it is a pity that the design was not better. The treatment group received specific and non-specific therapy (exercise therapy and regular supervision from a nurse, with occasional medical review), while the controlled group received neither on leaving hospital. As the non-specific factors were uncontrolled, the conclusion that simple exercise rehabilitation is of benefit is invalid.

Astley Ainslie Hospital,
Edinburgh EH9 2HL

MARTYN ROSE

Mebendazole and hydatid disease

SIR,—Mr D R Osborne (19 January, p 183) makes some pertinent observations on the dubious value of mebendazole in hydatid disease. There are, as he says, no published data on drug levels in serum or cyst fluid. Using the drug in a dosage of 60-200 mg/kg body weight/day in three divided doses given eight hourly after food, I am obtaining serum levels of 20-160 ng/ml. Levels peak about two hours after a single oral dose and may be undetectable eight to 10 hours later. These data will soon be published. Most of my patients have complicated, inoperable hydatid disease and so I do not yet have many data on drug levels in cyst fluid. It would be interesting to know the dosage Mr Osborne used and the timing of his samples. Was the drug given with food, which increases the serum level 10-fold?

Like Dr I M Lyon and Mr K W Reynolds (3 November, p 1111), I also have patients who have developed acute pain in the cyst, and tenderness and fever during treatment. I do not know the cause, but in one case serial computed tomography is showing progressive collapse of the cyst wall, which is shrinking away from the radiological margins of the cyst—a phenomenon that may well leave tissues prone to infections or immunological inflammation.

As to cost, mebendazole may be expensive but so is admission to hospital for major abdominal surgery, and the drug offers the only hope for patients with inoperable disease. Perhaps the most important point of Mr Osborne's letter is to stress the immediate urgent need for co-operative effort in and outside this country to conduct a proper trial of this drug. We must standardise our techniques of assessment and pool our data. Otherwise we shall never know if mebendazole is any good, and under what circumstances.

ANTHONY BRYCESON

Hospital for Tropical Diseases,
London NW1 0PE

*. *We sent a copy of this letter to Mr Osborne, whose reply is printed below.—Ed, *BMJ*.

SIR,—Thank you for giving me this opportunity to reply to Dr Bryceson's letter.

The dose of mebendazole we use is 200 mg thrice daily after meals for 30 days.¹ Our samples of serum and intact daughter cysts were all taken at operation after seven days' administration of the drug, but 10 hours after the last dose.

The endogenous proliferation typical of *Echinococcus granulosus* means that living scolices are contained within the cyst. It would seem that serum levels of mebendazole are not as important as cyst wall and cyst fluid levels actually in contact with viable

scolices, especially free-floating daughter cysts.

I note with interest the patient case in whom shrinkage of the cyst wall was observed on serial computed tomography. This indicates the effect of mebendazole on the "ectocyst." However, until a therapeutic regimen can be identified which will kill daughter cysts I still argue that the treatment is not cost effective.

I wholeheartedly agree with Dr Bryceson's request for co-operation and standardisation. I would be interested to know what method he uses to measure mebendazole levels and would be happy to supply him with samples of serum, cyst wall, and cyst fluid from patients taking the drug.

D R OSBORNE

Academic Department of Surgery,
Royal Free Hospital School of Medicine,
London NW3 2QG

¹ Bekhti A, et al. *Br Med J* 1977;iii:1047-51.

Lumbar puncture

SIR,—I cannot agree with all that Drs C Clough and J M S Pearce have to say in their article on lumbar puncture (2 February, p 297).

The perpendicular line is commonly measured from the iliac crest and usually runs between two interspaces. The more caudal space (L3/4) is often wider and more inviting; the more cephalad is in my experience an easier route to success.

Five millilitres of lignocaine is not only generous but unnecessary and in my opinion a hindrance. The pain-sensitive structures in the area are skin, periosteum, dura, and the nerve roots. Only the skin should be anaesthetised and only 0.1 ml at the most is required. The use of 5 ml causes trouble because it obscures the palpation of the interspace.

I would recommend (in a right-handed operator) that the left thumb is placed firmly on the spinous process cephalad to the interspace being used, and parallel to the line of the spinous processes. It should be kept there while the lignocaine bleb is made and it should not be removed until after the lumbar puncture needle has been inserted through the bleb, aiming slightly cephalad, a few millimetres from the tip of the thumb. Thus the left thumb ensures that the needle is introduced in the correct skeletal midline. With very mild obesity the cutaneous midline can drop with the patient on his or her side. It also ensures that there is no slip of skin on spine as the needle is introduced through the former.

RICHARD GREENHALL

Department of Neurology,
Radcliffe Infirmary,
Oxford

SIR,—Dr D C Thrush (23 February, p 564) describes Queckenstedt's test as a useless ritual but might not the entire practice of manometry at lumbar puncture be so described? Those who advocate manometry should produce evidence that it influences diagnosis or management. Just before publication of the article by Drs C Clough and J M S Pearce (2 February, p 297), I discovered that in Salford Area Health Authority, approximately 1000 disposable spinal manometers were purchased in a 12-month period at a cost of £660. It may be a small sum in relation to the authority's total budget but, if the tradition of manometry was allowed to die, the National Health Service would be

saved a substantial amount of money. Even small savings cannot be scoffed at when we are in the midst of a financial crisis.

A C YOUNG

Department of Neurology,
Salford Royal Hospital,
Salford M60 9EP

Massive arterial thrombosis and oral contraception

SIR,—The report by Drs P M Holt and D Hollanders (5 January, p 19) on systemic arterial thrombi in a woman taking an oral contraceptive reminds us of a similar case, which we reported in 1975,¹ in a patient who presented with acute pancreatitis. At necropsy there were multiple large infarcts of several organs, including the pancreas, myocardium, and liver.

One aspect of the problem is the possibility that this complication is under-reported. We suspect that these cases may not be notified to the Committee on Safety of Medicines, and that likewise the death certificate may not mention the possible role of the contraceptive drug. We wonder whether these aspects were observed in the case reported by Drs Holt and Hollander. Publishing does not provide sufficient safeguard because we know from experience that it may be difficult to have such reports accepted by the more widely read weekly medical journals. Their recognition should not depend entirely on the "accident" of editorial acceptance.

MURRAY E FOSTER
D E B POWELL

Royal Dental Hospital of London,
London WC2H 7LJ

¹ Foster ME, Powell DEB. *Postgrad Med J* 1975;51: 667-9.

Participating in execution and medical ethics

SIR,—Dr Felicity I S de Zulueta (16 February, p 486) is concerned that doctors may be required to carry out executions by lethal injections, in those states where it is now permitted by law, and asks that the BMA should condemn all forms of participation in this. However, this point is already covered by the World Medical Association's Declaration of Tokyo, to which BMA was a signatory; and the declaration is in fact reproduced in the BMA's *Handbook of Medical Ethics*.

On a lighter note, one might ask why do they need doctors to do this. Are they afraid of the risk of air embolus or infection perhaps?

W NORMAN-TAYLOR

Chorleywood, Herts WD3 5NT

Manpower planning and accurate information

SIR,—I provide an information service to the regional postgraduate committee of the South-west Thames RHA and so keep records of all SHO, registrar, and senior registrar posts and changes in establishment. I have recently noticed the following remarkable "changes": registrar posts have been created without recourse to the region and its manpower committee; a district has funded "a locum senior registrar" without regional or central manpower approval or educational approval;

a registrar post has been "converted" to an SHO post without the area being told; and a house officer post has been "converted" into an SHO post without the postgraduate dean, the university, or the GMC being told (though this would be acceptable for six months if there were no applicants for the post).

The only posts funded at district level which can be justified purely on service grounds without approval by area, region, and the Central Manpower Committee (CMC) are SHOs and clinical assistants. All registrar and senior registrar posts must be approved through area and region all the way up to the CMC, which controls the number of posts and their distribution in England and Wales. The number of registrar posts is tied to the number of senior registrar posts, which in turn is related to expected consultant vacancies. Allowance is made in the calculation of the registrar establishment for the many overseas graduates who will return to their own countries. At present if a region's establishment of registrars or senior registrars is above the national rate it is unlikely to be allowed additional posts by the DHSS unless they are in a shortage specialty. All senior registrar posts must be approved by the appropriate higher training committees as well as the CMC before they are established. Once created posts cannot simply be upgraded or downgraded.

Each region has a target number of house officer posts to meet the increasing output of medical schools. House officer posts cannot be "converted" to SHO grade, except on a temporary basis in agreement with the region. Training approval from royal colleges and faculties cannot be assumed for new posts without due consultation. Indeed, the creation of a new post could affect the approval of existing posts. The confusion within the profession surrounding medical staffing may be the result of the relatively new concept of providing a district service and the designation of "training" grades, which, in order to provide a suitable career structure, must be tied to the number of consultant vacancies.

The administrative problems are, I suggest, the result of the unique position of medical staffing in NHS personnel departments. Personnel work is increasingly concerned with legislation and trade union liaison. Medical staffing may seem to be a vacuum for some career-minded administrators and tends to be undertaken by a small section that may work in isolation from the rest of the personnel department. Thus those administrators responsible for medical staffing may be unaware that the "establishment" is several posts in different grades and not the number of doctors in post in the hospital at any given time. Furthermore, they may never have been told the procedures for creating new posts or ensuring that these are approved for training purposes.

My findings in South-west Thames RHA are presumably not peculiar to that region. I am convinced that a more informed and disciplined approach to medical staffing can benefit the profession and NHS administration as well as improving the quality of patient care. Accurate information concerning the present manpower establishment should be a prerequisite for planning the future distribution of and career structure for doctors, but it is generally impossible to obtain. It has taken us over two years to obtain limited data for this region—and there is still room for improvement—but national data are

needed, as several reports on medical manpower have shown. I find it surprising that most junior doctors are apparently indifferent to a state of affairs which will have profound repercussions on their career prospects.

R S VINER

British Postgraduate Medical Federation,
London NW1 5HD

Breaking contracts

SIR,—Am I alone in bemoaning the attitude of some members of the profession to the contract of employment in the hospital service? A couple of weeks ago a senior house officer was offered a post at another hospital provided that he could start the following week; this would entail his breaking his current contract, which requires him to give a month's notice. As he was given to understand that unless he agreed to start on the stipulated date he could not have the job he reluctantly decided to accept these terms. This, of course, leaves his hospital in difficulties and with the expense of agency fees.

Only this week a junior doctor was offered a post at my hospital, which he accepted with apparent enthusiasm, and the next day he telephoned to confirm his starting date. A couple of days later he telephoned again to say that he had now accepted another job, and was quite oblivious of the effects of this decision, let alone his legal responsibilities. I suppose that we should rejoice that at least he attended for interview unlike many of his colleagues, who fail to turn up, and also let us know eventually that he did not intend to take the job—nowadays one awaits the arrival of each new appointee with trepidation, as it is not unknown for them just not to turn up.

I share the bewilderment of the administrators at this behaviour. Surely as members of a learned profession we should at least have some idea of the implications of a contract and not deliberately dishonour it or incite others to do so.

JULIAN NEELY

Crawley Down, West Sussex RH10 4EY

Medical advisory machinery

SIR,—In his letter to you (1 March, p 649) Dr Lionel Kopelowitz presented the arguments for requiring health authorities to seek medical advice from the Association through its divisions. At its meeting on 28 February the NE Thames Regional Council of the BMA debated this subject and rejected the arguments set out by Dr Kopelowitz.

The arguments which swayed the Regional Council were as follows: (1) Many divisions are so inactive as not to be able to give reasoned advice. (2) Linked with (1), the assertion that the provision of medical advice was too important to the community to be used as a device for resuscitating (perhaps) moribund divisions. (3) Professional advice comes better from sources other than a trade union, which may have difficulty in giving objective, disinterested guidance. (4) There were doubts about whether it was reasonable to consult this association and not others, and indeed whether the BMA should claim to represent the views of those who are members of no association. (5) Many hospital consultants hold the opinion, no matter how unfounded it is, that the BMA represents GP

interests rather than theirs. (6) Since most problems about which health authorities might require advice are concerned with hospital management, an area of greatest concern to hospital staff, it seems illogical to dilute the advice given by hospital staff with the expressed opinion of other doctors.

It seemed clear to the regional council that health authorities should not seek professional advice from BMA divisions at all.

REUBEN GRÜNEBERG

Department of Microbiology,
University College Hospital,
London WC1E 6AU

Cutting the drug bill

SIR,—The cost of pharmaceutical services to the family practitioner services budget is justifiably a cause of considerable anxiety both inside and outside the Department of Health. It is therefore heartening to note the growing concern over consumption of drugs now being expressed publicly by doctors, pharmacists, health departments, and, most importantly, patients.

An example of the initiative some prescribers are taking is that outlined by Dr Monte Lubel and partners in their letter to you (23 February, p 569). They chide the DHSS for not taking a more active advisory role in the matter of encouraging widespread use of generic names in the general medical practice prescribing. One particular suggestion is that there should be an updated *British National Formulary* produced by the DHSS.

Some readers will know that the Joint Formulary Committee of the BMA and the Pharmaceutical Society of Great Britain is already engaged in producing a completely new style of BNF, which is likely to include not only more comprehensive prescribing information than its predecessors but also an indication of comparative prices of drugs. The Department has made the necessary financial arrangements to purchase and distribute this publication twice a year. We believe that this should encourage doctors to exercise responsibility and accountability while retaining their vital clinical freedom to prescribe in the patients' best interests according to the doctors' clinical judgment.

Dr Lubel also suggests a core of DHSS "reps" who would sell the idea of prescribing economy. He correctly points out that doctors in the DHSS Regional Medical Service (RMOs) already have this role, but he is wrong in suggesting that it is only in connection with high-cost prescribers. The RMO has other duties apart from visiting general practitioners and as the ratio of RMOs to GPs is 1 per 500 and pharmaceutical representatives to GPs 1 per 7, we are at some disadvantage. In his final sentence Dr Lubel makes the important point that drug therapy may not be indicated as often as some prescribers or patients believe. Perhaps the question, "Should I prescribe at all?" should take precedence over, "Which is the most economical drug to prescribe?"

H YELLOWLEES
Chief Medical Officer

Department of Health and Social
Security,
London SE1 6BY

SIR,—Your correspondents from Westcliff-on-Sea (23 February, p 569) draw attention to the