Because doctors work with individuals and carry some of the load of patients' fears and confusions day in day out they can't escape into theoretical concepts and rationalisations about "the public." In the proposed monitoring groups, to be set up jointly one hopes, can opportunities be found for TV producers to sit in on some outpatient sessions or general practitioners' surgeries in the week following a medical TV programme? They need to hear and feel the response of patients, not just intellectualise about it. (No time? Call it in-service training.)

Every one of us is at some time a patient or a patient's relative or friend. And most of us, including producers, have the many negative idiosyncrasies listed by Mr K Sabbagh (18 March, p 713). To be fair we could add some more positive ones, such as patience, good will, reliability, courage, and adaptability for a start. We are, as viewers or "consumers," human beings, often vulnerable, with needs and rights which require recognition from the powerful "producers"/providers of both camps.

JANET BODMAN

Cleeve,
Bristol

SIR,—If other aspects of your journal bear as little relationship to factual truth as certain phrases in your leading article (18 March, p 667), then we are all of us in the gravest danger.

In that issue you say that "recent news bulletins announced that doctors in Russia have 'cured' a girl with retinitis pigmentosa." You add, "Perhaps the BBC believes the news value outweighs any risk of raising false hopes in hundreds of families. . ."

This false statement—let me not mince words: this lie—is quite intolerable to those of us who work in BBC Television News. Nowhere did we say that anyone had been "cured": indeed, the truth is entirely the opposite—the words "no cure" were used.

You point out that in June 1976 you made a comment on the subject. In June 1976 we carried an interview with the appropriate ophthalmologist expressing all his doubts about the Russian treatment. The interview arose from an invitation to a conference called by the appropriate professional body to publicise their scepticism.

You write, "Nothing that has been said so far, however, has answered the case for more responsible treatment of medicine on television." Your deliberate and fanciful distortion of the care with which BBC Television News approaches medical matters indicates quite clearly that you are not prepared to give responsible treatment to television by the medical profession.

ALAN PROTHOROE
Editor,
BBC Television News

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SIR,—Your leading articles (11 February, p 323; 18 March, p 667) and correspondence columns echo the worry felt about the behaviour of the television "experts" who have power beyond their dreams without any responsibility, and this is in medicine, where the effects can be assessed by professionals used to skilful, time-wasting obstacles in their path (like Mr Karl Sabbagh (18 March, p 713) in three columns trying to obscure political activity and scapegoating by saying there is such

pressure on producers that consultation cannot be promised). I feel your suggestion of real political enforcement of balance as in Norway is a solution that should be tried, as the present bias is affecting patients and causing unnecessary suffering.

I have a patient whose family took over nine months to accept electroplexy, and the dramatic change for the better after treatment surprised them. I wonder how many more cases there are in the country, and the ECT programme that had the negative effect was the last of three different attempts (one probably made ECT seem helpful by including a patient in the hypomanic state well able to overwhelm the doubts of two or three depressed clients and ivory-tower types).

More important than the specialised interest in medicine is the question "Quis custodiet ipsos custodes?" If the producers make such a mess of an area that doctors understand, what can they be doing everywhere else? The distinguished man of science is less likely to have his field of science "critically televised" and may not realise how to tilt the balance, for example, on road accidents, so studies on road marking are ignored even though they could reduce accidents comparatively cheaply—at political cost, however, as these are areas where economies are made first by the unscientific.

D G MAYNE

Armagh, NI

Vacuum pipelines for anaesthetic pollution control

SIR,—Dr M Rosen (21 January, p 176) in his capacity as chairman of the British Standards Institution (BSI) committee on central piped vacuum (CPV) deprecates its use for the removal of anaesthetic pollution. I would like to suggest that, on the contrary, its use for this purpose should be encouraged unless there are stronger reasons to the contrary than he puts forward.

His first objection, that it is designed for clinical use and should not be used for the benefit of the staff, seems rather unreal. Surely, in the limit, their interests are the same?

The technical objections he adduces also seem very unsubstantial. If the CPV is inadequate it cannot of course be used, but the fact that it is below British Standard (BS) specification does not necessarily mean that it has no spare capacity. The BS specification¹ calls for a quite unrealistically high flow rate, the equivalent of about half the suction orifices being wide open simultaneously. In fact, of course, when sucking, the flow is only, at most, a few hundred millilitres a minute instead of the 40 l/min specified, and suction outlets are seldom left open because of the noise they make. This hospital, being new, is generously supplied with suction outlets so that, on paper, its pumps are insufficient. In fact, observation shows that only one out of the four pumps ever runs and then only about half the time, even since we started using the pumps for scavenging.² It therefore seems unlikely that in most hospitals there is really no spare CPV capacity.

Dr Rosen says that there is an "unquantifiable" ignition hazard, but in fact it can be shown by simple calculation to be negligible. Apart from the fact that ether is now very little used, the expired air concentration in a 30/60 %

mixture of oxygen and nitrous oxide is at the lower limit of flammability.³ Our system dilutes it 5:1 at the point of emission and it is further diluted by air from other outlets before it reaches the pumps. In any case undiluted expired air has always been liable to enter the CPV whenever a sucker is used in the mouth or trachea, and no explosions appear to have resulted so far.

Another alleged hazard, not mentioned by Dr Rosen but cited in DHSS HC(76)38, is the effect of halothane on pump oils. Our pumps have been carefully examined at intervals in the last two years and have shown no signs of undue wear, but in any case I believe the hazard to be non-existent. The only published source⁴ refers to an observation by a manufacturer of vaporisers who used a high-vacuum pump for extraction of air from the working area. The pump broke down after four months and its oil smelt strongly of anaesthetic agents so the firm concluded that the agents were the cause of the breakdown. In fact, however, a high-vacuum pump used against a low vacuum will break down because its oil does not circulate, and will accumulate vapours because its oil is seldom replaced. In reciprocating pumps the only oil to make contact with vapours is immediately blown out with the exhaust. Even an oil-sealed rotary pump has its oil refilled weekly and completely changed about every two months.

CPV is a very expensive capital investment and if, as I have suggested, it is usually underused its employment for scavenging would make good use of an otherwise wasted asset. There is a great temptation at present for hospital or district engineers to say "no" to avoid controversy and thus commit the NHS to a great deal of unnecessary expenditure. It would therefore seem desirable for the BSI and the Department of Health and Social Security to change their negative attitude towards its use to a positive one.

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¹ BS 4957:1973. London, British Standards Institution.

² Davenport, H T, *et al*, *British Medical Journal*, 1976, **2**, 1219.

³ Macintosh, R, Mushin, W W, and Epstein, H G, *Physics for the Anaesthetist*. Philadelphia, Davis, 1963.

⁴ McInnes, I E, and Goldwater, H L, *Anaesthesia*, 1972, **27**, 340.

Is cholestyramine helpful in uraemic pruritus?

SIR,—Pruritus can be a most distressing symptom in chronic haemodialysis patients for which no effective treatment exists. Last year Dr D S Silverberg and others (19 March 1977, p 752) presented the results of a double-blind controlled study in 10 chronic haemodialysis patients using two doses of 5 g cholestyramine daily. These patients were randomly assigned to two treatment groups: five took cholestyramine in juice and five took a methylcellulose placebo in the same dose. Pruritus was graded 0=none, 1=slight, 2=moderate, and 3=great. A daily pruritus score was calculated for each patient before and during treatment and the means of the scores of 21 days before and 28 days during treatment were compared. In four of the five patients taking cholestyramine pruritus decreased considerably within four days, while some improvement occurred in only one of the five patients taking the placebo. This result seemed to be encouraging