given that of five patients with deteriorating renal function, three were on gentamicin alone and two on gentamicin plus a cephalosporin. Of the three on gentamicin alone they say, "All three patients were also suffering from transplant rejection and toxæmia, and interpretation of these results is therefore difficult." Of the two on gentamicin plus a cephalosporin they say, "Although in both cases rejection was occurring, we could not exclude nephrotoxicity."

They do not present any evidence to explain why in the one situation they conclude, "attributable nephrotoxicity not observed," while in the other they conclude, "may have produced nephrotoxicity." Furthermore, in view of the accumulating evidence that gentamicin appears to be potentially more nephrotoxic than some other aminoglycosides¹⁻³ attention might have been drawn to the fact that, whether or not it was attributable, all five patients who showed deteriorating renal function were actually receiving gentamicin and not one of the other aminoglycosides included in the study.

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¹ Neu, H L, and Bendush, C L, *Journal of Infectious Diseases*, 1976, **134**, suppl, p S206.

² Kahlmeter, G, Hallberg, T, and Kamme, C, *Journal of Antimicrobial Chemotherapy*, 1978, **4**, suppl A, p 47.

³ Whelton, A, et al, *Current Chemotherapy, Proceedings of the 10th International Congress of Chemotherapy*, 1977.

* *We sent a copy of this letter to Dr Noone, whose reply is printed below.—ED, *BMJ*.

SIR,—The reason for the different assessment of the patients with deteriorating renal functioning is as follows.

Of the three patients on gentamicin alone, two were undergoing severe rejection with acute loss of renal function and received gentamicin for suspected (but unconfirmed) sepsis. The third patient on gentamicin alone had very poor renal function and was receiving regular haemodialysis in the unit. He was admitted in a very ill state with *Pseudomonas aeruginosa* septicaemia and his already deteriorating renal function continued to decline during his treatment with carbenicillin and gentamicin. It was considered that the modest rise in blood urea observed could be accounted for by his septic state. On the other hand the two patients who were receiving cephalosporin and gentamicin together had a much milder degree of rejection and still had useful renal function which deteriorated during antibiotic therapy. So although rejection was occurring, one could not rule out the possibility of a nephrotoxic affect.

As regards Dr Woodcock's other comments, most of the work comparing the nephrotoxicity of gentamicin and tobramycin has been performed in experimental animals and it is well known that there are marked inter-species differences in susceptibility to the toxic affect of aminoglycosides. In the only double-blind trial performed in humans there was no significant difference in nephrotoxicity between gentamicin and tobramycin.¹

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¹ Wade, J C, et al, *Lancet*, 1978, **2**, 604.

The Year of the Child: an objective for rich nations

SIR,—The United Nations has designated 1979 as the Year of the Child. In the wealthy countries there is still widespread ignorance of the fact that a mother's ability to love and enjoy her baby but yet accept the privation which caring for children brings may be damaged irreparably by lack of close and continuous contact between mother and infant in the immediate postnatal period.¹

Western culture has "forgotten" that such contact, and in particular the suckling of an infant in intimate peaceful surroundings, produces physical arousal in the mother which gives her pleasure and helps her develop the essential attachment to her baby.

We should like to propose that one objective for this Year of the Child should be to ensure that babies are placed in their mother's arms as soon as possible after birth to be handled and kissed and suckled. In this matter we in Western countries have much to learn from the third world, where in most cultures close skin-to-skin contact is established immediately and suckling occurs freely throughout the post-natal period.

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¹ Kennel, J H, and Klaus, M H, *Maternal Infant Bonding*, Mosby, St Louis, 1976.

Central venous catheter embolism

SIR,—I was interested to read the timely reminder from Drs A C Edwards and Edgar Sowton concerning the management of central venous catheter embolism (2 September, p 669). To their credit, the Department of Health and Social Security issued a letter in March 1972¹ suggesting to all supplies officers that the "Through-needle" variety of catheter be withdrawn. This move arose from the disturbingly high incidence of this serious complication being reported in the world literature. Apart from the danger of embolism occurring during insertion, the flimsy plastic needle protector provided does not always prevent the movement of the catheter against the needle. The patient is thus potentially at risk the whole time. This is especially the case if the antecubital fossa route is used and the patient is restless or confused. The catheters need not be wasted; they can be introduced as mentioned via a large Sherwood Argyle Medicut needle or using a guide-wire technique.² Alternatively, one of the more modern central venous catheters could be used. Although the Bard might say "Much ado about nothing," the litigation which follows³ is usually directed at the operator and not the manufacturers producing an instrument which can cause such complications and deaths.

The patients reported by Drs Edwards and Sowton were fortunate that the catheters were radio-opaque. I feel that this is a vital requirement for central venous lines. The placement of a radiotranslucent catheter can of course be checked by injecting contrast medium. However, if during its life the catheter kinks and fractures or is accidentally cut during a dressing or removal procedure embolism could occur and the fragment would be almost impossible to detect. Some of the recently introduced catheters fail to

have this requirement and in my opinion should not be used.

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¹ DHSS File No R/B 1026/18 DS (Supply) 6/72.

² Goy, J A E, *British Medical Journal*, 1976, **2**, 21.

³ Medical Defence Union, *Annual Report*, 1977, p 23.

SIR,—Drs A C Edwards and Edgar Sowton (2 September, p 669) have presented an admirable case for the removal of lost catheters by percutaneous technique. It should be emphasised that this technique is applicable only to the retrieval of foreign bodies recently lost into the vascular system. Catheters which have been in the circulation for months become epithelialised and firmly attached to vessel walls where they happen to touch them. We have been unable to remove pacing catheters and broken pieces of Holter valve systems which have become so attached. Leaving such intravascular jetsam in situ does not appear to cause trouble once epithelialisation has occurred. However, pulmonary emboli may be generated by clot forming on plastic tubing recently introduced into the circulation.

To avoid the risk of such embolisation and to allow the removal of the lost catheter by snaring it early referral of such cases to a centre with the necessary skill is desirable.

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Misuse of hypnosis

SIR,—While in general agreement with the spirit of Dr D Waxman's letter (19 August, p 571), I am afraid that the letter may give some impressions which were not perhaps intended. People with medical and dental qualifications are not the only therapists using hypnosis under the NHS in a responsible and proper manner and it is surely for this reason that the Metropolitan Branch of the British Society of Medical and Dental Hypnosis, of which Dr Waxman is president, admits such people to its training courses. First we must consider just what hypnosis is, and second just how in modern practice the therapeutic process is implemented by a number of differently trained specialists.

Without going into the matter in too great detail, I think that we can agree that "hypnosis" is a technique by which people's behaviour and experience can be modified. There is nothing specially "medical" or "dental" about it. In current NHS practice much behaviour modification is in the hands of clinical psychologists, some of whom use hypnosis as an adjunct to the process if they see fit. Behaviour modification is also operated by specially trained nurses,¹ and I know of a clinic where physiotherapists use a form of hypnosis.

Regarding my second point, I would refer to the reception which the Royal College of Psychiatrists' memorandum to the Trethowan Committee received from a fair number of psychiatrists of the younger generation² to make it quite clear that it is now accepted that the therapeutic process is a matter for teams of differently qualified specialists working in harmony.

Naturally we want people to act only within

the limits of their own recognised competence in both diagnosis and treatment, but I think that Dr Waxman's use of the term "lay" is ambiguous. While "lay" originally meant "non-clerical," it is now sometimes understood to mean "non-medical," and hence his reference to "lay therapists" in the first paragraph of his letter is perhaps misleading. The fact that his own society is helping to give training in hypnosis to professionals who are neither medically nor dentally qualified should make clear the recognised status of hypnosis in therapy today.

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¹ Marks, I M, in *Advances in Behaviour Therapy*, ed P M Herson. New York, Academic Press, 1974.
² *British Journal of Psychiatry Supplement*, 1973, 123, 26.

Patient package inserts

SIR,—Your leading article (26 August, p 586) mentions a number of criticisms of patient package inserts, including making patients afraid of adverse reactions. It is also possible for the inserts to make patients afraid of their illness. Ten years ago I wrote to the manufacturers of Quinoderm acne cream objecting to the wording on their insert. This states that "the pustular and cystic forms of acne are of major importance, as the destruction of tissue and resultant scarring produce permanent disfigurement in a disease which often resolves spontaneously in later life." In my opinion this description is both unnecessary and, more important, when read by the troubled adolescent with acne must produce much unhappiness and anxiety. The dread of all with acne, but the outcome of only a few, is that the lesions will never clear—this insert appears to confirm the secret dread.

Ten years ago a representative of the manufacturers assured me that they would change the wording to a more suitable form. I now invite the manufacturers to carry out this undertaking. In the meantime, as and when I prescribe the product I shall continue to note on the prescription, "Without insert."

J DEANE COLLINGE

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Side effects of antibiotics in mountain climbers

SIR,—Dr D S Reeves and his colleagues (5 August, p 410) state that, compared with the original compounds, tetracycline derivatives may give improved blood concentrations, "but whether this results in fewer side effects is unproved." Mountain climbers are prone to many infections of the gastrointestinal and respiratory tracts for which

antibiotics are indicated but have learnt by bitter experience that both the illness and the side effects of antibiotics can be equally enhanced and distressing at great heights. The following small study may be useful.

Forty mountain climbers in the Peruvian Andes climbed at heights between 4900 and 6400m (16 000 and 21 000 feet). They often suffered from a variety of intestinal and respiratory infections. They were offered an antibiotic without recognising or being told its nature—ampicillin, tetracycline hydrochloride BP, or lymecycline in a randomised order—two unlabelled commercial capsules twice daily for three to four days. The table shows the freedom from side effects of lymecycline as opposed to ampicillin and tetracycline hydrochloride, as shown in previous studies in hospital patients.¹⁻³ In nine later episodes of intestinal or respiratory infection the climbers all demanded lymecycline; one only complained of abdominal discomfort. It thus seems an antibiotic of choice for mountain climbers.

The lymecycline was supplied by Montedison Pharmaceuticals Ltd. The study was helped by grants from Glaxo Research Ltd and Leo Laboratories Ltd.

A PINES

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¹ Pines, A, *et al*, *British Medical Journal*, 1964, 2, 1495.
² Pines, A, *et al*, *British Medical Journal*, 1968, 2, 735.
³ Pines, A, *et al*, *British Journal of Diseases of the Chest*, 1968, 62, 19.

Successful defibrillation in general practice

SIR,—We wish to report the following case, which may be unique.

One of us (ADS) was called one morning recently to the home of a 49-year-old man with chest pain. He had previously been well but over the previous few days had had chest pain apparently relieved by antacids and attributed by him to indigestion. That morning the pain had been much worse and had radiated to neck and left arm. It had been present for 35 min when ADS arrived, followed 10 min later by JB, the new trainee assistant in the practice.

Physical examination, apart from the obvious distress of the pain, was negative. Following a presumptive diagnosis of myocardial infarction the patient was given 8 mg of Cyclimorph (morphine and cyclizine tartrates) intravenously. Arrangements were made for transfer to the local coronary care unit (CCU) 18 miles away.

The ambulance arrived as we were about to leave some 20 min after first arrival. At that point the patient became unconscious, with a suffused face and no palpable pulse. He was pulled off the couch and external cardiac massage (ECM) and occasional mouth-to-mouth assistance with ventilation were started. The ambulance was despatched to the local cottage hospital for the electrocardiograph and

portable defibrillator, recently acquired with funds raised locally by the Rotarians. The acquisition of the defibrillator had been met with varying degrees of scepticism about its likely usage.

Within 10 min the defibrillator arrived. The patient continued to require ECM, but his colour stayed good and his pupils small. Indeed, the major problem was that he kept surfacing and he had to be given 20 mg of Omnopon-Scopolamine intravenously to sedate him. The first shock produced a steady regular pulse, but it was short-lived and two further shocks were required. On the advice of the consultant in the CCU, relayed over the phone, the patient was given 100 mg of lignocaine intravenously.

We accompanied the patient in the ambulance to the CCU. The journey time was 25 min and the journey started some 40 min after the first onset of what must be presumed to have been ventricular fibrillation. The patient's condition was stable in the ambulance, not unconscious but drowsy enough to be quite relaxed. He is soon to be discharged from hospital, well, with the diagnosis of myocardial infarction confirmed.

This case has two areas of importance. Firstly, general practitioners should not assume that they are never likely to find access to a defibrillator to be of any value. An offer of such a piece of equipment should be seriously considered. Secondary, primary intensive coronary care might be considered to be within the province of interested trained general practitioners who have access to the appropriate equipment. Such a service could complement or in some circumstances take the place of mobile hospital teams.

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When and why are babies weaned?

SIR,—I would like to challenge several of the comments made by Dr Herbert Barrie (26 August, p 633) about the "nonsense" of giving solids to babies before 4-6 months.

Hunger in breast-fed babies is due to an inadequate milk supply, not to a need for solids. It is suggested that instead of feeding the baby more frequently to prevent hunger he should be given solids. However, the disadvantages of possible obesity due to frequent breast feeds must be weighed against the disadvantages of early solids. Two- to three-hourly breast feeding in any case won't necessarily stop the baby crying—he may want to suck more than that and it is ill-advised to put across the idea that breast-feeding should be timed in this way. Babies allowed unrestricted access to the breast suck not according to any schedule but in a random way, sometimes taking extremely frequent feeds or even wanting to suck on and off for several hours on end and sucking for anything from a couple of minutes to an hour or so at each breast. Growth is at its height in the third month and an increase in crying is the baby's way of informing his mother that he wants to suck more and so increase her milk supply by raising her prolactin levels.

It is well proved that the fully breast-fed baby has seven times less allergy in infancy than the baby given foreign protein, partly because the baby's gut lining is protected from damage by, and the ingress of, foreign protein

Comparative incidence of side effects

Antibiotic	No of patients	Total side effects	Diarrhoea for first time	Severe abdominal discomfort appearing or increased
Ampicillin	8	5	2	3
Tetracycline hydrochloride .. .	10	5	2	3
Lymecycline	8	0*	0	0

*P < 0.05.