CORRESPONDENCE

Changed outlook in aplastic anaemia J R Hobbs, FRCP.....506	Misuse of statistical methods I A Kinsella, FIS.....510	Mechanism of acupuncture analgesia D B James, MB.....512
Occupational exposure to inhaled anaesthetics H T Davenport, FRCP(C), and others; S Mehta, FFARCS, and others.....506	Blood pressure measurements in SI units I O B Spencer, FRCP.....510	Payments by patients T Russell, MRCP.....512
Characteristics and prognosis of alcoholic doctors M M Glatt, FRCPsych.....507	Future of child health services J C Oakley, MRCP; W J Bassett, MB.....510	Loss of doctor in the course of duty G C C MacVicker, MRCS.....512
Mobility for the disabled R C B Aitken, FRCPsych.....507	Henoch-Schönlein purpura due to food sensitivity B W S Robinson, MB.....510	Working after retirement: a raw deal N B Eastwood, FRCP.....512
Royal College of General Practitioners D R Cargill, BM; Raine E I Roberts, MRCP.....508	Mucocutaneous lymph node syndrome J W Scopes, FRCP, and J A Hulse, MRCP.....511	Ophthalmic services for the elderly P A Gardiner, MD.....513
Self-poisoning with drugs D I R Jones, MB.....508	Pancreatic diagnosis C J Mitchell, MRCP, and others.....511	Easing the squeeze B O Scott, MRCS.....513
Multiple courses of ancrod (Arvin) therapy N C Thomson, MRCP, and others; G D O Lowe, MRCP, and others.....508	Cardiomyopathy after gonadotrophin treatment T W I Lovell, MRCP, and G D Porter, MB.....511	Earlier retirement? E Want, MB; J A Chisholm, MB.....513
General practitioner's role in management of labour P Curzen, FRCP, and Ursula M Mountrose, MRCP.....509	Rubella reinfection? G Haukenes, and others.....511	Assessment of GP trainees K E G Reeves, MB.....513
The reprint game J M T Hamilton-Miller, MRCPATH; J F Adams, FRCPED; V R Pickles, MD; R Finlayson, FRCPATH.....509	Geriatricians v psychogeriatricians P Catlin, MB.....511	Doctors and pressure groups N L Webb.....513
	Methadone and the elderly R P Symonds, MRCP.....512	Points from Letters Hospital practitioner grade (P L Mulrooney); Deputising services and the "emergency doctor" (F M Owers); Smallpox vaccination for students? (A W L Beatson); Chlorphenesin in bed wetting (A A Bapty); Management of appendicitis (F T Crossling); Health at "O" level (Vera Hartley); An IUDD record? (H E Reiss); A conglomeration of containers (J W M Humble).....514
	Scoring of erosions in rheumatoid arthritis C R Lovell, MB, and M I V Jayson, FRCP.....512	

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Changed outlook in aplastic anaemia

SIR,—While your leading article on this subject (8 January, p 63) is welcome, it seems a pity that it made no mention of the early British contribution in 1958¹ or of the development of the closed method of collecting and administering bone marrow, which is generally agreed to be the best in current use.² It is a pleasure to acknowledge these contributions, which have come from the department of Professor J G Humble, who has done so much at Westminster Hospital to promote bone marrow transplantation.

Later you state that "the procedure has to be restricted to patients with a sibling donor." I cannot agree with this in that the search should always be extended to other blood relatives, as successful grafting can be made from such a donor.³ Furthermore, there have been two very good successes from unrelated donors⁴ and at least three good partial results. While the use of unrelated donors is still in the experimental stage, with the help of Dr D C O James we have on nine occasions to date found donors unrelated to the recipient who show no significant increment in counts per minute in well-standardised⁵ mixed lymphocyte reactions, which were set up in each direction to check whether the possible donor's cells would attack the patient's or whether the patient would reject the donor's. The great tragedy is that five patients with aplastic anaemia all died within 1-6 days of such donors having been found and the real test of having attempted the actual graft could not be made. To assess a

possible donor requires at least one week, and then another eight days are needed before a graft.

With the further improvement in prognosticating⁶ it can now be clearly decided very early on for some patients that a graft is the treatment of choice. The above five patients, in retrospect, were all in this category and the tragedy is that no attempts to find a donor were made until it was too late. My main reason for writing is to advise my colleagues that a potential donor should be lined up as soon as possible for all such patients irrespective of whether they really have to proceed to the actual attempt at a graft. It is now also clear⁷ that every transfusion increases the risks of sensitising patients with less subsequent chance of successful grafts—for example, with less than 15 transfusions 86% survived and with more than 50 transfusions only 32% succeeded.

The plea is for an early decision and an early donor match for such patients so that they are not transferred to centres as bad risks with almost no platelets or phagocytes and already riddled with sepsis. As Nelson said before Copenhagen, "Lose not an hour."

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¹ Humble, J G, and Newton, K N, *Lancet*, 1958, **1**, 142.

² Pegg, D E, and Kemp, N H, *Lancet*, 1960, **2**, 1426.

³ Hobbs, J R, et al, *Postgraduate Medical Journal*, 1976, **52**, 90.

⁴ Foroozfar, N, et al, *Lancet*, 1977, **1**, 210.

⁵ Yamamura, M, et al, *Journal of Immunological Methods*, 1976, **10**, 367.

⁶ Lohrmann, H-P, et al, *Lancet*, 1976, **2**, 647.

⁷ Report from ACS/NIH Bone Marrow Transplant Registry, *Journal of the American Medical Association*, 1976, **236**, 1131.

Occupational exposure to inhaled anaesthetics

SIR,—We are glad that Dr P V Cole (25 December, p 1563), agrees with us (20 November, p 1219) that there is lack of information about the exposure of theatre staff to anaesthetic agents. We thought of using blood samples as he suggests but, after consideration, we rejected them because inhalation anaesthetics are so rapidly absorbed and excreted that a blood sample reflects mainly the most recent exposure of the subject and the result depends critically on how soon after exposure the sample is taken. The example quoted by Dr Cole, carbon monoxide, is very suitable for blood sampling as it is rapidly absorbed and slowly excreted, but for more volatile substances integrated sampling is essential.

Drs D W Bethune and J M Collis (22 January, p 234) question our use of active scavenging with central piped vacuum (CPV). We believe that the objections to the use of CPV are more theoretical than practical. The flow rate of our system is limited to 40 l/min by a restricting orifice and unless all the bypass holes in the suction hood are occluded, which seems to us almost impossible, no dangerous suction can be applied to the patient. Our pumps have more than sufficient spare capacity