response to treatment may be misleading in an individual patient but this does not necessarily mean that it cannot be used as an assessment of response in a double-blind crossover study involving 20 patients.

With regard to their comments on the efficacy of intravenous aminophylline we would point out that our study was designed to assess the effects of salbutamol when given intravenously and by IPPB and therefore much comment about aminophylline would have been irrelevant. We cannot, however, support their claim that aminophylline is the bronchodilator of first choice in the treatment of severe acute asthma in hospital.

With regard to Dr Anderson's question, the dose of salbutamol administered by IPPB when a 0.5% solution is nebulised for three minutes via a Bennett ventilator cannot be precisely stated because of the several variables associated with this method of delivery.² However, it can be assumed that the maximum dose delivered does not exceed 10 mg.² Although we accept that we cannot state the precise dose of salbutamol administered by IPPB we cannot see how this "can make it difficult to assess our findings." These clearly show that 0.5% salbutamol administered by IPPB for three minutes (a nebulised dose not exceeding 10 mg) is more effective and less toxic than salbutamol 500 µg given by slow intravenous injection in the treatment of severe acute asthma. The dose of a bronchodilator drug given by IPPB does not have to be precise to achieve a maximum therapeutic effect.³

In a study involving treatment of severely ill patients there are advantages in being able to nebulise a drug for a constant period of time rather than administering a precise volume of solution. We would, however, agree that if our study had been designed to compare the effects of two drugs given by IPPB then it would have been desirable to make attempts to ensure that the same dose of drug was given to all patients.

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¹ Knowles, G K, and Clark, T J H, *Lancet*, 2, 1357.
² Choo-Kang, Y F J, Parker, S S, and Grant, I W B, *British Medical Journal*, 1970, 4, 465.
³ Paterson, I C, et al, *British Journal of Clinical Pharmacology*, 1977, 4, 605.

Mutual help service for doctors

SIR,—It is surprising that the letter from Mr K N Hambly, "Service for psychiatrically ill doctors?" (14 April, p 1020) has so far prompted little response, since it touches on a subject of extreme importance—and, of course, great sensitivity—to the profession.

Past experience suggests that if the medical profession does not solve its own problems others will sooner or later interfere to do this for it in ways it will not like. The problem Mr Hambly highlights can be expanded beyond that of the psychiatrically ill doctor. The profession needs to look into devising some form of confidential mutual help network and early warning system to assist and to defend doctors who are running into trouble in their working relationships, whether this is caused by psychiatric illness, physical disorder, or personality problems.

The first type of case is that of the doctor

who for some reason himself feels the need for help and advice, but is unsure of to whom he can turn for a fair, reliable, and confidential hearing. The second type arises when a doctor or doctors are so concerned about a colleague's health that they want advice about what they should do on his behalf. Thirdly, there is the doctor who is behaving in a manner which is apparently unreasonable and is causing distress to others on account of some idiosyncrasy of personality, a failure in the performance of his duties, or a change in his relationships with those about him.

In all these examples a doctor needs help for his own sake and to protect him and his patients before any of his action brings harm and discredit to him personally, his patients, and the profession.

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"Outwith my competence"

SIR,—The recent correspondence about "outwith" reminded me that 10 years or more ago I had to address the Conference of Local Medical Committees as a local representative, and the word had appeared in the GMSC report. I recall saying that only natural discretion prevented me from pressing a motion "Out with OUTWITH," since I felt that any attempt on my part to "have it out with" the redoubtable Dr James Cameron, the main author of the report, would probably result in his fellow Scot Dr Clark, who was chairman of the conference, crying "Out with him." I cannot remember now if I succeeded in persuading conference to support my main motion, but "outwith" provided a novice speaker with a laugh and I have liked the word ever since.

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SIR,—I am mystified at the correspondence this matter has provoked and the fact that no proper explanation of "outwith" and "with-out" has yet been offered.

The antonym is "within," which has a purely physical meaning. Its counterpart in a physical sense used to be "without," but this is now archaic because of its ambiguity; the word also means "not in possession of." Hence the present word "outwith." For example, "I am outwith my car" means something quite different from "I am without my car." And, incidentally, "outwith" is not a Scotticism. If you would like a current example of that consider the word "clerkess."

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Written information for patients

SIR,—I fully approve of the recommendations of Dr D A Ellis and others (17 February, p 456). In endocrinology this advice is particularly appropriate.

In this unit we have a number of printed or typed standard forms which we issue to patients (with copies going simultaneously to their general practitioners) to cover situations including the following: (a) thyrotoxic patients on carbimazole or propylthiouracil—warning of the significance of sore throat or

unexplained fever and appropriate action; (b) patients on vitamin D with or without calcium treatment—warning of the symptoms of hypercalcaemia, and appropriate action; (c) patients on corticosteroids either therapeutically or for replacement—with instructions on handling infections, operations, etc (in addition to information etched on a metal bracelet); (d) diabetics—a variety of forms to cover a number of topics.

In addition, in the majority of patients referred for an endocrine opinion or for long-term management copies of the letter to the referring doctor are usually sent to the patient as well (except where diagnosis or management is unusually controversial or where personal factors related to the patient's ill health are likely to cause distress if sent to the patient). In particular, whenever a patient with hypothyroidism is discharged from the clinic, the patient is given a detailed letter concerning presentation, physical signs, the laboratory tests which proved the diagnosis, usually the aetiology, and the recommended dosage of long-term thyroxine therapy. This should ideally prevent the common problem in endocrine clinics of the patient referred with a query about whether she needs her thyroxine. Patients seem to appreciate receiving the forms and especially the copies of letters to the referring doctor.

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Sacroiliac strain

SIR,—May I hasten to defend your claim (17 March, p 706) that there is no pathological basis for sacroiliac strain? There was a time when I used to make this diagnosis with gay abandon and absolute confidence in the correctness of both my examination and my diagnosis. Then I read James Cyriax on ailments related to the spinal column and intervertebral discs.¹ I thought that an interesting subject for research would be to try to refute Cyriax, which I have failed to do.

As part of this work I have been searching for the mythical sacroiliac strain for 25 years, during which time I have suffered the great disillusionment of finding only four cases which could possibly stand up to this diagnosis, and all of which were in pregnant women. I used the diagnostic criteria given by Cyriax together with an extra one of my own invention—applying my whole weight with a jerk on the sacrum of the prone patient, a test which cannot, of course, be carried out on the pregnant.

I discovered that my error had been one I have observed in everyone I have ever seen examine a patient with "sacroiliac" pain. The back is prodded till a tender spot is found on the posterior iliac border or the muscles just medial to it and up goes the shout of "sacroiliac strain." But the nearest point of the sacroiliac joint is behind the ilium two inches or more lateral to the part which has been prodded. The posterior iliac border is nowhere near the sacroiliac joint. Furthermore, this is a difficult joint to reach with an injection.

The natural history of the pain is that there are some cases of primary pain in this area, but the majority start with central back pain which moves to the posterior iliac border, thereafter frequently proceeding to the symptoms of sciatica. A large proportion of these cases respond to manipulation of the spine as for an