no complications. An abnormal pancreatogram absolutely defines pancreatic disease. There are some difficulties in interpretation of very minor changes and in distinguishing obstruction due to cancer or pancreatitis, at least when clinical information is withheld. A normal pancreatogram does not completely exclude cancer. We have seen one patient with a normal main duct radiograph (with poor branch filling) among 55 cases of pancreatic cancer. Equally, a normal pancreatogram does not exclude an early stage of chronic pancreatitis, as judged histologically. Here, however, the clinical picture is usually one of recurrent pain with a raised serum amylase. The diagnosis is already made and a normal pancreatogram, far from being misleading, is helpful in protecting the patient from pancreatic surgery. Conversely, an abnormal pancreatogram provides a map on which to plan surgical triumphs.

When faced with a patient with obscure upper abdominal pain we are concerned for the diagnosis and exclusion of peptic ulcer disease, gall stones, gastric and pancreatic cancer, and chronic pancreatitis. In this context ERCP (which includes gastroduodenoscopy, retrograde cholangiography, and pancreatography) is a powerful tool.

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Lomotil in acute diarrhoea

SIR,—In his article on this subject (20 November, p 1240) Dr D R Bell has given a paragraph to diphenoxylate with atropine (Lomotil) which may be misleading.

As he so rightly says, Lomotil is popular nowadays. This is because it is found to be effective and commonly free from side effects. Like most other drugs of therapeutic value, it has unwanted additional actions, but these are not frequently encountered. Warnings are provided that Lomotil should not be given with sedatives and cerebral depressants, but one wonders where he derived his information that "it can potentiate the effects of alcohol dramatically."

The broad statement that the drug "is no longer recommended for children" is unacceptable. It must be asked, On whose recommendation? How old are the children? What are the facts in support? There are no references at the end of the article. The Committee on Safety of Medicines accept its use in children from 1 year of age.

If the drug has the dangers he implies Dr Bell should have been as precise about dosage as the manufacturers. Equally as important, the drug is not related to morphine but to pethidine and there is no evidence that long-term administration leads to habituation. When overdosage does occur with respiratory depression the drug of choice in treatment is naloxone.

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*.*We sent a copy of this letter to Dr Bell, whose reply is printed below.—ED, *BMJ*.

SIR,—Of course it is true that Lomotil is commonly free from side effects, but a responsible review of current practice cannot

afford to ignore side effects that do sometimes occur. The statement that Lomotil "can potentiate the effects of alcohol dramatically" is based on personal observation and is intended to warn against giving Lomotil with alcohol or any other central nervous system depressant drug. The manufacturer's literature recommends "caution" under these circumstances; I think my recommendation to avoid such combinations is more helpful.

The use of Lomotil in children below the age of 12 is a matter for the physician's own discretion. My article was intended to reflect the consensus of current medical practice in Britain and I believe I have done this.

That prolonged use of diphenoxylate can cause dependence of the morphine type is stated in Martindale's *Extra Pharmacopoeia*.¹ The same source also refers to a report of coma and cardiac arrest in a 2-year-old child after ingestion of as few as six Lomotil tablets.²

I agree that the manufacturer's 1973 recommendation of nalorphine as the preferred antidote to diphenoxylate poisoning has now been superseded and that naloxone, being free of depressive effects itself, is the drug of choice.

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¹ *Martindale: The Extra Pharmacopoeia*, ed N W Blacow, 26th edn, p 1117. London, Pharmaceutical Press, 1972.

² Henderson, W, and Psaila, A, *Lancet*, 1969, **1**, 373.

The hospitals we need

SIR,—Dr R M Emrys-Roberts has summarised the Oxford cost-effectiveness study concisely (4 December, p 1385). The thoroughness of the Oxford experiment deserves wide recognition and it is sad that our colleagues there have had to give the financial kiss of death to their brain-child so early in the life of the community hospital. What is not clear is why the Department of Health and Social Security accepted this experiment as the blueprint for their own discussion document.¹ Experience of some 350 general practitioner hospitals containing some 9000 beds, much of it now fully recorded by Hospital Activity Analysis, has been available for some time. The scope and costs of providing hospital services in small units could usefully have been subjected to open debate before any discussion document was produced.

The main difference between the more active GP hospitals and the Oxford Community Hospital Programme is one of emphasis on the hospitals' acute role. Arbitrary limitation of this aspect of hospital work is likely to lead to a severely limited service to the community in question and subsequent loss of cost-effectiveness. In Brecon the casualty:admissions ratio is 5:1, and the x-ray:admissions ratio is 3:1. The casualty department is the busiest and relatively most efficient in the hospital, with a referral rate to district general hospitals of less than 10%. This compares with an inpatient referral rate of 30% to DGHs from the community as a whole, 70% being treated in Brecon Hospital. Transfer costs for patients in the Oxford area were a significant cause of loss of cost-effectiveness. The more acute services that are provided locally, the less this factor will predominate.

The chief loss in the debate so far has been the potentially useful term "community hospital," which has been elevated to a great

height only to be shot down on financial grounds—the most devastating of all at the moment. The Association of General Practitioner Hospitals is about to produce a document in similar terms to those of the DHSS for further discussion. Could not the name "community hospital" be viewed afresh from the time of its publication?

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¹ Department of Health and Social Security, *Community Hospital. Their Role and Development in the National Health Service*. London, HMSO, 1974.

SI: two years on—a lesson for the Royal Commission

SIR,—I share the lack of enthusiasm in your leading article (1 January, p 5). Molar concentrations are largely irrelevant to clinical medicine—I can count on my toes the times I have used them in clinical decisions in the past two years. If I want the plasma osmolality I do not add six experimental errors and a few false assumptions: I measure it.

New graduates acquire facility with the new system as we did with the old, but for my generation the switch to SI wiped out, at a stroke, 25 years of experience in interpreting results. Two years later I respond emotionally to creatinine and urea in SI units but I still convert dextrose, calcium, phosphate, urate, bilirubin, and blood gases into "old units" before making decisions. This was entirely predictable by anyone who had watched the more necessary introduction of multi-equivalent mEq for the common electrolytes 20 years earlier. We were told that the transition to SI would be quick and we would soon be wondering what all the fuss was about, but for those of us who have 10-20 years' clinical practice ahead and know we will never be as sharp with the new units as we were with the old the transition is pestilentially slow.

At the outset I wrote to Sir George Godber protesting against the new system and urging him at least to preserve the mm Hg for blood pressure. I received a bland reply from one of his colleagues saying there were no major problems with the changeover; I could only conclude that he never treated patients or read the *BMJ* and the *Lancet*. Had he been brain-washed by a handful of biochemists and failed to realise that laboratories can express their results in eils and furlongs at the touch of an electronic calculator, but they are interpreted by clinicians? We were assured that 20+ official bodies had been consulted, but the Department of Health and Social Security, having created Cogwheel, never used its own system to sound the opinion of those who would have to use SI in their daily work.

It is this lack of contact between the Elephant and Castle and the front line of medicine that I hope the Royal Commission will notice. Some decisions (including the future of SI) have to be made centrally but a lot more could be devolved, provided resources are shared fairly between regions and cash limits are applied impartially across the country. If these objectives are achieved is it really necessary for the minutiae of building plans, painstakingly drawn up with local consultation, to be rescrambled in London? Indeed, does the DHSS need to be involved at all in decisions about the siting and size of hospitals or health centres? Need we have uniform policies across