Management of self-poisoned patients in hospital

SIR,—Although we are in broad agreement with the conclusions of Dr R Gardner and his colleagues (18 November, p 1392) we would dispute the methods they adopted to assess success or failure in management. It has been clearly shown that psychiatrists show no uniformity in the management of this group of patients.¹ Therefore it is not surprising that physicians proved to be as competent. We would also dispute that success in management can be assessed solely by a junior physician agreeing with the psychiatrist who has trained him over future management.

Quite correctly Dr Gardner and his colleagues state that many self-poisoning patients "have taken tablets or medicines prescribed by medical practitioners." However, in a recent study of 236 patients suffering from overdoses in Newcastle upon Tyne we found that 20% were receiving psychiatric treatment at the time of their overdose while a further 25% had at some time been under the care of a psychiatrist. This would not support the conclusion that better training in psychiatric assessment necessarily offers any advantage. We would suggest that from their data one has the right to conclude only that physicians are equally as incompetent as psychiatrists in assessing these patients and that perhaps we should look further to see if another professional discipline can help us.

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¹ Blake, D R, and Mitchell, J R A, *British Medical Journal*, 1978, 1, 1032.

Caring for babies of very low birth weight

SIR,—Your leading article (21 October, p 1105) correctly stresses the intensive care required by these infants. However, there are two areas in which your article was, in my view, mistaken.

Firstly, you imply that neonatal intensive care units and special care baby units (SCBUs) are two separate things, the former offering all the facilities you describe and the latter a far more basic level of care, sometimes not even extending as far as checking the babies' temperatures. I cannot say whether this is true for parts of London, as you suggest, but in the rest of the UK I think it is true to say that almost every SCBU provides the skilled care, including ventilation, which you regard as the hallmark of a neonatal intensive care unit. The latter name has not been used up to now to avoid provoking parental anxiety and I hope we shall not have to change merely to convince one or two purists that "so many years in SCBU" on a curriculum vitae does not mean just looking for a thermometer.

My second point concerns the transportation of sick neonates. There is more danger of something going wrong in transit than in a proper SCBU and it is courting increased morbidity and mortality to encourage a policy of abandoning the present provision of adequate intensive care in most hospital SCBUs in favour of transporting a larger number of sick babies longer distances to fewer regional centres. Where unexpectedly a sick baby is born at home or in a hospital without proper SCBU facilities then of course safe transportation to the SCBU (my kind, not

yours) is important. However, the uterus is the best transport incubator and when problems can be predicted it is safer to transfer the mother before delivery to a hospital with full obstetric and neonatal services.

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Social mobility in African patients with duodenal ulcers

SIR,—We have studied the occupations of 206 patients (150 Indians and 56 Africans) with duodenal ulcers and compared them with their parents and with patients with other gastrointestinal diseases. These included 31 with chronic pancreatitis, 25 with irritable colon, 51 with oesophageal reflux, 14 with ulcerative colitis, 71 with miscellaneous gastrointestinal diseases. There were also 124 controls. All patients were subjected to endoscopy, and appropriate diagnostic studies were undertaken before assigning them to the various diagnostic groups. A study of number of years in the urban environment revealed no differences between the patients of any diagnosis, race, or sex. This contrasts with Susser and Stern's hypothesis that duodenal ulcers are associated with early urbanisation.¹ Segal *et al*² have shown that significantly more patients with duodenal ulcer in Johannesburg were born in towns than their controls. They claim that this fits with Susser and Stern's theory of early urbanisation; but this requires explanation, as the greater numbers of patients born in Johannesburg appear to show the opposite. Duodenal ulceration is a common condition in Durban, in both Indians and Africans. It is possible that there are different characteristics in the population compared to Johannesburg.

Regarding the study of the effect of occupational position, we feel that Segal *et al* erred in arbitrarily grouping together professional, technical, clerical, and transport workers for comparison with service and production workers and ignoring other groups. They used only a classification of occupational prestige (status). We have examined occupational position on three scales—namely, prestige, based on the work of Castle³ and Schmidt⁴ in Southern Africa; a scale based on authority or control over others; and a scale based on responsibility. The last two scales were developed in the Centre for Applied Social Sciences of the University of Natal. We found that Indian males with duodenal ulcers had significantly improved on their parents' prestige (χ^2 6.3; $P < 0.01$), unlike other patients and controls, but were more likely to be in the lower category of authority compared with those with other gastrointestinal diseases (χ^2 25.8; $P < 0.0005$). Indian females with duodenal ulcers showed no distinctive occupational prestige but tended to be in lower classes of responsibility compared with other patients (χ^2 5.3; $P < 0.025$). African males showed no distinctive position on any scale whatsoever compared with their parents, other patients, or controls.

It is apparent that our findings are not consistent across race groups and sexes, suggesting that stresses within occupational categories may manifest differently in different communities. The diminished authority and responsibility in some groups of ulcer patients, with or without increase in prestige, suggests that "powerlessness" in the work situation

may be important in the causation of stress. We are at present carrying out a more detailed research project designed to identify the nature and occurrence of the stresses themselves.

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¹ Susser, M, and Stern, Z, *Lancet*, 1962, 1, 1115.

² Segal, I, *et al*, *British Medical Journal*, 1978, 1, 469.

³ Castle, W N, *Tropical Doctor*, 1978, 8, 44.

⁴ Schmidt, J J, *Beroepsprestige onder die Bantoe in 'n Stedelike Gemeenskap*. Pretoria, Human Sciences Research Council, 1973.

Dealing with residual bile duct stones

SIR,—One method of dealing with residual bile duct stones after choledocholithotomy is the technique of wire basket extraction through the T-tube track, popularised by Burhenne.¹ In some patients, however, the small calibre and the tortuosity of the track make the procedure difficult and time consuming, leading to an unnecessary increase in the radiation exposure to the patient. Furthermore, when the T-tube is brought out in or near the mid-line there is the added hazard of increased exposure to the radiologist's hands. When the T-tube is brought out laterally the hands may be kept out of the primary beam.

While it is appreciated that in the practice of most surgeons residual stones are unusual, nevertheless they do occur. The purpose of this letter is to point out that in view of the problems mentioned above removal of stones by the Burhenne technique is greatly facilitated if (a) the T-tube is brought out directly lateral to the common duct and (b) the largest possible T-tube, preferably at least 12 French gauge, is used.

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¹ Burhenne, H J, *Radiology*, 1974, 113, 567.

Extending the role of the clinical nurse

SIR,—I write in response to your leading article (11 November, p 1320) on "Extending the role of the clinical nurse."

The point about specific, appropriate, and adequate training for nurses to whom traditionally medical functions are delegated is well made. In the Soweto service stress is laid on a health care team approach with primary health care nurses and doctors working together. The former manage alone 80% of the problems of the daily sick (a substantial contribution), but the doctor is available in the Soweto Clinic for referral of more complex disorders or on request. This arrangement is not simply one of necessity or expediency but a positive measure to provide better health care services by suitably trained people able to communicate and relate realistically to the people they serve and having the time and interest to do this. It enhances vital community participation in health matters and allows optimal use of available manpower. Is it realistic, considering the cost and content of specialised knowledge involved in present medical training, to expect doctors to meet the entire needs of primary health care in any community? One may employ a cordon bleu

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.

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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