when prescribing monoamine oxidase inhibitors we should not only consider dietary amine intake.

L D GARDNER

West Baldwin, Isle of Man

Air embolism after removal of intravenous catheter

SIR,—I was interested to read the report from Dr Sheena M Ross and others (14 April, p 987) concerning a case of fatal air embolism occurring after the accidental removal of a central venous catheter. I suggested that air embolism might occur via the introducing cannula last year¹ and unfortunately my prediction has proved correct. There have now been about 34 reported cases of serious air embolism occurring when central venous catheters are used and the common cause at the present time is accidental disconnection of the administration sets from the catheter hub. The complication has been noted during dressing changes and also the insertion procedure. Ordway² has shown in animals that fatal quantities of air can rapidly enter the venous circulation through fine-bore cannulas.

I think that the introducing cannula should be withdrawn clear of the skin in order to remove the hazard of air embolism and to minimise the risk of infection from the sequestered blood lying between the central venous catheter and the introducing cannula. Finally, air embolism has been reported to occur via the track of a recently removed catheter³ and an occlusive dressing should be placed over the wound when catheters are removed.

J L PETERS

University College Hospital,
London WC1E 6AU

¹ Peters, J L, and Armstrong, R, *Annals of Surgery*, 1978, 187, 375.

² Ordway, C B, *Annals of Surgery*, 1974, 179, 479.

³ Paskin, D L, Hoffman, W S, and Tuddenham, W J, *Annals of Surgery*, 1974, 179, 266.

Motorcycle accidents

SIR,—I wish to take issue with Dr J G Avery (10 March, p 686) and his interpretation of motorcycle accident figures.

I submit that it is meaningless to apply the figures for the United States to Britain as driving conditions and habits there are very different from those in this country (for example, there is no limitation on the size of a motorcycle purchased by a novice save his resources, and he may buy an enormously powerful, unstable, and almost frighteningly vulnerable machine with little or no experience). It is not therefore surprising that accidents of primary effect, such as loss of control while cornering, are comparatively common. In England, however, there is a limitation on the capacity of the motorcycle one may buy until one has passed the test, providing a small benefit in terms of safety; far greater safety is inculcated by taking the RAC/ACU (Royal Automobile Club/Automobile Union) training course; this, sadly, is not compulsory.

A fairly recent survey¹ indicated that, of all accidents involving motorcyclists aged 17 and over, blame of any sort could be attributed to the motorcyclist in less than 33%. In another survey,² reported in this journal (6 January, p 39), one-third of the motorists actually

failed to see the motorcycle. What is more, of the 120 accidents examined in detail, 31 were caused by another vehicle leaving a minor road into the path of the motorcyclist and another 13 were caused by another vehicle turning across the path of an oncoming motorcyclist—in neither case, patently, could any blame be attached to the unfortunate rider. These two types of accident contributed almost three times as many to the total as the next major cause, loss of control while cornering, and were six times more frequent than the number of crashes caused by a motorcyclist turning into the path of another vehicle. This sheds a different light on Mr Eugene Hoffman's "menace on the roads" (p 686); and Dr Avery's comment that there seems to be no other method than helmet compulsion for "significantly reducing the carnage" seems positively pathetic in its inadequacy.

The fault does not lie with the poor, much-maligned, and all-too-often dead or seriously maimed motorcyclist, and it does not lie with the legislator who believes that polyurethane and fibreglass cocoons immunise against C3-4 dislocations (the commonest cause of death in instantly fatal accidents is cervical cord rupture). It lies with the multitudes of motorists of questionable visual ability who notice nothing less than five feet across. I'm not surprised that the poor motorcyclist has had enough. He was been monumentally long-suffering, he has donned his helmet, turned a tasteful day-glo orange (new colour seen recently—nausea green), dutifully put his headlamp on permanently, and swathed himself in reflective tape. All to no noticeable avail.

Legislation that compels people to do things must be bad legislation—if I wish to take up an NHS bed being rescued from my own Bacchanalian or nicotinic excesses that is "socially acceptable," but should I choose a motorcycle (primarily a fuel-and-resources-efficient way of transport, let us not forget) parliamentarians obediently rear up like Bateman's horrified guardsmen. I hope that it is clear from the foregoing that the answer lies in re-educating the car driver by making the driving test more stringent, so that people are more aware of the smaller vehicles on the road. To be fair, I would like to see the RAC/ACU test made compulsory since the Government seems unlikely to set up a sensible training scheme.

So the answer? Train everybody better; and, incidentally, let us have some action on drunken driving—a motorcyclist friend of mine was in an orthopaedic ward for three months after being mown down by a drunk driver travelling the wrong way round a roundabout.

R COTTINGHAM

St Thomas's Hospital,
London SE1 7EH

¹ Transport and Road Research Laboratory, *Motorcycle Accidents and Injuries*. Crowthorne, TRRL, 1973.

² Transport and Road Research Laboratory, leaflet LF 576. Crowthorne, TRRL, 1975.

Coronary artery spasm

SIR,—A clue to the nature of the "perverted internal secretion which favours spasm of the arteries" mentioned in your leading article (14 April, p 969) may lie in a relationship between coronary artery spasm and migraine.

Twelve patients who suffered from both

migraine and chest pain of an anginal nature were investigated by Leon-Sotomayor.¹ In six of them coronary arteriograms were carried out, four showing segmental spasm accompanied by anginal pain, which was promptly relieved by nitroglycerine. In four of the six the angiogram precipitated migraine. These and other observations and investigations led him to suggest that the underlying mechanism was an exaggeration of sympathetic activity. A similar but opposite alteration in vasomotor tone affecting both cranial and cardiac vessels is suggested by Ekblom² to explain the remission of anginal pain during periods when his patient suffered from cluster headaches. If migraine and coronary spasm share a common pathology this association is unlikely to be always innocent. Leviton³ has shown that the risk of a fatal heart attack is apparently increased in people with migraine, particularly in the younger age groups.

If there is such an association it is surprising that there are so few observations in the literature, for if it exists it should be fairly common. These pilot studies suggest that it is worth looking for. Much migraine can be avoided by appropriate management. Perhaps the same can be done for cardiac spasm.

WILLIAM COPPINGER

Reading,
Berks RG7 6NT

¹ Leon-Sotomayor, L A, *Angiology*, 1974, 25, 161.

² Ekblom, K, and Lindahl, J, *Headache*, July 1971, 157.

³ Leviton, A, Malvea, B, and Graham, J R, *Neurology*, 1974, 24, 669.

Proteinuria at high altitude

SIR,—It will be fascinating to read the account by Drs A R Bradwell and J Delamere of 17 trekker-doctor-scientists collecting 24-hour urine samples (2-3 litres each?) for 14 days in the Himalayas, which they refer to in their letter (21 April, p 1083). Presumably aliquots were preserved and analysed back in Birmingham and details of the methods used will be vital.

Preservation and transport present immense difficulties in the tropics. Aliquots I took at heights of up to 7500 metres on a technically easy climb in the Hindu Kush showed strong protein reactions to Bili-Labstix but variable results in laboratory analysis in London, because of deterioration during transport despite keeping them as cold as possible.¹ Aliquots I took at 6000 metres in the Andes were ruined by defective refrigeration in a British Airways plane. Most other "field" investigators have similar experience. So, though Bili-Labstix estimations are crude they compensate by allowing freshly taken samples of urine to be assessed on the spot, by contrast with the inevitable deterioration in samples brought back to the UK for analysis.

Obviously ordinary trekking to moderate heights is very different from difficult high-altitude mountaineering in activity, exposure, and ease of collection of samples. Mountaineers would give a very "blue" answer to requests to collect 24-hour specimens of urine during technically difficult, dangerous, long, and exhausting climbs. My data do give a fair picture of physiological trends in the particular circumstances, though with the small numbers of climbers differences could not be valid statistically.

Rennie and Joseph's paper² will still be considered a model study by most until

Bradwell and Delamere's account is available for comparison.

A PINES

East Herts Hospital,
Hertford SE13 7HU

¹ Pines, A, Slater, J D H, and Jowett, T P, *British Journal of Diseases of the Chest*, 1977, **71**, 203.
² Rennie, I D B, and Joseph, B, *Lancet*, 1970, **1**, 1247.

Commonwealth Medical Association

SIR,—I learn with amazement and considerable distress that Council has placed on the agenda of the next Annual Representatives' Meeting an item advocating that the BMA should resign from the Commonwealth Medical Association. I can hardly believe this is true.

As a past president of the BMA, I had the privilege and pleasure of being the first president of the CMA—a body formed and sponsored by the BMA. The CMA has since its inception faithfully supported the principle and standards—clinical, scientific, and ethical—of British medicine. We should not have to remember, but perhaps in this day and age we do, that Commonwealth medicine is British medicine. For the "senior partner" to resign on the specious excuse of saving the paltry sum of (I believe) £400 is surely evidence of a policy so petty, mean, and frighteningly parochial as to be almost incredible.

At this particular time in our history neither this country nor for that matter its medicine (which I trust the BMA still feels its responsibility to represent) has so many friends we can afford to throw them away with gay abandon. Are trust, tradition, and friendship to be casually thrown away for a few "pieces of silver"? I sincerely hope Council will rapidly have second thoughts on this matter and expunge this disgraceful item from the ARM agenda.

PORRITT

London NW8

SIR,—As the first vice-president of the Commonwealth Medical Association and as the chairman of the Overseas Committee which advocated that the BMA should found this organisation, I am greatly distressed to find that a proposal to the ARM to withdraw from the CMA has been put forward by Council (7 April, p 19 of Annual Report of Council).

It is true that the days of Empire are past but there has been the constant and continuing close relationship of what were former colonies and dominions to this country. A very great degree of friendship and collaboration has remained. These developments arose from the evolution of independent states and were right and proper, but for the UK to cast off former friendships is indicative of our waning national spirit in a country which once deserved the term great. We are casting and destroying our heritage, discarding our friends, and regarding our interests as limited to the UK. Something which has taken decades to build up is going to be destroyed at a stroke and may never be revived. The BMA in future will be seen as concerned with parish-pump politics and home trade-union activities.

I am aware that the CMA involves expense and it might well be that in days of financial stringency curtailment of its activities may be necessary, but to abandon it is both unwise and in my opinion dishonourable. If this is our point of view then we cease to deserve the regard, affection, and respect with which hitherto the BMA has been regarded by other

members of the Commonwealth and I would be ashamed of the Association.

ERIC C MEKIE

Edinburgh EH8 9DW

PPP plan for BMA members

SIR,—I am delighted to see that Mr J G W Gelling (14 April, p 1022) is sympathetic to the problems I mentioned earlier (24 March, p 826). My only regret is that he has not sufficient courage of his convictions to extend the concession to all patients in the plan and not to a selected few, which seems to be rather arbitrary and unfair. I would hasten to add, however, that my criticisms were not directed at PPP specifically, and indeed I did state that all provident associations have some form of restriction on outpatient fees. I have certainly no complaint about the PPP plan as a whole, which compares well with the others.

Mr Gelling goes on to ask how the private diagnostic investigation facilities are to be provided, but this is not the problem which currently affects me. At present in the Guildford area I can provide private diagnostic facilities in my own specialty but with an increasing number of patients opting to have outpatient investigations on the Health Service it is doubtful if the provision of such services, which inevitably involve the provision of expensive apparatus, will continue to be an economic proposition. When setting up new laboratories I have no doubt that some form of capital support would be required and there would certainly be a role for private enterprise, whether from the provident associations or from elsewhere. However, in that case also a reasonable return for the money invested would be expected and indeed might be more rigorous in this context, as it would be a commercial enterprise expecting a competitive amount of interest on the capital involved.

The local area health authority has just ruled that access of private patients to the newer facilities being provided in our new hospital when it opens later this year will not be allowed. It therefore seems that this form of test will not be available privately as there would be inadequate use privately to warrant the expenditure and it will not be available at the local hospital on a private basis either. Surely this is yet again a warning that in due course investigation facilities will become a National Health Service prerogative unless we take action now. Once the investigations are entirely under the NHS private medicine will be at jeopardy except for those few illnesses which do not require modern technological investigation.

S G BAYLISS

Royal Surrey County Hospital,
Guildford, Surrey GU2 5LX

The new consultant contract

SIR,—The following statement has been signed by 83 clinical scientists, with honorary consultant status, working in Medical Research Council units and university and medical school departments throughout Great Britain.

"We wish to bring to the profession's attention our condemnation of the proposed consultant contract. We assume, perhaps naively, that we will be offered the same salary as our full-time NHS colleagues who choose to opt out of the right to do private practice. In addition, some additional payment for not being able to complement our salaries by

doing domiciliary visits would be advisable if academic work is not to suffer. However, despite these safeguards, it is clear to us that the salaries of consultant medical academic staff must fall behind those of our NHS colleagues as it will prove impossible to assess an academic's worth in terms of 'sessions'."

"We do not favour extra-duty payments or 'banding' for on-call commitments as this will be unworkable and divisive in our context. If the present proposed contract is implemented, it is hard to see how any young doctor will be able to consider a research career. Many established clinical scientists will also be unable to come to terms with this situation and either return to full-time NHS appointments or leave the country. We urge all those who value clinical research in this country to vote against the consultant contract. If the profession does not accept the contract, then the BMA should negotiate a straightforward increase in salary."

The signing of this letter by a large number of clinical scientists who hold honorary consultant appointments underlines their fear that medical research will suffer if the proposed consultant contract is implemented. I believe that the relatively high standard of medicine and surgery in this country is partly due to the close association of clinical research with routine clinical practice in both our medical schools and our peripheral hospitals. The proposed contract will increase the drift of potential medical scientists away from research, with disastrous consequences.

Some may think that the short-term gains in income are worth a "Yes" vote but it is becoming clear that the long-term implications are not so attractive.^{1 2} I hope the above letter, signed by some of our eminent medical scientists, will persuade your readers to vote against the contract and will encourage the BMA to seek alternative ways of improving remuneration and conditions.

A D B WEBSTER

MRC representative, Medical Academic Staff Committee,
Northwick Park Hospital and Clinical Research Centre,
Harrow, Middx HA1 3UJ

¹ Booth, C C, *et al*, *British Medical Journal*, 1979, **1**, 755.
² *World Medicine*, 24 March 1979, 39.

* **In its annual report the Medical Academic Staff Committee made the following comments on the implications for clinical academic staff of the NHS consultants' new contract: "The introduction of the new consultant contract without adequate preparation being made for clinical academic staff would have the most serious repercussions on academic medicine. . . . The overall remuneration in terms of payment for work done and fringe benefits is even now considerably greater in the NHS than in the academic medical world. There will be greater differences with the introduction of the new consultant contract. The Clinical Subcommittee is convinced that comparability for those holding honorary contracts must include remuneration for work such as emergency recalls and domiciliary visits undertaken for the clinical care of patients. The committee has discussed the type of contract [and] feels that [it] should be of the same type as the present contract in that it should not be work sensitive. . . . It is impossible to ensure that medical academic staff receive *identical* sums of money for doing the same work as an NHS equivalent. It should not be impossible to ensure that there is equality of remuneration within a range of plus or minus £500."—ED, *BMJ*.