There have been no further episodes of skin lesions or systemic upset.

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Hazard of chemical sympathectomy

SIR,—The essential requirement in performing injections with neurolytic solutions is firstly to ensure correct needle placement and secondly to make sure that the solution spreads in the correct tissue plane so as to destroy only the intended nervous tissue. Drs J M B Burn and L Langdon (29 April, p 1143) deny the need for radiological control for chemical sympathectomies on the grounds of expediency and on the basis of their own experience. They miss the point that cases of paraplegia, including the one described by Dr R C Smith and others (4 March, p 552), have occurred for the very reason that the operator was unaware of any error in the needle placement or aberrant spread of solution. The potential for inaccurate needle placement is well illustrated in the study by Brechner and Brechner,¹ who showed that even with technical proficiency check x-rays after final positioning will show up to 40% error in needle placement.

When x-ray control with an image intensifier is used from the start accurate placement of the needles is very rapid, reducing patient discomfort to a minimum. The satisfactory position of the needles having been seen, subsequent injection of radio-opaque solution then determines the accuracy and extent of spread, allowing for minor adjustments when an occasional intravascular dispersion is seen. We therefore strongly recommend, as the safest practice, that all neurolytic injections in the region of the vertebral column should be made under x-ray control.

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¹ Brechner, T F, and Brechner, V L, in *Advances in Pain Research and Therapy*, ed J J Bonica and D Albe-Fessard, vol 1, p 679. New York, Raven Press, 1976.

Treatment of ulcerative colitis

SIR,—The article "Ileostomy or ileorectal anastomosis for ulcerative colitis" (3 June, p 1459) was a most interesting discussion of the surgical controversy. Given such a theme, it is understandable that only lip-service was paid to medical aspects of treatment and no reference whatsoever was made to psychological approaches.

Psychological factors have a significant effect in the onset of the individual exacerbation and in determining the patient's response to and the handling of this illness. The evidence for the effectiveness of psychiatric

intervention has been comprehensively reviewed.¹ If more patients with ulcerative colitis were to receive psychiatric help it may well be that there would be no need for such papers and I would appeal to all doctors concerned with such patients to consider psychiatric referral.

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¹ O'Connor, J, in *Modern Trends in Psychosomatic Medicine*, 2, ed O W Hill. London, Butterworths, 1970.

A Russian visit

SIR,—Dr John Coope (Personal View, 20 May, p 1343) seems to display a measure of impatience with the Russian doctors and staff who were good enough to show him their polyclinic and discuss their work with him.

I would suggest that if a group of Russian doctors without a word of English between them were to knock at the door of a British health centre they would be fortunate to receive such courteous treatment. Also there might be many a "chief" who felt as strongly as the Russian that the local doctors of his team are not employed to sit around discussing the British and Russian medical systems.

There may be something to be said for a direct approach to investigating medical systems in other countries. There is also something to be said for at least informally spying out the land first, and certainly for arranging for one's own interpreter.

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Heart-rate response to standing as a test for automatic neuropathy

SIR,—We were interested in Dr W J MacLennan's observation of an abnormal heart-rate response to standing in seven elderly subjects (25 February, p 505), and its confirmation by Mr D J Oliver (20 May, p 1349). As autonomic dysfunction in the form of postural hypotension occurs quite commonly in the elderly,¹ our "30:15 ratio" may provide a simple way to confirm it. In reply to Mr L Oppenheimer (25 February, p 505), who wonders whether the blood pressure was taken into account in our observations (21 January, p 145), the mean blood pressure of the 15 diabetics with autonomic neuropathy was 146 ± 37 mm Hg (systolic) and 87 ± 10 mm Hg (diastolic). Although higher than in the group of 10 "older normals" (124 ± 12 systolic, 80 ± 6 diastolic), this difference was not statistically significant. Thus his suggestion that there might be baroreflex resetting related to hypertension, leading to an "apparent" neuropathy of the baroreflex arc, is not borne out by the blood pressures of our diabetics. Moreover, our subjects had severe generalised peripheral and autonomic neuropathy as shown by a number of tests in addition to those testing the integrity of the baroreflex arc.

Mr Oliver raises the question of individual beat-to-beat variation, which could invalidate the "30:15 ratio." In our experience, based on computer analysis of the individual R—R intervals, beat-to-beat variation usually disappears on standing only to reappear some 30

beats later; but his letter underlines the need for some flexibility in the interpretation of the ratio. We found in any individual that the maximum tachycardia was not necessarily at exactly the 15th beat, or the relative bradycardia at exactly the 30th beat; and in practice it is also sometimes not possible to press the ECG marker button at exactly the point at which the subject starts to stand up. Because of this, in our routine ECG-measured 30:15 ratios we now take the point of maximal shortening of R—R that occurs at or around the 15th beat. In Mr Oliver's example, if he had taken any of the beats 11-14 he would have obtained a "normal" 30:15 ratio.

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¹ Caird, F I, Andrews, G R, and Kennedy, R D, *British Heart Journal*, 1973, **35**, 527.

Surgical haemorrhage in patients given prophylactic heparin

SIR,—I was interested to read the paper by Mr N H Allen and others (20 May, p 1326) and was impressed by their method of assessing interoperative and postoperative blood loss following transurethral resection of the prostate. However, I find their interpretation of the results a little worrying.

In their table they state that the mean postoperative blood loss in the controls was 71 ml with a range of 0-351 ml, while in the heparin group the mean value was 135 ml, and the range 0-774 ml, and they state that these values are significantly different from each other. They do not, however, state what statistical test was applied to obtain their P values and I fear that as they have quoted mean values they have used a parametric test. With the mean values and ranges quoted the distribution of data is obviously grossly abnormal and the higher mean value in the heparin group could well be due to one or two higher results. Therefore the values given for the postoperative haemoglobin (12.1 g/dl in the control group, 11.8 g/dl in the heparin group) may give a truer picture of the actual situation.

A better comparison for the postoperative blood loss between the two groups would be obtained by using the median value and obtaining statistical probability using the Mann-Whitney or Wilcoxon tests.

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The other crisis of health care

SIR,—In 10 major points Dr A E Finnegan (6 May, p 1211) has tried to show that the French system of health care is "infinitely better" for the average "Frenchman in the street" than is our own. He says this on the basis of a year's experience in France and Belgium. May I reply on the basis of what I saw during a year spent in France? I particularly had the opportunity to look at the care of the old, the poor, and the chronically sick. I will take some of his points individually first.

Dr Finnegan's first point is the freedom of choice of the French patient to visit any