should, if possible, be rushed to hospital for admission to an intensive care ward. The cause of the blindness is most likely to be due to a serious underlying medical condition, which can there be assessed and treated without delay.

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¹ Parsons-Smith, B. G., in *Medical Ophthalmology*, p. 329. Ed F. C. Rose. London, Chapman and Hall, 1976.

Control of blood glucose in labour

SIR,—We were surprised at the implication in the paper by Drs T. E. T. West and C. Lowy (14 May, p. 1252) that the control of the blood glucose levels during labour in diabetic women by continuous infusion of glucose and insulin is an innovation which has received no mention in standard texts. Since the eighth edition (1961) of the *Textbook of Medical Treatment* by Dunlop, Davidson, and Alstead¹ has discussed the alternative means of meeting the energy requirements of diabetics being prepared for delivery per vaginam, concluding, "It is generally safer and easier to give the glucose by continuous intravenous infusion to which insulin is added."

It has been routine practice in this centre since 1955 to give diabetic patients in labour continuous intravenous infusion of glucose (0.5 g/l), 0.5 l 4-hourly, soluble insulin being added directly to each bottle or polyethylene container without albumin, in amounts calculated from a knowledge of each patient's dietary carbohydrate and daily insulin requirement over the previous few days. Blood glucose is measured at frequent intervals (nowadays by reflectance meter) and the dose of intravenous insulin, generally 2-4 units hourly, adjusted accordingly.

We agree with the conclusions reached by West and Lowy as to very satisfactory results of this policy, but it would be unfortunate if the impression were created that successful management of the diabetic in labour requires, and is dependent upon, the infusion of insulin by means of a syringe pump, when all that is required is its direct addition to the bottle containing the glucose solution.

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¹ Dunlop, D. M., Davidson, S., and Alstead, G., *Textbook of Medical Treatment*, 8th edn. London and Edinburgh, Livingstone, 1961.

Detection of bone metastases

SIR,—Dr N. W. Garvie in his letter (7 May, p. 1219) wondered whether the more effective demonstration of skeletal metastases affects the prognosis of patients with cancer. It is generally accepted that skeletal metastases per se do not affect the prognosis but usually indicate that the patient has other sites of dissemination—for example, pulmonary or hepatic lesions—which may affect the prognosis. It has been shown in patients with apparently "early" mammary carcinoma that

the presence of a positive scintigram indicates an extremely poor prognosis although there are no other signs of dissemination of their carcinoma.¹ No patients with a positive skeletal scintigram were alive and apparently free from tumour at five years compared with 66% of patients with a negative scintigram.

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¹ Galasko, C. S. B., *British Journal of Surgery*, 1975, **62**, 694.

Intravenous naftidrofuryl

SIR,—We have been conducting a trial of intravenous naftidrofuryl (Praxilene) for patients with pregangrene and gangrene, similar to that reported by Mr C. R. J. Woodhouse and Mr D. G. A. Eadie (21 May, p. 1320). We have treated 26 patients so far and have had no instances of thrombophlebitis. The only difference between our method of administration and theirs is we give 200 mg of naftidrofuryl in 500 ml of dextrose saline. We have evidence which suggests that the infusion of 500 ml of fluid over a short time causes vasodilatation, and this may promote more rapid flow through the peripheral veins.¹ We agree with Mr Woodhouse and Mr Eadie's conclusions and suggest that the complication can be simply overcome by using a larger volume of diluant.

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¹ Humphreys, W. V., et al., *British Journal of Surgery*, 1976, **63**, 691.

The nurse's role in immediate postoperative care

SIR,—I read with interest the paper by Drs D. S. B. Stephens and J. Boaler on the nurse's role in immediate postoperative care (7 May, p. 1199). The National Association of Theatre Nurses has been aware of this situation for some time, and you may be interested to know that, following discussion with the General Nursing Council for England and Wales, we have now finalised a syllabus of theatre training for student and pupil nurses which will cover recovery room nursing.

As this research points out, recovery facilities in the majority of hospitals are available within the theatre suite, so recovery room nursing should be taught during the learner's secondment to theatre. However, the student nurse may come to theatre for only two weeks' observation, and the pupil nurse may not come at all, for theatre training is optional for this grade. In a recent national survey on operating departments carried out by the National Association of Theatre Nurses the percentage of student nurses coming to theatre for two weeks only was 28%. Because of this some schools of nursing are sending the learners to theatres for an extra period of one to two weeks to work only in the recovery area with qualified nurses.

With rapid advances taking place in medicine, we must sympathise with anyone involved in compiling any syllabus for those in the health care field. Recently, at the

Infection Control Nurses Association Conference urgent changes for medical students and newly qualified doctors were requested because of the lack of tuition given in the effects of cross-infection and its control.

I was rather surprised that the authors did not mention escort nurses. In my own situation these are all qualified nurses who escort the patient from the ward to the anaesthetic room and, following surgery, recover the patients and escort them back to the wards. I know I am not alone in the South-east Thames Region in providing this service to our patients.

The Joint Board of Clinical Nursing Studies, the nursing body responsible for post-basic education, recommends a period to gain experience in recovery room nursing for qualified SRNs and SENs in the curriculum for their courses on operating department nursing and anaesthetic room nursing.

Lastly, could I point out that I feel sure that it is not a shortage of nurses but a lack of resources to employ qualified nurses that is the main reason for the situation described?

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Acute epiglottitis in an adult treated with nasotracheal intubation

SIR,—Acute epiglottitis, often with involvement of the aryepiglottic folds, hypopharynx, and base of the tongue¹ and usually due to *Haemophilus influenzae* type B (2), is a relatively rare, life-threatening infection mainly affecting infants and preschool-age children, but it also occurs in adults.^{2,3} The patient often has rapidly progressive and frequently abrupt airway obstruction,⁴ relief of which is mandatory. Nasotracheal intubation seems to be the treatment of choice in children, but there is little information as to the treatment to be preferred in adults.³ Dr B. D. Linaker (30 October 1976, p. 1045) reported a case in which tracheostomy was considered necessary. We report a case of epiglottitis in an adult successfully treated with nasotracheal intubation.

The patient was a 34-year-old man with a 12-h history of sore throat and breathlessness. On admission to hospital he was mildly dyspnoeic and complained of difficulty in swallowing and increased salivation. Pulse was 78/min and temperature 39.2°C. The mucous membranes in the pharynx were hyperaemic. There were scattered rhonchi over the lungs. Direct laryngoscopy showed a red and swollen epiglottis. The erythrocyte sedimentation rate was 17 mm in 1 h and the white cell count $14 \times 10^9/l$ ($14\,000/mm^3$). Chest x-ray was negative. Laryngeal swabs showed a growth of *Haemophilus influenzae* sensitive to ampicillin. Initially the patient was treated with humidified oxygen, adrenaline (1:1000) 0.5 mg subcutaneously, hydrocortisone hemisuccinate 200 mg 6-hourly intravenously, and ampicillin 2 g 6-hourly intravenously. The treatment did not improve his respiratory condition. Therefore about 4 h after admission nasotracheal intubation with a Portex plastic tube 7.5 mm in diameter was performed under halothane anaesthesia, medical treatment being continued along with standard care for intubated patients. After 48 h direct laryngoscopy showed a completely normal epiglottis and the patient was extubated. There was no respiratory problems after extubation. He was discharged six days after admission.

Opinions still differ as to whether the treatment of acute epiglottitis should be