concentrations are several orders of magnitude below those which may cause trouble with oil immersed pumps.

It is to be hoped that the National Institutes of Health recommendations¹ for acceptable limits are based on more reliable calculations, though it is difficult to see how dose-response curves can have been obtained from the available data.

B M WRIGHT

Clinical Research Centre,
Watford Road,
Harrow, Middx

¹ Whitcher, C, *et al*, *Development and Evaluation of Methods for Elimination of Waste Anesthetic Gases and Vapors in Hospital*. DHEW publication No 75-137. Washington DC, US Government Printing Office, 1975.

Congenital dislocation of the hip

SIR,—I would like to add two points to your leading article on the early diagnosis of congenital dislocation of the hip (21 May, p 1303).

Firstly, it needs to be emphasised that consistently successful detection at birth requires an enthusiast who is closely involved in the screening programme. Thus on a small scale, where one man has the opportunity to oversee the whole scheme, screening appears to be very effective¹⁻⁴ in reducing the incidence of later presentation of the established dislocation. Wherever larger series have been reported over a widespread area^{5,6} screening has been less successful, and it is on this type of result that we must now be trying to improve.

Secondly, Fredersborg's experience,⁷ which you report, with abduction splintage in the neonate is not in common with most units in this country. These splints (a) cause avascular necrosis of the capital epiphysis in some cases and (b) fail to control some dislocatable and dislocated hips. When assessing results of early splintage it has to be remembered that between five and 10 unstable hips at birth have to be detected and successfully treated to prevent one dislocated hip from presenting later on. Mitchell's⁸ and Williamson's⁶ studies therefore show an incidence of late hip pathology which is almost unchanged.

M E CONYBEARE

Nuffield Orthopaedic Centre,
Oxford

¹ Barlow, T G, *Journal of Bone and Joint Surgery*, 1962, **44B**, 292.

² Rosen, S von, *Journal of Bone and Joint Surgery*, 1962, **44B**, 284.

³ Moore, F H, Paper presented at BOA Spring Meeting, April 1977.

⁴ Hughes, J R, and Conybeare, M E, Study 1965-75, awaiting publication.

⁵ Bjerkreim, I, *Acta Orthopaedica Scandinavica*, 1974, Suppl 157.

⁶ Williamson, J, *Journal of Bone and Joint Surgery*, 1972, **54B**, 13.

⁷ Fredersborg, N, *Journal of Bone and Joint Surgery*, 1976, **58B**, 272.

⁸ Mitchell, G P, *Journal of Bone and Joint Surgery*, 1972, **54B**, 4.

Hygiene in NHS hospitals

SIR,—The letter (7 May, p 1215) on hygiene in National Health Service hospitals by Drs G A J Ayliffe and Mr B J Collins epitomises in our opinion the kind of attitude that has landed health authorities in the trouble they are in today in relation to food hygiene. While not wishing to enter into the argument of whether NHS hospitals should or should

not be liable for prosecution, we find the reference to two sets of standards quite unacceptable. To suggest that the regulations are anything other than common sense is unfair, and with the greatest respect to those working in hospital infectious diseases units we are not convinced that they are the best people to advise on food hygiene matters, and in any case, if they are, what have they been doing all these years to permit the present state of affairs?

We note in the letter that environmental health officers should be invited to inspect catering facilities but that any recommendation should then be considered by the "hospital authorities," who will decide on order of priority. This is nothing short of patronising.

It is recognised that it may be a question either of improving hygiene standards or developing an important facet of health care, but we consider that a planning committee should not arbitrarily defer recommendations of a professional officer who has been invited to make them without first giving that person a chance to explain his views. Indeed in this locality the chief environmental health officer has a permanent place on the health service control of infection committee.

HARVEY GORDON
Community physician

GRAHAM ASTON
Borough Environmental Health
and Housing Officer

Epsom

A confidence trick

SIR,—Among my other activities this week I have spent an hour with a senior registrar short listed for our vacant consultant post and I have chaired a meeting of a subcommittee discussing the Health Service Board's activities. The senior registrar informs me that his National Health Service salary is over £13 000 a year, whereas my basic National Health Service salary after three and a half years as a consultant is £7300. With vasectomy and domiciliary visits my salary can reach £11 000, but it is only with my small private practice that I reach as much money as a senior registrar. It seems ludicrous that Government-sponsored vasectomies are necessary to raise my salary in this way and it is evident that my private practice subsidises the National Health Service (a) by saving the Government 2/11 of my salary; (b) bringing in some income to the National Health Service at the rate of £45 per bed per day; and (c) by just about maintaining the semblance of differential between consultants and junior staff.

Without private practice in National Health hospitals consultants would have to become either geographically part-time or full-time, and yet they would be unable in many cases to fit more work into the week than they do at the present, and the Government would pay 2/11 more in salaries for very little return. As Professor Harold Ellis pointed out (28 May, p 1408), the vacated beds will remain unfilled since their use depends on availability of medical and nursing staff and theatre space, etc.

Yet the squeeze on private practice in the National Health Service goes on. In our area we have lost 60% of our beds on the grounds that they were previously under used. If they were under used, what harm was private practice doing the National Health Service?

We now only have 10 beds and at least 20 part-time consultants sharing them. Since we are now allowed at any time to exceed 10 beds we cannot achieve 100% bed occupancy, and thus we will probably lose more at the next round of cuts. I ask the unions, the Government, and the Health Service Board what they think they are achieving. The Health Service Board particularly and the Minister are acting with blind haste in their application of the Health Services Act. The outcome will be no improvement in the National Health Service, disgruntled senior doctors demanding more National Health Service money to make up for lost private practice, and consultants spending more time away from their National Health Service bases.

Please tell me, Mr Fisher and others, if you read this journal, even if your intentions were honourable, do you not think you have got it wrong? If you do admit this it may not be too late to revise the situation.

E FIELD

Chairman of the Subcommittee of
Private Practice to the Greenwich
Health District

London SE18

Refusal of award

SIR,—Having read David Loshak's article in the *Daily Telegraph* of 27 May concerning the report of the Independent Pay Review Body I was encouraged to read that the Hospital Consultants and Specialists Association would refuse to accept the award and would return it to the Government, starting pay negotiations afresh on 1 August. From a tactical point of view it would be an advantage if the BMA did the same thing for the rest of the profession. This would probably enable us (1) to get a higher award in the next round, and (2) being paid at the beginning of the "wage pay year" would be more advantageous than being paid at the end of it with inflation running at 17% a year.

An alternative approach would be to put the squeeze on ourselves, refuse derisory pay awards altogether, and beat the Government at their own game, thus precipitating the retirement for financial reasons of many elderly GPs, whose pay, which is inflation-proof-linked, would be safeguarded. The resulting fall in the numbers of GPs would perhaps put pressure on the Government. This would be better than doctors going on strike or leaving the NHS, which most of us would find distasteful.

G R GENOVESE

Salisbury

Sudden blindness in polymyalgia arteritica

SIR,—I agree with Drs A G Freeman and R W Ross Russell (28 May, p 1412), who remark that delay in commencing treatment of even a few hours may result in irreversible visual failure. This urgency is not widely appreciated, nor is the fact that blindness may be the first symptom of giant cell arteritis.

I have recommended¹ that the treatment of any elderly patient who suddenly loses the sight of one or both eyes should be an immediate intravenous injection of dexamethasone 10 mg given by the general practitioner. Then, as in a cardiac emergency, the patient

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.

GERALD PARSONS-SMITH

Charing Cross Hospital and
Western Ophthalmic Hospital
(St Mary's)

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) 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.

JUDITH M STEEL
LESLIE J P DUNCAN
B F CLARKE

Royal Infirmary,
Edinburgh

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.

C S B GALASKO

Department of Orthopaedic Surgery
Hope Hospital,
Salford

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.

DAVID CHARLESWORTH

Department of Surgery,
University Hospital of South Manchester

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?

MARY C DONN

Chairman,
National Association of Theatre Nurses

Bromley

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