this more apparent than in gynaecological oncology, which is an established subspecialty and demands knowledge of chemotherapy and radiotherapy as well as surgery. By encompassing the various medical disciplines a better understanding of the pathophysiology and natural history of gynaecological malignancies is obtained. This is important when dealing with a group of cancers which may still benefit from surgery, even in the light of seemingly hopeless metastatic spread. The aid of nursing staff familiar with surgical as well as oncological techniques is vital. A well-trained gynaecological oncology nurse is invaluable in the care of these patients and often provides a sympathetic link between the patient and her doctor, who may not be aware of her more personal problems.

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Preoccupation with hypertension

SIR,—Am I alone in being concerned about the current wholesale preoccupation with hypertension? To take an otherwise fit person and pronounce him to be medically substandard and needing supervision for the rest of his days is arguably to diminish his quality of life. This should be carefully balanced against the benefits it may bring.

I think we are losing this balance. I see many patients referred back to me "for treatment of hypertension" who have had a raised blood pressure found on some occasion and who turn out to be normotensive. In many of their minds a lingering doubt clearly remains. There are many others in whom for one reason or another it is impractical or inadvisable to achieve normotensive levels and who are needlessly alarmed by thoughtless words spoken to them.

I do not decry the value and need of treating hypertension but unhappy with the tendency of fashionable campaigns to produce a nation of medicated neurotics, especially in borderline cases.

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An obstetrician epidural service

SIR,—Professor B M Hibbard and others reported on obstetric anaesthetic and analgesic services in Wales (22 September, p 698). No reference was made to an epidural analgesic service given by obstetricians (not anaesthetists) in one unit. This omission was surprising as the authors had been informed both by personal communication and by a paper presented by one of us (GR) at a symposium on obstetric anaesthetic services at the University Hospital of Wales in February 1978. We have delayed writing our letter until the most recent data for 1979 were available.

The numbers of deliveries from 1973 to 1979 at the West Wales General Hospital, Carmarthen, is shown in the table together with the numbers of epidural anaesthetics administered for pain relief in labour and the percentages of deliveries in which epidurals were given. One obstetrician (GR) was single handed from July 1973 until the appointment of the second Consultant (PB-W) in May

1976—hence the increased numbers from 1976 onwards. Of the 135 epidurals given in the last two years, 20 were given by anaesthetists.

Professor Hibbard and his colleagues refer to an epidural incidence of 15% of all deliveries in those units where epidural analgesia was "freely available" and where the staff consisted

Number and percentage of deliveries in which epidural anaesthetics were given for pain relief at West Wales General Hospital, 1973-9

Year	No of deliveries	No (%) of deliveries in which epidurals given
1973	1146	17 (1.4)
1974	1169	15 (1.2)
1975	1162	12 (1.03)
1976	1262	39 (3.1)
1977	1309	41 (3.1)
1978	1356	70 (5.8)
1979	1476	65 (4.4)

of two full-time obstetric anaesthetists and their junior staff. Our numbers are small by comparison, but the epidural service was largely provided by only two obstetricians, and for medical indications in nearly all cases. We wish to acknowledge the tremendous dedication and support from our midwives at Carmarthen. They have frequently administered the "top-up" injections and no serious mishap has ever occurred.

In the paper presented by Professor Hibbard and his colleagues the distribution of anaesthetists in Wales is skilfully avoided, though it is well known that the only two full-time obstetric anaesthetists are in the South Glamorgan Area Health Authority (Teaching), complemented by eight senior registrars in rotation and even greater numbers of registrar-grade anaesthetists. We appreciate and acknowledge the excellent teaching provided at the University Hospital, Cardiff, but we fully support the view of Dr D J Bowen and others (15 December, p 1587) that obstetric anaesthetic services should be improved where deficiencies clearly exist. At Carmarthen we look forward to the appointment of the fifth consultant anaesthetist in 1980, who will have a specific number of obstetric sessional commitments.

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Bicycles and health

SIR,—Dr Ronald Williams (22-29 December, p 1617) gives a fascinating review of those advanced movers man and the bicycle. I would add a fragment on depreciation—the example, I imagine, not being unusual.

My present machine, essentially standard, cost me approximately £5 in 1930 and has run constantly since. The first decade, when I was a student and junior, it laced me intensively about London with sallies around southern Britain and after that similarly, at lower mileage, in the north and constantly about town. It may well run another 50 years, but if we take 10 pence per year depreciation this should, I suppose, on viewing from values now, be corrected to approximately £1 per year. Economical?

Providing spaceway for the cycle should be on the agenda of the academy of health you urge (p 1611). Incidentally, I should prefer that this were a small EEC body. Agriculture

and transport much concern health and are likely to be promoted there.

H F BARNARD

Beverley, N Humberside

SIR,—A patient treated recently in this hospital demonstrated a point raised in Dr Ronald Williams's excellent article (22-29 December, p 1617). A 58-year-old woman was admitted with acute breathlessness, and after bronchoscopy under general anaesthesia failed to maintain adequate ventilation. In determining her prognosis the physicians stressed to the anaesthetists that the patient, even though a very heavy smoker, had basically good lung function as she had been using her bicycle regularly prior to her admission.

Cycling is the most efficient form of transport known in the animal and mechanical kingdoms; 3.33 kJ (0.8 kcal) per gram per kilometer are consumed when walking, 0.63 kJ (0.15 kcal) per gram per kilometer when cycling. It is far less tiring to ride than to walk the same distance. Energy expenditure, oxygen consumption, and cardiac stress will be low when cycling; and in this case the patient's performance was erroneously used as an assessment of lung function and tolerance to exercise.

Cycling may give extra, useful mobility to those suffering from angina of effort and chronic lung disease.

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The persistent salmon patch

SIR,—Dr H B Valman (12 January, p 91) writes, "Diffuse capillary naevi on the face, eyelids, or occiput are common and resolve within a few months." I think most agree that telangiectatic naevi (salmon patches or stork bites) in the newborn over eyelids and glabella usually subside very rapidly but anyway within a year. However, there is much difference of opinion regarding the fate and indeed the incidence of the nuchal or occipital naevi. From our findings in the aged¹ and those of Øster and Nielsen² and Bettley³ it seems likely that salmon patches over the neck which appear in the newborn are very common and usually persist throughout life rather than resolving within a few months of their appearance.

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¹ Verbov J, Steinberg R. *Br J Dermatol* 1974;**90**:586-7.
² Øster J, Nielsen A. *Acta Paediat Scand* 1970;**59**:416-23.
³ Bettley FR. *Br J Dermatol* 1940;**52**:363-70.

First-aid treatment for acute coronary thrombosis

SIR,—Your expert's answer to the above query (15 December, p 1565) disturbs me regarding two points.

Digoxin can itself produce any type of dysrhythmia and to give it intravenously during the acute stage of infarction when the cardiac muscle is irritable and very vulnerable is fraught with danger. This applies not only when the tachycardia is of sinus origin

(caused by anxiety, inappropriate, or paroxysmal) but even more so if it is of ventricular origin. The commonest cause of ventricular tachycardia is acute cardiac infarction, and the differentiation at the bedside between a paroxysm of ventricular tachycardia and one of supraventricular origin is by no means easy. Both usually give a heart rate of 160 or more beats a minute and one of the few differences is that in ventricular tachycardia spacing of the beats may be irregular and this may be clinically perceptible. Your expert, who recommends intravenous digoxin for a heart rate that "becomes fast and irregular," could easily convert what might be a ventricular tachycardia into ventricular fibrillation.

Nor am I happy with the routine use of lignocaine to prevent primary ventricular fibrillation. This is a longstanding controversy but there is increasing opinion today not only that it may be of no use but that it may actually be harmful. Pantridge¹ in 1970 found lignocaine to be ineffective against ventricular ectopic beats occurring in the first hour of the clinical onset of acute myocardial infarction. In 1971 Chopra *et al*² showed that both ectopics of R on T type and multifocal ectopics were resistant to lignocaine, and that the only ectopics which were easily abolished were those occurring in diastole—and these in any case are considered relatively benign and unlikely to produce primary ventricular fibrillation. Darby *et al*³ in 1972 found that ventricular tachycardia and fibrillation occurred no less frequently in the group treated with lignocaine than in the control group. Lie *et al*⁴ in 1974 in 400 successive patients with acute cardiac infarction found that 5% developed primary ventricular fibrillation in the lignocaine-treated group as opposed to 4.3% in the control group. Moreover, Bleifeld⁵ showed that ectopic beats, sinus bradycardia, and second-degree atrioventricular block were more common in the lignocaine-treated group than in the control group; and concluded that lignocaine should not be used routinely in acute cardiac infarction.

Furthermore, your expert does not mention that it is necessary whenever one gives lignocaine intravenously to give it very slowly—taking at least two minutes to administer 100 mg of a 1% solution; otherwise toxic effects of lignocaine, such as bradycardia and hypotension, are apt to occur. This is particularly important in the elderly, where following its administration many authors⁶⁻⁸ have reported sinus bradycardia, ectopic beats, sinoatrial block, and even cardiac arrest.

Incidentally, I am sure that your expert is referring to dipyrindamole and not disopyramide in connection with antiplatelet aggregation action.

I agree that your expert was attempting to "oversimplify" the problem, but I hope not at the expense of creating new problems.

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¹ Pantridge JF. In: Scott DB, Julian DG, eds. *Lidocaine in the treatment of ventricular arrhythmia*. Edinburgh: Livingstone, 1971:77-81.

² Chopra MP, Thadani U, Portal RW, Aber CP. *Br Med J* 1971;iii:668-70.

³ Darby S, Cruickshank JC, Bennett MA, Pentecost BL. *Lancet* 1972;ii:817-9.

⁴ Lie KI, Wellens HJ, Durrer D. *Eur J Cardiol* 1974;1:379-84.

⁵ Bleifeld W, Merx W, Heinrich KW, Effert S. *Eur J Clin Pharmacol* 1973;6:119-26.

⁶ Lippstad CT, Forfang K. *Br Med J* 1971;ii:537.

⁷ Jeresaty RM, Kahn AH, Landey AB. *Chest* 1972;61:683-5.

⁸ Cheng TO, Wadhwa J. *JAMA* 1973;223:790-2.

*With regard to the first point, we regret that we printed disopyramide rather than dipyrindamole. The similarity between these two names presents a recurring problem. Dr Morgan points out that intravenous lignocaine must be given slowly. Of course, no drug should be given fast intravenously, and lignocaine is no exception. There are indeed papers suggesting that this drug may not be useful but at least it rarely seems to do harm. If the heart is beating very fast and the patient is hypotensive it must be slowed. Clearly an electrocardiogram, correctly interpreted, is desirable but we live in an imperfect world. We do not agree that ventricular tachycardia and rapid atrial fibrillation would often be confused. The irregularity of ventricular tachycardia is obvious on paper but usually slight compared with that of atrial fibrillation. The rate of atrial fibrillation can be slowed by a beta-blocker or by verapamil but we would not regard these as safer than digoxin in this hypothetical emergency.—Ed, *BMJ*.

Effects of naloxone on pethidine-induced neonatal depression

SIR,—We report a follow-up on children included in a neonatal study of the effects of naloxone on pethidine-induced depression of respiration, feeding, and measures of behaviour.¹

Nineteen of 29 infants included in the original trial attended for examination when aged 10-16 months. At birth nine of the infants had received placebo (normal saline) and 10 naloxone hydrochloride 200 µg intramuscularly. At follow-up all were rated on the Cardiff standardisation of the Denver developmental screening test² and were neurologically examined. No differences were found between the placebo and naloxone groups of children. Of the nine children in the placebo group one had delayed gross motor and two had delayed fine motor development. Two of the children in the naloxone group had delayed gross motor achievements.

These findings complement the results of the original trial, which indicated that 200 µg intramuscular naloxone at birth seemed to reverse the undesirable effects of pethidine up to 48 hours after birth. We conclude that naloxone did not disproportionately affect development.

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¹ Wiener PC, Hogg MPJ, Rosen M. *Br Med J* 1977;ii:228-31.

² Bryant GM, Davies KJ, Newcombe RG. *Develop Med Child Neurol* 1979;21:353-64.

Resuscitation of the newborn

SIR,—Dr A R J Bosley (15 December, p 1590) is incorrect in stating that the Penlon bag was not designed for use with an endotracheal tube. Mushin and Hillard mentioned such an application in their original description.¹ The ability of the device to create airway pressures up to 80 cm H₂O was also noted. In using a

leak hole in the inflating valve (instead of an ordinary blow-off valve with a preset pressure limit) the authors found that as pulmonary compliance increased (with inflation of the lungs) the maximum pressure obtainable would fall. This variable blow-off effect was justified by pointing out that the inflation pressure needed for totally airless lungs² may often be 80 cm H₂O, so it was illogical to use a blow-off valve preset at a lower figure. Nevertheless, in another study, which compared the Penlon bag with the Ambu neonatal bag, which uses an equally novel mechanism, again not dependent on a blow-off valve, it was found³ that both gave maximum pressures of about 85 cm H₂O with either a high or a low resistance. However, the Penlon created a maximum pressure of 175 cm H₂O in a closed system compared with only 85 cm H₂O with the Ambu bag.

Despite these comments, these "flat" babies will not survive without someone inflating the lungs with one of a multitude of devices at his disposal. The fact that they all carry risks of pneumothorax, which may prove fatal, does not alter the situation. Endotracheal intubation of the neonate is often difficult to perform and to teach⁴ but may be life saving. With the appalling UK perinatal mortality statistics, can we afford to limit the resuscitation abilities of the obstetric team?

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¹ Mushin WW, Hillard EK. *Br Med J* 1967;ii:416-7.

² Rosen M, Laurence KM. *Lancet* 1965;ii:721-2.

³ Rondio Z, Rawicz M. *Anaesth Resus Intensive Therap* 1976;4:273-9.

⁴ Rosen M, Mushin WW. *Lancet* 1968;ii:1307.

Towards fewer handicapped children

SIR,—Your recent leading article "Towards fewer handicapped children" (8 December, p 1458) mentions the relation between severe handicap, low birth weight (<2500 g), and low socioeconomic group and suggests that researchers might best employ themselves by identifying which particular components of socioeconomic deprivation result in an increased incidence of handicap. Surely part of this research has already been done.

Improved maternal nutrition during pregnancy in low socioeconomic groups is known to increase average birth weight, reduce the incidence of low-birth-weight babies (<2500 g), and reduce perinatal mortality. Thus in Guatemala¹ adequate maternal dietary supplementation during pregnancy in village dwellers resulted in an average fall from 30% to 9% in the incidence of low-birth-weight babies. Similar findings are demonstrated in developed countries. In Montreal² reduction in the incidence of low-birth-weight babies (<2500 g) and a decrease in both perinatal and neonatal mortality was shown in a high-risk, low-socioeconomic study group subjected to "intensive nutritional care" (counselling and dietary supplementation) throughout pregnancy.

With such improvements in birth weight and reduction in perinatal and neonatal mortality can one not expect an attendant reduction in morbidity, including mental and physical handicap? While attention is focused sharply on perinatal intensive care, could we not reduce perhaps the size of the perinatal problem by instituting "intensive nutritional care," including dietary supplementation