midwives who form an integral part of the primary health care teams. Thirdly, the unit is situated in the district obstetric hospital and, although autonomous, is subject to the same professional disciplines and patient management policies as generally prevail there. Fourthly, selection of patients for GP booking, while not entirely inflexible, is maintained within well-defined guidelines. Fifthly, GP contact and consultation with specialist staff is promoted and ongoing participation of the GP in cases transferred to consultant care is encouraged. A regular series of lunchtime meetings is held to update practitioners with advances in obstetrics and thus maintain high standards of antenatal and intranatal care. Finally, the unit is subjected to regular and penetrating audit when statistics are examined and problem cases discussed in depth by GPs, consultants, and midwives.

In conclusion, while universal induction of labour, fetal monitoring, and epidural analgesia may in some eyes be the counsel of perfection for intranatal care, three questions must be asked: (1) Is such a policy economically feasible on a nationwide basis? (2) Are the results so greatly superior to more traditional systems of care? (3) In any case, is this what the patient wants and expects? Until these questions can all be answered in the affirmative there may yet be a place for the GP obstetrician and community midwife backed by proper training, support, and facilities.

M J V BULL

John Radcliffe Hospital,
Oxford

¹ Lloyd, G, *British Medical Journal*, 1975, 1, 79.

² Wilkes, E, *et al*, *British Medical Journal*, 1975, 4, 687.

³ Curzen, P, and Mountrose, U M, *British Medical Journal*, 1976, 2, 1433.

Alcohol and cirrhosis

SIR,—Minerva's discovery (25 February, p 516) that there has been a ninefold increase in cirrhosis of the liver in Finland between 1964 and 1974, due supposedly to a trebling in alcohol consumption, is impossible to reconcile with statistics from the World Health Organisation.^{1,2} She also fails to mention the fact that mortality from the disease in Finland, as in other northern countries, is remarkably low compared with the death rate of the more southern Europeans, who are predominantly wine drinkers. The accompanying table gives the death rates per million of population from cirrhosis of the liver in 1967 and 1972 for Finland and other representatives of the two groups.

The 38% increase in cirrhosis mortality in Finland between 1967 and 1972 is inconsistent with the alleged 800% increase between 1964 and 1974, and it still leaves spirit-drinking Finland with only 13% of the cirrhosis death rate of wine-drinking France in 1972. If

drinking is really the main cause of cirrhosis of the liver then it must be due to some constituent of wine other than alcohol which is not carried over by distillation into spirit. Only a comprehensive survey of the relationship between all types of alcoholic drink and drink mortality will permit an unprejudiced judgment of the effects of alcohol. I strongly suspect that the negative correlation between alcohol consumption and deaths from ischaemic heart disease would far outweigh any positive connection with cirrhosis and that a regimen of moderate drinking of well-diluted spirits before and during meals would come out statistically as the ideal for long life.

GEOFFREY MYDDELTON

Glutières-sur-Ollon,
Vaud, Switzerland

¹ *World Health Statistics Annual*, 1967, vol 1, Vital Statistics and Causes of Death. Geneva, World Health Organisation, 1970.

² *World Health Statistics Annual*, 1972, vol 1, Vital Statistics and Causes of Death. Geneva, World Health Organisation, 1975.

Traumatic tenosynovitis of the wrist

SIR,—With reference to your leading article (4 March, p 528), until 1947 I used to treat cases of tenosynovitis in plaster-of-Paris for three weeks. When it was removed they were usually symptom-free but frequently relapsed in a few days. In 1947 a gardener came to see me with a bad tenosynovitis crepitans. I told him I would have to put him in plaster-of-Paris for three weeks and he would have to stop work. He said he could not do this as he had a cow of his own which he had to milk every day. I told him that if he carried on like that he was unlikely to get better. I applied an Elastoplast bandage and hoped for the best. He came to see me a week later having milked his cow every day and remained at work and he was symptom free. I removed the Elastoplast and he did not relapse.

Since then I have encouraged all patients with tenosynovitis to remain at work. I apply an Elastoplast bandage and ask them to apply deep friction to the tender area through the Elastoplast and show them how to do it. I cannot remember any that did not get better in a week, nor do I remember any relapsing.

H O PATON

Swaffham, Norfolk

Factors affecting length of hospital stay

SIR,—The paper by Dr L Carol Fernow and others (4 March, p 556), compiled from a great deal of clerical work, confirms the well-known fact that "length of stay . . . is complex, and that these complexities should be taken into consideration before establishing norms." Quite so.

Even if "the study shows that much new information could be [made] available routinely" what good would this do? Suppose that after allowing for patient and process variation some differences in length of stay were found among the surgeons in an area health authority. It would be argued that some of the difference was due to unavoidable factors such as day-of-week of operation leading in some firms to the optimal discharge day falling at the weekend (no ambulances and shops shut). Eventually, after consideration of every variable in the hospital it might

be shown that one or two surgeons kept their patients in a day or two longer than their colleagues did. These surgeons would certainly argue that this policy was better for their patients (fewer return cases, complications, GP consultations, etc). A very expensive investigation might disprove this claim to the satisfaction of some non-clinicians but not of the doctors concerned, who are unlikely to alter their policies.

The collection of the routinely recorded information that this study uses can only add to administrative costs at a time when everyone is trying to reduce these costs. Qui bono?

ROGER HOLE

Department of Urology,
North Ormesby Hospital,
Middlesbrough, Cleveland

Inactivation of agent of Creutzfeldt-Jakob disease

SIR,—In the interests of neurosurgeons, pathologists, virologists, and others who may have to deal with material from cases of Creutzfeldt-Jakob disease it is important to clarify the puzzling and possibly inaccurate description given in your leading article "Creutzfeldt-Jakob under control" (25 February, p 463) of the conditions leading to the inactivation by wet heat of the related agent of scrapie.

The combination described, of a temperature of 121°C and a pressure of 20 psi (1.4 kg/cm²), is in theory obtainable in an autoclave if only two-thirds of the air has been removed. The above figures occur in Gajdusek's article referred to¹ and also in an earlier one of his² so may be a correct description of the results of his procedures, but it is a very unusual way of using an autoclave and the conditions operating in the vessel under these circumstances are probably not uniform.

If, however, his autoclave was used in the normal way with all the air evacuated or discharged either the temperature or the pressure is incorrect, as 121°C then corresponds to 15 psi (1.05 kg/cm²) and 20 psi to 126°C.

In order to be sure that autoclaving will inactivate the agent of Creutzfeldt-Jakob disease, about which rather less is known and which will often be embedded in tissue debris, it would seem extremely important to set out clearly, accurately, and in full how the autoclave should be operated to achieve inactivation.

A M M WILSON

Bacteriology Laboratory,
City Hospital,
Edinburgh

¹ Gajdusek, D C, *et al*, *New England Journal of Medicine*, 1977, 297, 1253.

² Gibb, C J, jun, and Gajdusek, D C, *Abstracts of 3rd International Congress for Virology*, Madrid, September 1975, p 47.

Aids to drug compliance

SIR,—We were very interested to read Dr M R Klaber's letter (4 February, p 302), in which he made some valuable suggestions regarding aids to drug compliance.

The concept of a "calendar pack" has been considered by our group working on aspects of drug compliance but was rejected on the grounds of expense and the significant increase in storage space that would be required in

Regional mortality from cirrhosis of the liver^{1,2}

Country	Deaths per million		Percentage change
	1967	1972	
<i>Northern Europe</i>			
Finland	32	44	+ 38
England and Wales	28	34	+ 21
Sweden	74	102	+ 38
Norway	38	46	+ 21
<i>Southern Europe</i>			
France	357	342	- 4
Spain	203	221	+ 9
Italy	248	318	+ 28

hospital pharmaceutical departments and general practice pharmacies.

A study by one of us (BCD)¹ showed that a significant number of patients wanted further information regarding their drug treatment. We have decided to provide this by means of a new system of labelling (see figure). We are at present investigating whether this has a significant effect on patient compliance.

B C DAS
A WILLIAMS
Area Pharmaceutical Officer,
Salford AHA(T)

Ladywell Hospital,
Salford, Greater Manchester

¹ Das, B C, *Modern Geriatrics*, 1977, 7, 22.

Otosclerosis

SIR,—May I comment on your interesting leading article on otosclerosis (14 January, p 63), in which you express the view that “experienced stapedectomists can expect initial success rates of over 95%, and the complication of early sensorineural hearing loss should occur in under 2% of cases”?

In the 1960s the enthusiasm among otologists for stapedectomy was very great. Here was the almost complete answer to otosclerotic deafness. Now, in the 1970s, the optimism of many experienced surgeons is distinctly less and one would wish that the failure rate could be given more prominence. In a letter dated 31 March 1976, in reply to mine, Mr Andrew Morrison, senior consultant otolaryngologist at the London Hospital, wrote: “I think the failure rate from this operation is much higher than is generally realised and I know that I for one am always very careful now before advising surgery.” A skilled and experienced surgeon at another London teaching hospital expressed the view at a conference in July 1975 that perilymph fistula after stapedectomy is a “major problem.”

With reference to another point made in the leading article, that the recurrence of conductive deafness may be dealt with by further surgery and the results should be comparable to those of primary operations, may I again quote from a statement made by the same surgeon at the July 1975 conference? “With a recurrent conductive loss it must be made clear to the patient that there is a greater risk of damaging the residual hearing than was involved in the original procedure.”

General practitioners in the main seem not

to be aware of the shift of opinion since the 1960s. Also, in view of the fact that as late as 1976 an article appeared in a paramedical journal written by a young ENT surgeon in which the success rate was given as “about 98%,” it might be appropriate to lay further emphasis on the considerable risks involved in stapes surgery, the results of which are sometimes quite disastrous.

Now that the ear-level hearing aid is being issued free of charge to patients for whom it is suitable many surely would choose this alternative if, through their family doctor, they were made aware of these risks.

FLORA JACOBS
Retired social worker

London W14

Bromocriptine-induced mania?

SIR,—We were most interested to read the letter from Dr D Vlissides and others (25 February, p 510), and we would like to report a very similar case.

Our patient was 29 years old and two weeks post partum. She too had received bromocriptine twice daily for eight days post partum for suppression of lactation. On the fourth day she started becoming overactive, elated, and aggressive. These symptoms became progressively worse and she was admitted informally to the psychiatric unit on the 14th day post partum. Initially she was treated with haloperidol 20 mg four times daily and she settled quickly. Medication was then reduced slowly over a period of seven days. At the end of this period all her psychotic signs and symptoms had disappeared.

Bromocriptine may have been an aetiological factor in this patient's puerperal mania.

NANCY M BROOK
IAN B COOKSON

St Catherine's Hospital,
Birkenhead, Merseyside

Typhoid and its serology

SIR,—We read with interest your leading article (18 February, p 389) and fully support your conclusions—namely, that laboratory confirmation of a clinical diagnosis of typhoid depends essentially on bacterial culture.

We wrote to you four years ago (13 April 1974, p 121) querying the validity of the Widal test when used for screening for enteric fever in water board employees. We believe that Brodie's findings provide the sort of evidence needed to remove many of the misconceptions associated with the serology of the enteric fevers and of the carrier state and suggest that legislation regarding routine Widal testing of water board employees should be revised.

A F M S RAHMAN
M E COWAN

Lister Hospital,
Stevenage, Herts

Hazard of chemical sympathectomy

SIR,—We were interested to read the report of paraplegia occurring as a complication of chemical lumbar sympathectomy (4 March, p 552). This possible danger has been recognised since the earliest accounts of the technique¹ and is due to some of the neurolytic agent, usually phenol, being deposited in the

subarachnoid space. This may happen if a needle passes through the intervertebral foramen or pierces a dural sleeve which may surround the somatic nerves in the paravertebral spaces.

This complication is entirely preventable. Reid's excellent method² has been improved further by the use of radiological control with a swinging-arm image intensifier which allows visualisation of the exact position of the tips of the needles.^{3,4} A further refinement is to inject radio-opaque material such as meglumine iohalamate 60% (Conray 280) to see the exact spread of the solution.⁵

We have performed over 200 chemical lumbar sympathectomies in the past four years and do not believe that this technique should be performed without radiological control. In the absence of an image intensifier a check anteroposterior and lateral x-ray should be taken before the injection of the neurolytic solution. In this way serious complications will not be produced, and a simple and effective technique will not fall into disrepute.

ANTHONY RUBIN
BACHA MASTER

Pain Clinic,
Charing Cross Hospital,
London W6

¹ Haxton, H A, *British Medical Journal*, 1949, 1, 1026.

² Reid, W, Watt, J K, and Gray, T G, *British Journal of Surgery*, 1970, 57, 45.

³ Rubin, A P, Film—“Chemical lumbar sympathectomy.” ITT in conjunction with the Royal College of Surgeons of England, 1976.

⁴ Hughes-Davies, D I, and Redman, L R, *Anaesthesia*, 1976, 31, 1068.

⁵ Keane, F B V, *British Journal of Surgery*, 1977, 64, 519.

“The Way Forward”

SIR,—I am astonished that the Government's reiteration of its policy to finance improvements in the geriatric services by cutting acute services¹ has not provoked a more vigorous response. Few would deny that there is an urgent need to improve services for the elderly, but the proposed means of achieving this aim reveals a monumental ignorance of what is going on in acute units all over the country.

Last week I was on duty in a small provincial hospital; in a 24-h period there were nine emergency surgical admissions, two of them under 65, four over 80. A spot check showed a total of 67 surgical patients, of whom only 23 were under 65, while 21 were over 80. All in acute beds. I have no doubt that similar figures could be obtained in many places.

Can someone please explain how cuts in the acute services are going to help the elderly?

J A GIRLING

Ashford, Kent

¹ Department of Health and Social Security, *Priorities in the Health and Social Services, The Way Forward*, London, HMSO, 1977.

New consultant contract

SIR,—I have been a consultant for three years and in that time I have witnessed a decline in my living standards despite annual incremental increases in pay. Private practice does not offer a viable alternative to my whole-time contract and therefore I am totally dependent on an improvement in our contract. I have been particularly dismayed by the quiet and lame manner in which the BMA