patients was the thrombus confined to the calf. This is at variance with a large study,¹ in which thrombus was confined to the calf in 49% of 493 legs containing thrombus. To say that "there was a general reluctance on the part of individual doctors to perform phlebography on patients with negative ^{99m}Tc-red-cell scans" merely emphasises the bias of investigation in favour of their own technique.

Secondly, this technique apparently lacks the facility of radionuclide venography, its nearest rival in providing a simultaneous lung scan. Finally, the acid test of all new diagnostic procedures is whether they may be applied in the district general hospital as readily as the teaching hospital. Conventional phlebography fulfils this criterion. We remain unconvinced that this new technique can alter the situation in any way, being more demanding in time, expertise, skilled manpower, and expensive equipment.

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¹ Stamatakis, J D, *et al*, *British Journal of Surgery*, 1978, **65**, 449.

No more textbooks on primary care?

SIR,—How sad that Dr Ian Tait should plead for "no more textbooks on primary care or general practice" (27 January, p 256). He argues that the range of primary care is too comprehensive and the clinical activities too variable between different practitioners to allow adequate coverage in standard texts. Primary care, he believes, is "inherently resistant to ossification in any form of standard text."

These arguments could be used against any standard text for most major specialities and to that extent they are valid. Indeed, it might be argued that all knowledge becomes ossified the moment it is set down in texts; but there are many good reasons why the attempt should be made, which do not necessarily relate in an obvious way to the needs of an intended reader. The first is that the creative activity involved in writing and the critical activity involved in reading medical texts, even standard texts, advance our specialty. This alone is sufficient reason for producing them. Medicine, however, does not consist of some theoretical body of knowledge which exists independently from patients. It can be understood and described only in relation to a given population. It is for this reason that Ian Tait's statement that the textbooks the general practitioners uses "are no different from those that serve the rest of his profession" should be analysed most carefully.

Primary medical care, wherever and however it is practised, is first-contact care and the population served by the general practitioner is fundamentally different from that served by the hospital doctor. Most medical textbooks are written by hospital doctors who have gained experience and carried out research on hospital patients. Their findings are fine for hospital patients but they cannot be applied uncritically to general practice. They may be right but there are many good reasons why they may not be. I have referred before in

your columns (1 July 1978, p 53) to the mistakes we can make when we base diagnostic and management norms and even our ideas about aetiology and prognosis on a hospital population. Our textbooks must be different from those that serve the rest of the profession because our patients and their problems are different; as with all texts, there will be good and bad but with impending mandatory vocational training we have never needed the good ones more urgently. They must continue to embody sound research into clinical medicine in general practice and involve everyday problems such as urinary infection, ischaemic heart disease, hypertension, and a score of other conditions, so that aetiology and prognosis can be more soundly based and diagnostic and management norms can be set—thereby building up knowledge that is relevant to the needs of our patients.

Of course, we need the help of our colleagues in other specialties but our problems have many unique features and attempting to produce a "standard text" is one way of helping us solve some of them.

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Hazards of fiberoptic bronchoscopy

SIR,—I would like to make a few observations regarding the leading article on "The hazards of fiberoptic bronchoscopy" (27 January, p 212).

One of the problems of performing this investigation under local anaesthetic (apart from the fact that a large number of patients find it very distressing) is the choice of drugs used for "sedation." This usually varies between an opiate and a benzodiazepine, usually diazepam. While it is well known that opiates in general produce respiratory depression, it appears to be less well appreciated that in the elderly and infirm diazepam is equally effective in producing it, even in small doses (2.5–5.0 mg intravenously). This equally applies to patients with chronic respiratory failure. It is one of the anaesthetist's less enviable tasks to be summoned to an apnoeic patient under these circumstances, and asked to undertake intermittent positive-pressure ventilation, for what may eventually be several weeks, owing to upsets in the physiological norm for that patient—the more so since rarely is the anaesthetist consulted, prior to the bronchoscopy on these problem patients, about the most appropriate form of anaesthesia.

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SIR,—Your leading article on the hazards of fiberoptic bronchoscopy (27 January, p 212) appears to us to overstate the case. This is a pity because it might well discourage the setting up of a district fiberoptic bronchoscopy service, such as we have in this group, offering inpatient or outpatient bronchoscopy on almost any day of the week.

After twenty years' experience of rigid bronchoscopy and now five years' experience of fiberoptic bronchoscopy, we have no doubt that this is a simple procedure, largely trouble free, and a great scientific advance. We have carried out over 1000 fiberoptic bronchoscopies under local anaesthesia, with no complications whatsoever. We use no premedication and

have had no trouble with bleeding. In our previous series of 4000 bronchoscopies under general anaesthesia using the rigid bronchoscope, we had five deaths, one due to haemorrhage and one to rupture of a large upper lobe abscess, and three in patients with lung cancer complicated by severe cardiorespiratory disease.

Advantages of fiberoptic bronchoscopy include the retention of the cough reflex and the absence of any respiratory-centre-depressant drugs, making bleeding unimportant. Also there are several simple methods of administering oxygen during the procedure. Again, after operation or in an intensive care unit a patient with atelectasis can be sucked out easily since the bronchoscope can be taken to the patient's bedside and, similarly, a diagnostic test can be easily carried out on a sick patient without moving him from his bed.

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Antinuclear factor in patients on prazosin

SIR,—Dr A J Marshall and his colleagues (20 January, p 165) described an increase in frequency of antinuclear factor (ANF) in patients under treatment with the hypotensive drug prazosin. Overall, 19 of 57 patients (33%) were found to have ANF, with some developing autoantibodies only after commencement of the drug. In contrast, our own data on a larger group of patients indicate that therapy with prazosin is not associated with increased ANF incidence. We found ANF in 9.8% of 132 hypertensive patients treated with prazosin compared with 11.6% of 1087 patients treated with other hypotensive drugs.

In a previous communication (7 January 1978, p 14) we have shown that methyldopa is clearly associated with a raised ANF incidence, so further analysis of our data was necessary. This showed that the incidence of ANF in patients treated with hypotensive regimens excluding methyldopa (736 patients), in patients taking prazosin but not methyldopa (92 patients), and in untreated hypertensives (352 patients) was not significantly different (7.3%, 6.5%, and 6.0% respectively). The combination of methyldopa with prazosin did not increase the ANF frequency beyond that of the group on methyldopa alone (20.5% with methyldopa, 17.5% with methyldopa plus prazosin).

A criticism of Dr Marshall's paper is that their data have not been evaluated against large numbers of age-matched controls. This is important as the frequency of ANF increases with age and is higher in women than men. The first group of 47 patients on prazosin described by Marshall *et al* were aged 55–73. No information is given on the ages of their control populations. A comparison from our series of treated hypertensives aged 60–69 compared with those aged 20–29 shows the ANF incidence to be 16.7% in the former and only 2.6% in the latter, a greater than sixfold difference. Similarly, the incidence of ANF in women patients aged over 50 on treatment with methyldopa is 52%, while for all patients on treatment with this drug ANF was found in fewer than 20% (391 patients). Despite this frequency of ANF it was not, in these