Labetalol and priapism

SIR,—Prazosin, a drug with alpha-blocking action, has recently been suggested as a cause of priapism (27 October, p 1039). The occurrence of priapism during phenothiazine therapy has also been attributed to alpha-adrenergic blockade.¹ We have recently seen a 25-year-old Caucasian patient on dialysis with priapism in whom residual hypertension was treated with labetalol 400 mg twice daily. He had been haemodialysed twice weekly for two months and had received labetalol in increasing doses for 41 days. Priapism developed while he was on dialysis, failed to respond to early bilateral saphenocorporal anastomoses, and subsided eventually in 10 days. Labetalol was continued in the same dosage throughout the period of the erection. The patient is impotent after 10 weeks.

Priapism has also been reported as a complication of haemodialysis.^{2,3} It is therefore possible that the alpha-adrenergic-blocking property of labetalol or uraemia was the cause of priapism in our patient.

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¹ Dorman BW, Schmidt JD. *J Urol* 1976;116:51-53.

² Port FK, Fiegel P, Hecking E, Köhler H, Distler A. *Lancet* 1974;2:1287-8.

³ Sale D, Cameron JS. *Lancet* 1974;2:1567-8.

Wanted: a new wound dressing

SIR,—Some years ago I saw a scientific exhibit at the American College of Surgeons' meeting in Chicago. It showed the appalling effects of injuries caused by high-velocity bullets, the level of fatal infection being very high. I asked the surgeon in charge if he had ever considered using the Carrell-Dakin technique. "What's that?" he asked. I replied that it was the method of treating gun shot wounds which revolutionised war surgery in the 1914-18 war. "The 1914-18 war!" he exclaimed. "We never go back more than 10 years!"

I feel that your leading article on wound dressings (22 September, p 689) has much the same attitude, since it shows little awareness of how much has been done in the field of surgical dressings. The open method of Wallace was useful for the second-degree burn, but has been almost entirely abandoned in the treatment of the third-degree burn. It is difficult to understand why the Bunyan-Stannard occlusive envelope (developed during the last war), making possible the convenient irrigation with sodium hypochlorite, has been almost entirely ignored by surgical writers. It was non-adherent, painless, did away with painful dressings, and prevented cross-infection; and if its use was properly taught and applied it brought about excellent healing. I am glad to say that a modern version is becoming more widely used.

Over 20 years ago I invented a non-adherent dressing which allowed free drainage. It was known as Perfron, and was used for some years with success; but unfortunately the manufacturer to whom I entrusted the idea would not make large sheets and kept to the Band-aid type. My original experiments were aimed at a

suitable dressing for circumferential burns, which proved successful.

I have a later invention, based on the properties of hypochlorite, which is even more effective; but so far I have not succeeded in persuading a manufacturer to take up the idea. I can demonstrate a dressing which not only conforms to your specification but in addition is bactericidal and bacteriostatic. However, the immense cost of meeting the official requirements for clinical trials certificates has halted further development. No pharmaceutical firm will show interest unless it can be demonstrated that the product will be accepted by the official safety bodies, and no private individual can afford to proceed on his own. Catch 22. The difficulties facing the medical innovator are now almost insuperable.

If a new approach to dressing technology is urgently required, surely the authorities should be prepared to assist the innovator in his search for the most suitable material, instead of barring his way and setting up obstacles that require endless time and enormous cost to overcome.

I can supply full information on my developments to anyone interested.

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*.*This correspondence is now closed.—ED, *BMJ*.

Surgery in outpatients

SIR,—It should not be thought that the practice of performing relatively major operations on outpatients was developed only in the Royal Glasgow Hospital for Sick Children and "in other large institutions north and south of the border" (8 December, p 1459).

When Nicoll of Glasgow spoke at the annual meeting of the British Medical Association in Belfast in 1909¹ on the surgery of infancy and described the many operations he had done on children as outpatients, Robert Campbell of Belfast expressed strong approval of the practice—which, he said, he had followed in the Royal Belfast Hospital for Sick Children for some time.

By 1912 the list of outpatient operations in Belfast being performed on children included hernia, hydrocele, hare lip, cleft palate, knock knees, bow leg, enlarged tonsils, adenoids, enlarged glands, tumours, and cysts in the neck, and many other conditions.

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¹ Nicoll JH. *Br Med J* 1909;ii:753.

Parenteral nutrition before surgery?

SIR,—In your interesting leading article about preoperative nutrition (15 December, p 1529) I was surprised to see that the emphasis was on the parenteral route, in particular involving a central line. Most of the potentially lethal complications of parenteral nutrition involve the mechanics of its means of delivery, and surely rotating peripheral lines are the safest procedure when nutrition has to be given intravenously.

But why should the nutrition have to be parenteral? If the alimentary tract between the pylorus and anus is working satisfactorily it is a pity not to use it: enteral nutrition is safer, less time consuming, and cheaper than parenteral nutrition. It is a rare carcinoma of the oesophagus or stomach that cannot be negotiated preoperatively by a fine-bore soft feeding tube enabling satisfactory delivery of low-viscosity calories, protein, minerals, and vitamins to the small bowel.

The enteral route may also be used for nutrition in early stages after laparotomy or thoracotomy and laparotomy: the postoperative ileus affects the stomach and large bowel, and the small bowel ileus has usually resolved by 12 hours after surgery. If a fine-bore soft feeding tube is passed across any oesophageal or gastric anastomosis into healthy small bowel at the time of surgery, nutrition may be delivered into functioning intestine on the day after surgery. It is probably wise to pass a conventional nasogastric tube alongside the fine-bore tube, stopping 10 cm short of it, to provide early evidence of regurgitation and also to decompress any gastric remnant.

As far as the results of preoperative nutrition are concerned, trials should concentrate on accurate preoperative diagnosis of malnutrition and the effect of preoperative nutrition studied on these patients. If the morbidity of parenteral nutrition is avoided we may well find that theoretical advantages of peri-operative nutrition are borne out in clinical practice.

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Diagnostic kits and the clinical chemist

SIR,—As a clinical biochemist now managing a company in the diagnostic kit field, I was interested in the comments made by your correspondent Miss Mary Warner (15 December, p 1581). Although primarily aimed at side-room tests, the letter did make some unbalanced statements about diagnostics in general.

My own personal view is that the use of diagnostic kits in UK laboratories has enabled highly sophisticated medicine (particularly in the endocrine field) to reach communities distant from the teaching centres that would otherwise not have ready access to such rapid facilities. In the laboratory significant advances have been made in methodology by commercial innovations. Radioimmunoassays that took three or four days to complete several years ago can now be completed in five or six hours as a result of reagents which have short incubation times. Diagnostic kits therefore have made a very significant contribution to both patient care and laboratory efficiency.

All biochemical methodology must be shown to be accurate and reliable. This is true whether developed "in house" or bought from a commercial source. National quality control schemes, however, show that many assays are not accurate or reliable. Reputable companies have a professional reputation to maintain and most go to great lengths to ensure that accuracy and reliability are built into their products, and that they are backed up by extensive clinical trials before they go on sale.

Finally, manufacturers by their very nature can survive only by making a reasonable profit. Without this profit they would cease to