interested. Further, even if work does exist, the appointment to sessional clinical work will have to be covered by a separate contract.

G N CONSTABLE

Ipswich Health District Offices,
PO Box 7, Ipswich IP3 8NJ

Opiates in acute abdominal pain

SIR,—I am another who thoroughly endorses the views of Mr J C Angell (25 August, p 485) concerning the use of morphine before a definitive diagnosis is made. The practice of avoiding analgesics is still, in my experience, widespread, particularly among junior surgical staff.

Obtaining a diagnosis is often a protracted affair with long delays for the patient as he proceeds up the ladder of surgical responsibility. If opiates are to be withheld then we should ensure that the more experienced diagnostician sees the patient early in this process so that treatment, including analgesia, may be instituted rapidly.

But does morphine really cause so much trouble to the clinician? The "Moses" who delivered this commandment may have been influenced by the large doses used at the time— $\frac{1}{4}$ – $\frac{1}{2}$ grain (15–30 mg) for an adult. Current literature¹ claims that 10 mg provides satisfactory analgesia in 70% of adult patients with moderate to severe pain. This amount causes minimal side effects and is very unlikely to alter clinical signs. In fact, one may achieve more immediate relief with smaller doses if the drug is administered by slow intravenous injection, as has been described for postoperative analgesia.²

Perhaps one should remind those who are still generally timid in their use of potent analgesics that pain is the physiological antidote to the depressant effects of these drugs.

T J HUGHES

Walsgrave Hospital,
Coventry CV2 2DX

¹ Goodman, L S, and Gilman, A, *Pharmacological Basis of Therapeutics*, London, Macmillan, 1975.
² Fry, E N S, and Desphande, S, *British Medical Journal*, 1977, 2, 870.

Abuse of the National Health Service

SIR,—Concern is again currently being expressed in medical and political circles about the additional burden to the National Health Service caused by foreign nationals arriving in this country with demands for medical care. I would like to draw attention to a case that led to not only expensive treatment but also a hazard of communicable disease and further considerable expense in necessary follow-up examinations of contacts.

A young student arrived recently from South-east Asia to join a school of English on the south coast. After he had been in class for three weeks, the general practitioner who looks after the school received a copy of a report, forwarded by a consultant physician in South-east Asia, indicating that the student had been diagnosed earlier this year as suffering from active pulmonary tuberculosis, with x-ray findings that indicated appreciable infiltration and cavitation of the lungs, and had been started on a course of combined drug therapy. The general practitioner sent an immediate appointment to the student, who then absconded

to London, where he joined the class of another school of English, where he was in contact with other students for several days before being traced. He has now been persuaded to attend a London chest clinic. The treatment which he had allowed to lapse has been resumed, and the appropriate department of the Home Office has been asked what, if anything, can now be done about him.

It would appear that the student had no difficulty in leaving his own country, passing through a major British airport, and gaining admission to two language schools. Meanwhile treatment has been instituted at the expense of the National Health Service, and the number of contacts to be dealt with could be as many as 100.

KENNETH VICKERY

Eastbourne Health District,
Eastbourne, Sussex BN21 2BH

Cost of treatment in the NHS

SIR,—Mr J C Smith (13 October, p 940) suggests that all dispensed drugs be labelled with their true cost in order to bring home to patients the expense of their treatment and thus to aid compliance. He writes that the expense should also be brought home to doctors but does not suggest how.

It is doctors who write prescriptions, not patients. It is widely accepted that doctors frequently prescribe unnecessary medicines or expensive ones where a cheaper one would do just as well. It is doctors who are responsible for the NHS drug bill and who should be responsible for reducing it. It is also doctors who are responsible to a large degree for their patients' compliance: most patients will take their treatment conscientiously if they are told why and how.

I wonder whether the chief result of Mr Smith's scheme would be to make his patients feel guilty for being ill. I am not implying that this is his purpose, but may I point out that there is a simpler and older-established way of making ill people feel ashamed—the hanging of loud bells around their necks.

V P SMITH

The Old Grammar School,
St Ives, Cambs

Renal impairment and lithium

SIR,—A number of Scandinavian studies have suggested that severe renal damage may occur quite frequently in lithium-treated patients.^{1,2} This view has been challenged by Hullin *et al* (2 June, p 1457), who found slight elevations of serum creatinine in only five out of 106 patients on long-term lithium treatment.

We have found slight elevations of serum creatinine in only four out of 95 patients who have attended our lithium clinic during the past 12 years. Patients were excluded from this survey if they had taken lithium for less than three months, had a raised serum creatinine concentration before starting lithium treatment, less than three estimations of plasma lithium, or a history of hypertension or treatment with diuretics or other psychotropic drugs.

Serum creatinine was measured in different commercial laboratories, each with its own normal range. There were four patients whose serum creatinines exceeded the upper limit of normal by a mean of 22.6 $\mu\text{mol/l}$ (0.2 mg/100 ml). In this group there were three men and

one woman; their serum creatinine concentrations exceeded the upper limit of normal by 39.3, 22.6, 13.1, and 22.6 $\mu\text{mol/l}$ (0.3, 0.2, 0.1, and 0.2 mg/100 ml) respectively. Their mean age was 53.3 years, the mean duration of lithium treatment was 31 months, and the mean plasma lithium concentration was 0.82 mmol/l. In the patients with normal serum creatinines, the mean age was 47.3 years, the mean duration of lithium treatment was 45 months, and the mean plasma lithium concentration was 0.78 mmol/l.

Our findings indicate that long-term lithium treatment is associated with only mild renal impairment. Hullin *et al* commented that the patients with severe renal damage reported by others have had high plasma lithium concentrations. Hestbech *et al*¹ found interstitial nephritis in 13 out of 14 lithium-treated patients who had a mean plasma lithium concentration of 0.94 mmol/l. In contrast, the patients of Hullin *et al* had a mean plasma lithium concentration of 0.59 mmol/l. Our own group of 95 patients had a mean plasma lithium concentration of 0.78 mmol/l.

It may well be that the upper limit of the currently accepted therapeutic range for plasma lithium concentrations of 0.6 to 1.6 mmol/l³ is too high. It would seem prudent to maintain patients within a lower therapeutic range, especially as Hullin⁴ has reported that there was no increase in the frequency of relapse in lithium-treated patients with unipolar or bipolar disorders until the plasma lithium concentrations fell below 0.4 mmol/l.

DIANE KIMBRELL
E W D COLT
R R FIEVE

East 67 Street,
New York, NY 10021

¹ Hestbech, J, *et al*, *Kidney International*, 1977, 12, 205.

² Rafelson, O J, presented at International Lithium Conference, New York, 5–9 June, 1978, *Excerpta Medica*.

³ Schou, M, and Bastrup, P C, *Journal of American Medical Association*, 1967, 201, 696.

⁴ Hullin, R P, in *Proceedings of First International Lithium Congress*, ed S Gershon, N S Kline, and M Schou. Amsterdam, Excerpta Medica, in press.

Support for AETCEITIP?

SIR,—Dr D H Judson's *cri de coeur* (CDC) against the use of abbreviations (8 September, p 613) cannot be allowed to pass unsupported. His last appeal was "join with me," and I join with him entirely. I would like, through the medium of your correspondence columns, to let Dr Judson know that his is not a Lone Voice Crying in the Wilderness (LVCW).

English should be explicit—even in scientific and medical journals. Abbreviations are hardly ever explicit, seldom pretty, and often confusing. And never mind those who argue that "the context" will sort out the meaning of the abbreviations. May I give you some examples of mixed meanings? CNS has lost its time-honoured meaning and now stands for Community Nursing Sister. Recently I read a book review about EPNS. The book was a publication by the English Place Name Society. FPC can mean Family Practitioner Committee or Family Planning Clinic. Recently I experienced a most delicious transposition of abbreviations—a patient informed me that she had been fitted by the FPC with a UDI.

There are two other anathemas concerning the bastardisation of the English tongue, and you, Sir, and your fellow editors are party to