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.

B LEATHERDALE

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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

that compression of the oesophagus by the rigid aorta was the cause of her symptoms.

A man of 68 had noticed for a month that after the first few mouthfuls of each meal he had a vague epigastric sensation and then vomited the food without any acid taste. The remainder of the meal could then be swallowed normally. He had not had any difficulty in swallowing liquids. The "ultrasound swallow" gave a long, steady, squirting noise, easily imaginable as a narrow stream under pressure. He is well three months after resection of an oesophageal carcinoma.

A group of patients with symptoms such as sticking of food, retrosternal pain on swallowing, or acid regurgitation have been examined. Many showed swallowing patterns which were irregular in the number, timing, and volume of the pulses and in these patients the symptoms cleared spontaneously, which suggests that the upset was functional. These patients, who are usually rather anxious, have been reassured to hear the evidence that the water reaches the abdomen. This technique may provide reliable positive evidence of oesophageal incoordination and save some patients the ordeal of a barium swallow.

DOMINIC STEVENS

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Naming of drugs

SIR,—I refer to the letter from Dr G A MacGregor (18 November, p 1433) in which he points out that the same preparations (drugs) may be marketed under different names. You comment that his letter favoured the use of BPC approved names.

I have recently examined several aspects of the question of availability of drugs in third world countries. Another phenomenon of the naming of drugs has come to light. The same proprietary preparations made by the same manufacturers may have significantly different compositions depending on whether they are marketed in Britain or in Africa. Sonalgin in Britain contains paracetamol; in Africa this is replaced by phenacetin. Again, the paracetamol in Veganin in Britain is replaced by phenacetin in Africa. Saridone in the United Kingdom contains propyphenazone, but in Africa this is replaced by isopropylantipyrine. Are these compounds the same or different? The busy prescriber will have to find out for himself.

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Frusemide and renal enzyme excretion

SIR,—It was with interest that we read the recent letter from Drs S M Harding and A J Munro (18 November, p 1431) reporting the effect of frusemide on urinary *N*-acetyl- β -glucosaminidase (NAG) excretion. This has not been our experience in similar unpublished work in mice or man.

We have given 80 mg of frusemide at zero

time (9 am) to six healthy male volunteers aged 22-31. The subsequent mean urinary volumes and NHG content are shown in the table. Our results do not show any significant difference ($P < 0.1$) in outflow of urinary NAG in response to oral frusemide. We feel it is therefore unlikely that the increased urinary NAG found by Drs Harding and Munro can be explained by the normal tubular action of frusemide.

It is our conclusion that random urinary NAG estimation remains a sensitive indicator of renal tubular cell damage even after consideration of drug therapy.

J PETERSEN

P WHITING

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Nitrites—to ban or not to ban?

SIR,—Many thanks for publishing the article by Miss Barbara J Culliton and Mr Wallace K Waterfall (9 December, p 1613) on the banning of nitrites. The antics of the American Food and Drug Administration are frequently good for a laugh—or would be were it not for the possibility of the formation of a pressure group in this country to follow its example; witness the absurd banning of cyclamates.

There are thousands of angina sufferers the world over who in addition to their regular daily dose of nitrites in vegetables (80%) and smoked meats (20%) could easily consume as much again and more in the form of tablets to relieve their pain. So far as I am aware, although they have been doing this for over 50 years, there has been no suggestion that they are more liable to lymphomas or lymphoreticular changes than anybody else. Will someone with access to a sufficient number of cases please take the trouble to confirm (or refute) this before we get the formation of an NBG (nitrite banning group)?

A LEWIS

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Car doors

SIR,—The illustration (2 December, p 1552) of a cyclist swerving to avoid an opening car door depicts a hazard all too familiar, but please do not put all the blame on the motorist. Through no fault of his own it takes quite a long time for the less agile driver to climb out *after* he has made certain that nothing is about to overtake him. Car body designers appear to ignore ease of entry and exit, while most of the test drivers of motor journals are young and active and seldom mention such mundane matters, though hailing the cutting of 0.1 s from the 0 to 60 mph acceleration time as a major advance.

I personally have driven since the end of the first world war (certainly over half a million miles) and until I had recently to sell an old Mark VI Bentley I and any passengers had no difficulty in getting out of either side of the car.

The floors were flat and unobstructed and no one had to alight in the traffic stream. Two developments now prevent this. Firstly, it became illegal to fit rear-hinged doors to avoid any risk of their being blown open if they were not properly closed and the safety catches were not functioning. This was a good idea but made a rapid exit more difficult for the unathletic, especially in two-door models. The second and more dangerous trend is to divide a car into four rigid compartments by a high transmission tunnel often mated with an instrument console beneath the dashboard. This combination with gear and brake levers makes it virtually impossible for the driver to slide over and emerge from the near side on to the pavement and quite difficult for the off-side rear passenger to do the same. Anyway, why do front-wheel-drive cars have a tunnel at all? If there is no prop shaft a vestigial hump would be all that is necessary to convey rods, wiring, and pipelines.

What would we think of London Transport if buses were introduced which decanted their passengers into passing traffic instead of on to the pavement?

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Children with small stature

SIR,—We applaud Dr R R Gordon's plea (18 November, p 1434) for more height measurements on children, but we find his other remarks somewhat puzzling in the context of this plea.

We know of no evidence that parents of children with Turner's syndrome or growth hormone deficiency are short. However, the correlation between parental heights and those of their children with Turner's syndrome is maintained¹ so that affected children of short parents will certainly become apparent earlier.

In investigating short stature, as Dr Gordon implies, the crucial measurement is that of height velocity. If this is normal over a period of a year further investigations are unnecessary and likely not to be helpful, regardless of the height of the child on a height distance chart. Conversely, children with low growth velocities may well be within the centiles at the time of referral yet have a diagnosable condition requiring investigation and treatment. A single height measurement hardly ever constitutes an indication for investigation.

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¹ Brook, C G D, *et al*, *Archives of Disease in Childhood*, 1974, **49**, 789.

General practice records

SIR,—Your leading article on this subject (9 December, p 1587) is almost defeatist in tone. That good medical records contribute to good standards of care is a widely held belief in all branches of clinical medicine; it is more than an assumption. General practitioners have far too long laboured under the constraints of an out-of-date and outmoded official records system. It is greatly to their credit that an increasing number of GPs are breaking away from these constraints and introducing A4 records at their own expense.

Mean (± 1 SD) urinary volume (ml) and NAG excretion (mIU/h/mg urinary creatine) following 80 mg oral frusemide

Time (h)	Control (2 h)	0-2	2-4	24-26	26-28
Urine volume	114 $\pm$ 52	1377 $\pm$ 308	596 $\pm$ 178	45 $\pm$ 21	38 $\pm$ 41
NAG excretion	71 $\pm$ 12	65 $\pm$ 28	106 $\pm$ 70	58 $\pm$ 28	70 $\pm$ 44