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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 must be signed personally by all their authors.

Gynaecological laparoscopy

SIR,—In 1972 you published a paper by Professor D G Julian and myself on cardiac arrhythmias associated with laparoscopy.¹ The anaesthetic method employed in that investigation was subsequently heavily criticised in your correspondence columns because in the cases we reported endotracheal intubation was not performed, ventilation was spontaneous, and a small dose of non-depolarising muscle relaxant was given. That most anaesthetists agreed with the criticisms is obvious from the report of the working party of the confidential inquiry into gynaecological laparoscopy conducted by the Royal College of Obstetricians and Gynaecologists, recently published² (see leading article, p 1650). This shows that during the period covered by the inquiry (April 1976 to March 1977), of the 50 247 operations reported, only 9.6% of the patients were not intubated and only 14% breathed spontaneously. Indeed the working party states: "In such a potentially hazardous situation, it seemed surprising that nearly 10% of all cases (4750) were managed using a face mask."

Nevertheless 4750 is a very considerable number and if the potential hazard is so great one must have expected several mishaps to have occurred. This singularly failed to happen, the overall complication rate being 1612 of 42 829 (3.8%) with controlled ventilation as against 189 of 6990 (2.7%) with spontaneous ventilation. This difference is overwhelmingly statistically significant, and the working party's explanation that it could well be due to the fact that patients were intubated when things went wrong is wishful thinking at best.

One must admit that the way in which the data have been presented in the report,

particularly the over-use of crude complication rates, is unlikely to shed much light on many of the problems. The method of anaesthesia is not going to affect many of the listed complications such as haemorrhage into the abdominal wall. However, it is contended that the use of spontaneous respiration and a face mask will lead to problems of inhalation of stomach contents and respiratory inadequacy. In fact the incidence of regurgitation during surgery was nil. Of 50 247 patients, not one regurgitated stomach contents during the period of the pneumoperitoneum. Cardiac arrest occurred nine times and there were in addition four deaths. All these cases occurred in patients who had been intubated and whose ventilation was controlled, so it cannot be said that major catastrophes occurred more frequently in the non-intubated, self-ventilating group. Of the 38 patients who developed "anaesthetic complications" as surgical ones, only one breathed spontaneously with a mask. Where then is the evidence for the "hazard" of not intubating?

The report may also be criticised on two further major points. Firstly, the reluctance to diagnose what is almost certainly the most important cause of death, gas embolism. Only one of the four deaths is so designated while one other was clearly so and a third arguably so. Then there were the nine patients with cardiac arrest who were resuscitated. These seem to have been grouped together as if cardiac arrest were an inescapable feature of general anaesthesia. I would maintain that virtually the only two possible causes of cardiac arrest in intubated and ventilated patients are gas embolism and incorrect

placement of the endotracheal tube in the oesophagus. The latter could only be associated with successful resuscitation if the incorrect placement were diagnosed and corrected. Thus it seems likely that virtually all these cases were of gas embolism.

Secondly, one must agree with the conclusion of the working party that sterilisation carried out at the time of termination of pregnancy carries no extra risk. This is based on the crude complication rate, which is a ridiculous index of the extra risk, which is solely in terms of gas embolism. One of the four deaths took place in a pregnant patient and there are no data regarding the nine cardiac arrests. Only 6.6% of patients in the survey were pregnant. Until better proof of the safety of the combined procedure is available the conclusion of the working party is reprehensible.

Having made these somewhat severe criticisms, may I nevertheless congratulate the working party for undertaking this mammoth task, and for the data they have accumulated.

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¹ Scott, D B, and Julian, D G, *British Medical Journal*, 1972, **1**, 411.

² *Gynaecological Laparoscopy. The Report of the Working Party of the Confidential Enquiry into Gynaecological Laparoscopy*, eds G Chamberlain and J C Brown. London, Royal College of Obstetricians and Gynaecologists, 1978.

Rubella vaccination

SIR,—Although we feel that more should be done to reduce the incidence of rubella infection during pregnancy, we cannot agree with Dr Leonora A Crawford (3 June, p 1585) that rubella vaccination for both boys and girls is desirable. As long as 20 years may

elapse between vaccination at school and first pregnancy and we cannot be sure that vaccination alone, in the absence of immunological stimuli through contact with the infection, will maintain enduring immunity.

The vaccination of schoolgirls appears to be slowly taking effect: a large sample of haemagglutination inhibition tests on adult women gave a susceptibility rate of 17% in 1974; in 1978 it had fallen to 12.7%. In a survey of Essex school-leavers of average age 18 years in 1976 4.3% of the girls were susceptible. Taking only those who claimed to have been vaccinated, there were only 1.3% susceptible. Thus in 10-15 years we may expect a susceptibility rate of about 5%; if the acceptance rate is increased from 68% to nearer 100% it should fall to 1%; if retesting is carried out after vaccination then the incidence should almost vanish. It may soon be preferable to screen schoolgirls before vaccination in order to concentrate on the susceptibles.

The situation of women who were not vaccinated at school is more serious. Very little propaganda appears to emanate from central sources and no amount of local pressure appears to improve the appallingly low incidence of screening of non-pregnant women (below 10% and mainly nurses). The first visit to the antenatal clinic is the traditional occasion for screening, but the timing could hardly be worse. Preferable occasions are during visits to a family planning clinic or when submitting specimens for pregnancy tests. Certain groups of women must be screened before taking up employment—nurses, teachers, social workers, etc.—and failure of the employer to make the necessary arrangements might invoke action under the Health and Safety at Work Act.

However, the most important aspect is the education of women in this matter. They have come to understand the danger of rubella infection during pregnancy; the medical profession should co-operate with the media to persuade them to demand rubella screening as a routine procedure before pregnancy is contemplated. This would avoid situations that today cause great distress to a large number of women.

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Epidemic myalgic encephalomyelitis

SIR,—I disagree with the view you express in your leading article (3 June, p 1436) that the many epidemics you cite compose a single nosological entity. Outbreaks in hospital staff apart, these miscellaneous episodes and others described at the symposium at the Royal Society of Medicine may well have been as diverse aetiologically as they were geographically.

Nor do I agree that the Royal Free Hospital outbreak has now been proved to have been a form of encephalitis. Much play was made at the symposium on the occurrence of extensor plantar responses and of other evidence of organic disease. In fact, however, only two of the 292 patients had a frank extensor response¹ and one of these was later found to have multiple sclerosis. The other evidence adduced was equally unconvincing.

As I have previously explained,² it is relevant to consider the management of infectious mononucleosis in the Royal Free

Hospital at the time and the results obtained³—which bore no comparison with those described in a standard textbook.⁴ There seems to have been failure to realise how suggestible people are when they are ill or anxious.^{2, 5}

In a letter to *The Times*⁶ entitled "Vapour or virus" Sir Francis Walshe stated: "Epidemics of mass hysteria have punctuated history and doubtless a few centuries ago were attributed to witchcraft or demoniacal possession on evidence not less than that now evoking the mystic chant of the word 'virus.'" Though the Royal Free outbreak was a sorry affair compared with dancing madness, the classic form of mass hysteria,⁷ ataxia, vertigo, fits, and prostration were common to both. Nowadays the vapour or virus, or whatever the devil it is, seems to be most at home in nurses' homes (in "centres of excellence" particularly). Any one who wants to know if Walshe's statement could be pertinent to the Royal Free epidemic should not be content with your leading article: he should study the evidence for himself.

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¹ *British Medical Journal*, 1957, 2, 895.

² Easton, H G, *World Medicine*, 1977, 13, 13.

³ Dunnet, W N, *British Medical Journal*, 1963, 1, 1187.

⁴ Christie, A B, *Infectious Diseases: Epidemiology and Clinical Practice*, 2nd edn. Edinburgh, Churchill Livingstone, 1974.

⁵ Easton, H G, *British Medical Journal*, 1963, 1, 1473.

⁶ Walshe, F M R, *The Times*, 19 October 1965.

⁷ Dodds, E R, *The Greeks and the Irrational*. London, Cambridge University Press, 1963.

Improvement of perinatal care

SIR,—In your leading article (27 May, p 1372) on perinatal mortality you are guilty of an inaccuracy and a non sequitur when you refer to *The Place of Birth*¹ as advocating a move "back" to domiciliary midwifery and imply that this would necessarily lead to an increase in perinatal mortality or morbidity, or both.

It would seem that you have not read the book, for if you had it would have become clear that the introduction of 100% hospital delivery in England still leaves us a long way behind Holland, where the rate is in the region of 50%. What we advocate is a move "forward" to domiciliary midwifery (the distinction is nice but not precious); and we fail to appreciate why the concentration of abnormal midwifery in larger units properly staffed and equipped to cope with predictable emergencies should be incompatible with the conduct of predictably normal deliveries at home. Admittedly, a considerable proportion of emergencies are at present not predicted; but this may be partly the result of inadequate antenatal care and partly due to the present orientation of research in obstetrics. It is also important to point out that what matters is the final outcome and that there is a difference between the conditions in which obstetricians on the one hand and women on the other feel safe and those in which babies are safe.

What *The Place of Birth* argues is that both obstetric and paediatric establishments are becoming obsessed with our place in the perinatal league table at the expense of other considerations that we think are equally important and that the means that are proposed to achieve this end will not necessarily serve the purpose. For instance, it is by no means certain that special care units as opposed to

intensive care units are really necessary and they are certainly harmful. The joint committee² should have been more radical in their thinking and in their recommendations.

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¹ Kitzinger, S. and Davis, J., *The Place of Birth*. London, Oxford University Press, 1978.

² BPA RCOG Liaison Committee, *Recommendations for the Improvement of Infant Care during the Perinatal Period in the United Kingdom*, Discussion Document. London, British Paediatric Association and Royal College of Obstetricians and Gynaecologists, 1978.

How much physical therapy for patients with stroke?

SIR,—We welcome the attempt by Professor J C Brocklehurst and his colleagues (20 May, p 1307) to draw attention to the objectives of physical therapy for strokes. We fear that the conclusion they draw could result in the withdrawal of physiotherapy from patients who continue to require it and an increase in the permanent long-stay hospital population.

In their study patients were admitted according to bed availability to one or other of six different hospitals. Four hospitals provided no occupational therapy and three provided no speech therapy. When combined with the 24% incidence of pressure sores in the stroke patients this suggests that conditions for rehabilitation were below optimal. Physiotherapy in the article is measured in days, but in most hospitals the amount a patient receives is measured in minutes. It is important to know whether physiotherapy was carried out in isolation within a physiotherapy department or in the ward, supplemented by training of the nursing staff to reinforce the physiotherapy, together with integration with occupational therapy and speech therapy in the therapeutic team. It would be of interest too to know whether there was a between-hospital variation and it is necessary to know whether physiotherapy was of the traditional type or of the facilitative type such as Bobath or proprioceptive neuromuscular facilitation.

The results in this Manchester survey confirm that mobility continues to improve in 21% after 6 months and that 6% of the study group were restored to independence after 6 months. Withdrawal of trained therapists before this period will result in an increase in the study's current 16% of stroke patients remaining as inpatients at one year.

There also remains a real need to compare the performance of a fully staffed rehabilitation team working in the wards of a general hospital ward with the results of a stroke unit.

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* * * We sent a copy of this letter to Professor Brocklehurst and his colleagues, whose reply is printed below.—Ed, *BMJ*.

SIR,—Our study (20 May, p 1307) was a description of the management of patients with stroke as it happens at the present time and we agree with Drs Knox and Horrocks that the present situation leaves much to be desired. Our hope is that by indicating where