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.

M R LAW
R F P COPLAND
J G ARMITSTEAD
ROGER GABRIEL

Departments of Renal Medicine
and Urology,
St Mary's Hospital,
London W2 1NY

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.

JOHN BUNYAN

19, The Beach, Walmer, Kent

*.*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.

H G CALWELL

Office of Archives,
Royal Victoria Hospital,
Belfast BT12 6BA

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.

JOHN SHAW

Addenbrooke's Hospital,
Cambridge CB2 2QQ

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

exist, and many patients would be the worse off.

MICHAEL WALKER

Diagnostic Division,
Serono Laboratories (UK) Ltd,
Welwyn Garden City, Herts AL7 1HH

Monitoring blood glucose

SIR,—Mary Warner cogently puts the case for accurate and precise estimation of blood glucose in the laboratory, and Mr G Dixon and others commend the use of glycosylated haemoglobin in monitoring diabetic pregnancy (15 December, pp 1581 and 1582).

The days of the single clinic blood glucose estimation for assessment of treatment of diabetes mellitus must be numbered, since glycosylated haemoglobin levels reflect mean blood glucose over the previous six-week period, responding to either periods of hyperglycaemia or unexpected nocturnal hypoglycaemia.¹ When glycosylated haemoglobin estimation indicates a need for a series of blood glucose estimations in a patient, home monitoring of blood glucose using filter paper strips eliminates the need for the manipulation of a blood-glucose meter by a patient, the laboratory method having a between-batch coefficient of variation of 4%.² The worry that glycosylated haemoglobin will break down rapidly during a spell when the blood glucose is within normal limits, resulting in lack of detection of inadequate control, has been relieved.³ Any self-respecting clinical laboratory taking part in national quality control should produce more reliable blood glucose levels than can patients at home.⁴

Finally, with glycosylated haemoglobin estimations, carried out with a kit, costing about £1, and routine blood-glucose estimations costing less, if I were to spend less on laboratory estimations I would not wish to buy outpatient blood-glucose meters costing £200 with continuing (I nearly put "ongoing") costs for paper strips, which are liable to variation.^{5,6}

R D EASTHAM

Department of Pathology,
Frenchay Hospital,
Bristol BS16 1LE

¹ Gale EAM, Walford S, Tattersall RB. *Lancet* 1979;2:1240-1.

² Paisey R, Bradshaw P, Hartog M, West P. *Br Med J* 1979;2:1509.

³ Welch SG. *Lancet* 1979;1:728.

⁴ Legg EF, Sammons HG. *Lancet* 1979;1:1194-5.

⁵ Worth R, Johnston DG, Anderson J, Alberti KGM. *Lancet* 1979;2:742.

⁶ Lawson PM, Kesson CM, Ireland JT. *Lancet* 1979;2:742.

Medically qualified preclinical academics

SIR,—We were interested to read the article by Dr R R Sturrock (8 December, p 1513), and are delighted to see a letter from a medically qualified anatomist.

We would not decry the place of his teaching and research commitment, although we would not accept his argument that involvement in clinical activities would be detrimental to the "academic standards of the preclinical departments." It is only fair to point out to your readers that a number of professional anatomists, supported by their clinical colleagues, play an important role in the clinical situation by undertaking sessional NHS commitments while making very substantial contributions to university departments and, furthermore,

make time to organise and contribute to post-graduate basic science courses which have a good record in the training of those seeking careers in surgery, medicine, and other specialties.

We would argue a case for closer liaison between those in the preclinical departments and the clinical medical school, with an interchange in both directions. Further, we deplore the declining number of medical graduates entering preclinical departments. While we do not in any way deplore the service given by non-medically qualified staff, we nevertheless believe in the fundamental concept of medically qualified graduates teaching subjects such as anatomy to those people who are destined to enter general practice and hospital medicine. How else can structure and function be related to the disease processes they will ultimately see and treat?

We would direct the attention of your readers to an excellent article by McMinn entitled "Medical anatomists—a dying race,"¹ which argues that there is an increasing difficulty in attracting good people into clinical academic subjects, let alone the basic science field. Rightly he points out that remuneration is a major stumbling block in both instances but especially in the recruitment of medical graduates by preclinical departments. He makes a good case for most medical anatomists maintaining a special interest in some clinical topic or field that would enable them to have a clinical attachment and be paid on a clinical scale. McMinn, whose experience in these matters cannot be lightly ignored, ends his article by saying, "Do you or do you not want undergraduate medical students to be taught by full-time medically qualified preclinical teachers?" We would be interested to know what those individuals who currently determine policy are doing about this problem, which has been openly discussed since 1968. Further delay will inevitably mean the extinction of medical direction of education in human anatomy; we believe the consequences are likely to be as disastrous for medicine as the divorce of many aspects of university education in science, applied science, and arts from living reality has been for the British economy. We would suggest that letters extolling the virtues of the ivory tower approach to medical education do not and cannot improve the current critical situation. Furthermore, it is now, when NHS contracts are once more being discussed, that a serious attempt should be made to bridge the gap.

At a recent interview for a preregistration post in a provincial hospital one of us said to an applicant, "Tell me about the basic science training in your medical school?" His answer was brief, and to the point. "I have not done any dissection and my teachers had had no experience of either pathology or clinical examination of patients." Dr Sturrock's fear is for "inadequately treated patients and inadequately taught students." Our concern is exactly the same but we believe that vocational education demands the participation of individuals qualified and experienced in the field.

N ALAN GREEN

Norfolk and Norwich Hospital,
Norwich

R E COUPLAND

Department of Human Morphology,
University Hospital and
Medical School,
Nottingham NG7 2UH

¹ McMinn RMH. *Ann R Coll Surg Engl* 1979;61:406-7.

Revised consultant contract

SIR,—At a meeting held on 2 November by the East Dorset whole-time consultants the new proposed changes in the consultant contract were discussed. The reasons for holding such a meeting were the lack of consultations between us and our representatives at the CCHMS (contrary to the directions of the chairman in his letter of 22 September) and the alarming speed at which the new changes are moving towards implementation by 1 January 1980.

It was the feeling of the consultants that the proposed changes had completely ignored the basic and fundamental spirit that lies beyond those who are fully committed to the NHS. The whole-time consultants already devote most of their spare time (over and above their 11/11 sessional commitment and a duty rota) to the benefit of the NHS patients, and the great majority of them do not wish to indulge in private practice because of either the nature of their commitments or specialties or their beliefs. It was felt that being fully committed to the NHS deserves a special remuneration over and above the existing sessional pay scale.

Doubt and anxiety has also been expressed regarding the long-term effect on salaries of whole-time consultants. It was felt that the provision for 10% private earnings might be unobtrusively taken into account by a future Review Body when calculating whole-time consultants' overall income. Contrary to the statements made by the chairman of the CCHMS, the Review Body had on previous occasions taken such private income into consideration when calculating consultants' overall income.

The meeting welcomed the decision that all consultants should be free to do as they wish with their spare time. However, it was felt that the restrictions put on those whole-time consultants who opt for private practice are very restrictive and undemocratic, and an infringement on their personal liberty and freedom. It was therefore agreed that the new proposals are discriminatory against the whole-time consultants and are not acceptable because they amount to narrowing the differential between those who are wholly committed to the NHS and those who are not so committed by awarding an extra paid superannuable session to the maximum part-time consultants without similar recompense from NHS sources to the whole-timers.

It was resolved that for these proposals to be accepted, they should be amended to the effect that all whole-time consultants who because of the nature of their contract or type of specialty or devotion want to remain wholly committed to the NHS should be awarded the equivalent of an extra session, amounting to 1/11 of their existing annual salary, and that this extra session should be superannuable.

Should these proposals not be accepted, the new proposals should then be put to vote by balloting all the consultants and senior registrars as soon as possible.

M K EL DARS

Poole General Hospital,
Poole, Dorset BH15 2JB

SIR,—Under the new consultant contract all existing maximum part-time consultants can be paid for an extra session at the rate of 1/11th