cook to boil an egg, but it is hardly necessary or desirable.

Doctors should be important teachers of health care and be able to concentrate their other skills and expertise mainly on complex problems and diseases which are often their major interest. This would ensure the greater availability of appropriate care at all the required levels for people who might otherwise be denied this.

Many may feel threatened by change and resist any delegation of part of their traditional roles. Innovative schemes with all acting in a responsible fashion should ensure both the greater wellbeing of the community and justifiably earn the trust of patients. The primary health care nurse is a valuable member of the health care team in her own right and should not be seen as a "doctor-substitute" or assistant.

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Type II errors and ethics

SIR,—Your interesting leading article (11 November, p 1318) on "Interpreting clinical trials" summarised several points of importance for the clinician designing a trial; an additional point which you did not emphasise was the ethical implication. Not every clinician—or even his ethical committee—is acutely attuned to the details of statistical type II errors, but he should be aware of the possibility that his expected number of patients in a planned trial may be such that he has a high risk of missing a real reduction of as much as 25% in mortality (your example). The ethical problem arises if the trial procedures cause additional discomfort or risk for the patient, but the trial as a whole is very unlikely to identify as significant a therapeutic effect which the clinician would regard as worth achieving.

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Communication with Asian diabetics

SIR,—Dr Surinderhit Bakshi's comments (25 November, p 1500) on our paper (28 October, p 1198) suggest that literacy of patients was assessed indirectly by the ability to read hospital signs. If he reads our paper carefully he will appreciate that this is incorrect. Literacy was assessed by verbal questioning by two Asian-speaking medical students. Sixty-six out of 77 patients (approximately 85%) could not read or write English. Twenty-six said they were literate in their own language, but this contrasted with only six who said they had noticed hospital signs and 12 out of 200 who were given diet sheets in Asian over the previous two years. It was the discrepancy between these figures which led to the suggestion that the Asian literacy rate may have been an overestimate. We did not think to ask our patients about the ability to interpret ancient scripts, which is not relevant in this context.

Dr Bakshi's over-elaborate assertion that patients will not understand a dubbed film is pessimistic. We retain our optimism and hope the film will prove useful. I have already had an inquiry from another town about it so that the problem is not confined to Birmingham.

Finally, to use terms such as "accusing patients of falsely claiming literacy" is not helpful and this was not our aim. We merely wished to present data about this difficult problem.

At meetings I have been struck by the number of people who suggest that distribution of translated literature might be a helpful solution. I think our results show that literature in English is likely to be more effective because approximately 80% of patients had a person (usually a child) living in the same house who was able to translate the literature. We would agree that in many situations an interpreter is the best solution to the problem.

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Placement of central feeding catheters

SIR,—We read with interest the article by Mr E M Kiely (21 October, p 1123) describing the placement of central feeding catheters. While having no experience in infants, we are frequently confronted with this problem in our leukaemia and bone marrow transplantation programme, where young children present a similar problem. Over the years we have evaluated a number of percutaneous and cut-down techniques and on the basis of this experience we now introduce a Silastic catheter into the superior vena cava via the cephalic vein where it lies in the deltopectoral groove.¹ Placement can be effected under either general or local anaesthesia and, once in position, its position is checked radiographically.

In our experience neither thrombosis nor sepsis has been a problem and many of the catheters have been in place for six weeks or longer. The advantage of such a central venous line is that no further venepunctures are necessary since infusions are carried out and blood samples collected reliably and without difficulty from the same line. In addition the arms are free for physiotherapy and any movements the patient wishes to make. In contrast to percutaneous subclavian catheterisation this approach has been free of any complication. A similar technique has recently been reported.²

We believe this is a practical alternative to introducing the catheter in the groin, where a substantial length of artificial material lies within a major vein.

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¹ Jacobs, P, and Jacobson, J, *Journal of the Royal Society of Medicine*. In press.

² Blume, K G, et al, *Experimental Hematology*, 1978, 6, 636.

Listening to the lungs

SIR,—I find the opening sentence of your leading article (2 December, p 1515) somewhat alarming. To quote: "Today when examining the chest most doctors do not expect to learn much by using a stethoscope."

Whether or not the reasons for what I, as a general practitioner, hear every day through my stethoscope are scientifically accurate, the interpretations of the different sounds alter my

diagnosis, treatment, and management of each case. There is no doubt that over the years I have, through experience, changed my deductions from auscultation, but to suggest that most doctors do not expect to learn much by using a stethoscope is, I hope, rubbish.

There will always, of course, be those who write out a prescription before baring the chest and those who will wait for an x-ray and sputum culture before treating, but I hope that today's students will continue to be taught how to use a stethoscope and that they will believe, as I do, that they can learn from it.

A J JOHNSTON

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Syngamus in an Australian

SIR,—I was interested in the report by Dr G A C Grell and others (25 November, p 1464), having just read a similar report from Australia.¹ The authors describe a 42-year-old Queensland woman who presented with chronic cough, haemoptysis, and weight-loss following a 10-month visit to Guyana. At bronchoscopy a Y-shaped pair of *Syngamus laryngeus* worms, permanently joined in copulation, was successfully removed alive and intact from the mucosa of the secondary carina between the left upper and lower lobe bronchi with complete relief of symptoms. Reference is made to 25 previously reported cases of human syngamosis, 24 of which originated in South America or the Caribbean area and one in the Philippines.

Chest physicians and others should therefore be alert to the possibility of this unusual parasite in immigrants and returned travellers from the West Indies and elsewhere with unexplained respiratory symptoms.

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¹ Birrell, D J, et al, *Australian and New Zealand Journal of Medicine*, 1978, 8, 168.

"Ultrasound swallow"

SIR,—It occurred to me that a Doppler ultrasound flowmeter might be able to detect the movement of swallowed water. A Sonicaid D205 fetal heart detector has been used with interesting results.

The subject stands and the probe is placed high in the epigastrium pointing backwards, horizontally in the midline. The subject is asked to take a large mouthful of water and then to swallow. Normally the water passes within a second through the ultrasound beam and a loud "whoosh" is heard. A silence of a few seconds is followed by a second similar but quieter noise. After a further delay of up to 10 s a third, quieter and longer-lasting, flowing and bubbling noise is heard. There is some distortion of this simple pattern by increases and decreases of flow with breathing movements.

A patient with scleroderma gave the pattern of a single loud noise with a short interval between swallowing the water and its passing the probe. A patient known to have malignant enlargement of mediastinal lymph nodes had a normal three-phase pattern with accentuated pulses in time with systole. An 80-year-old woman with difficulty in swallowing showed the same pattern, and barium swallow suggested