with schistosomal ova is an essential part of the syndrome and that the immunological response a consequence of the infestation and not the cause of the neurological lesion.

In 41 cases of schistosomal spinal cord disease I have traced in the literature¹⁻⁵ the neurological deficit was caused by cord compression due to a discrete granuloma in 13. It would be superfluous to implicate an immunological cause in these cases. Of the remaining 28 cases, in which cord compression was not reported, the spinal cord was examined histologically in 18 and ova found in all of these. I can find no recorded case of this condition in which ova were looked for in the spinal cord and not found. This is in remarkable contrast to schistosomiasis without clinical spinal cord involvement, in which ova are rarely found in the cord.⁶

As ova appear to be invariably present in the affected part of the spinal cord in these cases it is difficult to avoid the conclusion that the lesion is a direct consequence of their presence and there is no need to postulate an immunological cause.

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¹ Marcial-Rojas, R A, and Fiol, R E, *Annals of Internal Medicine*, 1963, **59**, 215.

² Bird, A V, *Neurology*, 1964, **10**, 647.

³ Levy, L F, and Taube, E, *Central African Medical Journal*, 1969, **15**, 52.

⁴ Rosenbaum, R M, et al, *American Journal of Tropical Medicine and Hygiene*, 1972, **21**, 182.

⁵ Herskowitz, A, *Journal of Neurosurgery*, 1972, **36**, 495.

⁶ Gelfand, M, *Schistosomiasis in Southern Africa*. Juta, Cape Town, 1950.

Poisoning with mianserin

SIR,—I would like to make the following point regarding the letter from Dr P Crome and Miss Belinda Newman (23 July, p 260) concerning overdosage with maprotiline and mianserin.

They report the death of a 72-year-old woman who took an overdose of 60×10 mg mianserin and an unknown quantity of lorazepam. On admission her plasma level of mianserin was 110 μ g/l and that of lorazepam 500 μ g/l. While the level of mianserin was in the therapeutic range, that of lorazepam was in overdose.

W L SHAW
Medical Adviser,
Organon Laboratories Ltd

Morden, Surrey

Immunisation rates in Kent

SIR,—I was concerned to hear an extract from the BMA conference being reported on the national news in which Dr W J Appleyard quoted figures for the uptake of childhood immunisation in Kent. He stated that only 67% of children were being immunised against polio, diphtheria, and tetanus and only a third were being immunised against whooping cough.

The immunisation programme in Kent is computerised and I believe the computer's results to be suspect. I recently received a print-out showing that 46 children on my list had not been immunised. When these children were followed up it was found that six were either not on my list, had come on to it after their immunisations were complete, or mainly lived abroad. Twenty-three had been

fully immunised and in the remaining 17 cases the parents had elected not to have the whooping-cough component of the programme. Thus all the relevant children were accounted for. Discussion with several other GPs in south-east Kent revealed a similar picture. I reported these findings to the area health authority, but I believe that the quoted figures are still a gross underestimate of the true immunisation state of the county, which can be checked only by using the clinic and surgery records rather than relying on computer returns.

A R CRAWFORD

Tenterden, Kent

Danger of saline emetics

SIR,—The *Daily Telegraph* of 2 July drew attention to the dangers inherent in the use of salt and water as an emetic. This specially arose in relation to the unfortunate death of a patient given such an emetic following an overdose of drugs. The news item stated that death was attributed to a dangerous surfeit of sodium in the patient's body which caused a brain haemorrhage. It appeared from the evidence given at the inquest that there is a general unawareness of the danger of salt emetics.

Some 14 years ago I described and discussed this hazard in a case study of fatal hypernatraemia after a saline emetic.¹ The practice of attempting to induce vomiting by this method has become especially dangerous since the advent of the phenothiazines as this group of psychotropic drugs is so frequently prescribed and so frequently figures in overdoses, and many of them are potent antiemetics. Perphenazine, for instance, is 16.6 times more powerful than chlorpromazine as an antiemetic. Nor is it always known with patients who have taken drug overdoses exactly what drugs or quantities have been taken.

All things considered it is probably safest to discard this practice from our therapeutic armamentarium.

DERMOT J WARD

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Dublin

¹ Ward, D J, *British Medical Journal*, 1963, **2**, 432.

Dextrostix-Eyetone in the insulin hypoglycaemia test

SIR,—Dr M A Preece and Mr R G Newall (16 July, p 152) draw attention to the need for rapidly available blood glucose values during the insulin tolerance test (ITT) to avoid severe hypoglycaemia and to ensure a sufficiently low blood glucose concentration to elicit a growth hormone response. The Dextrostix-Eyetone procedure they describe goes a long way, in principle, to meet this need, but our own experience in routine rather than "research" conditions makes us urge caution.

We would make the following points: (1) Results improved with experience, even in the hands of one enthusiastic clinician. In practice, however, several of our housemen have had too little experience and time to develop the needed expertise. The very simplicity of the system encourages carelessness. (2) No quality control of the procedure is described. This is surely unacceptable for so important a test; the manufacturers themselves recommend the

regular use of Lab-Chek control materials. (3) Even under the favourable conditions of this evaluation the quoted precision is unimpressive. The error, so far as we can calculate from the figures quoted, is twice that of our routine laboratory method. (4) The major potential advantage, avoiding severe hypoglycaemia, is undermined by the one large, inexplicable error which the authors are honest enough to admit.

The Dextrostix-Eyetone system is tantalisingly close to being a major advance in monitoring of ITTs. We would stress the importance of adequate training and experience of the operator and regular quality control procedures.

A M BOLD
S E EVANS
K W GARVEY

Clinical Chemistry Department,
Queen Elizabeth Hospital,
Birmingham

Getting close to the patient

SIR,—With reference to the letter from Dr J L Ogle (16 July, p 191), surely we require more information before we consider altering the system? It is my experience that the sort of advice which he quotes and ridicules, even when issued by an area health authority, has usually been prepared by or after consultation with practitioners in the relevant specialty. This practice is certainly neither new nor the creation of the reorganised Health Service.

If such advice is given to hospital staff which is not the result of consultation it should, of course, be repudiated. If staff are asked to participate in the preparation of such advice they should formally decline to do so if they consider the task inappropriate and make it known to the members of the health authority that the issuing of such advice is unnecessary.

NORMAN MILLS

Ebbw Vale, Gwent

Debendox overdosage in children

SIR,—Following a previous report on Debendox overdosage in children¹ we would like to report a case treated here recently. It illustrates the dangers inherent in accidental ingestion of slow-release preparations when there is ignorance of their nature on the part of those for whom the drug is prescribed, particularly when the drug is commonly prescribed to an age group which is likely to have young children in the home, such as mothers suffering from vomiting of pregnancy.

A 3½-year-old boy was admitted from the accident and emergency department some time after midnight, having apparently been found by his mother 7 h earlier with an empty bottle which had contained an unknown quantity of Debendox tablets, each containing dicyclomine hydrochloride 10 mg, doxylamine succinate 10 mg, and pyridoxine hydrochloride 10 mg in slow-release form (57 were thought later to be unaccounted for). Because he seemed well at the time he had been put to bed and it was not until midnight that he became agitated and restless, precipitating his admission.

On arrival he was hallucinating and restless, with dilated pupils, a dry mouth, hot dry skin, and a tachycardia of 150/min. He was initially treated with pilocarpine 3 mg subcutaneously plus chlorpromazine 15 mg intramuscularly, with the oral admission of magnesium hydroxide as a purgative. He seemed to improve 90 min later after a further

dose of chlorpromazine and pilocarpine but then had a generalised convulsion. He was sedated with intravenous diazepam and given intravenous fluids. Later urinary retention was treated with intramuscular carbachol and he was started on half-hourly subcutaneous doses of pilocarpine, receiving in toto a dose of 24 mg in 12 h. Despite the purgation no tablets or shells were recovered from the stools. Twenty-four hours after admission he had fully recovered and was discharged with no apparent sequelae.

There are a few points raised by this case. Firstly, whether pilocarpine, as recommended by the makers of Debendox, is the best choice of antidote. It is said to counteract the peripheral effects of the drug, but in the above case it seemed also to control the central nervous system effects. However, it is difficult to obtain in injectable form and one wonders whether an anticholinesterase, such as neostigmine, more readily available, would be equally effective.

Secondly, the child in this case was given diazepam on two occasions without any adverse effects—both times 4 mg intravenously slowly. This is in contrast to Dr Meadow's experience of respiratory arrest following diazepam in a similar case.^{1 2}

We would recommend that the dangers of a Debendox overdose should be stressed to both the prescriber of the drug and the mother receiving it in view of the serious nature of the overdose. Any child swallowing an unknown quantity of this drug should have an emetic as soon as possible despite appearing well. The child should then be started on pilocarpine before signs of overdosage appear and this should be continued until symptoms have abated or for 12 h if symptomless.

In view of the findings at necropsy in one case in which 23 tablets were found just proximal to the ileocaecal valve,^{1 2} it might be helpful if there were a radio-opaque marker in the tablets, such as barium sulphate particles, so that if after vomiting there still appeared to be a significant number of tablets in the intestine these could be removed surgically if necessary.

We would like to thank Dr N J Hunter, consultant paediatrician, for his assistance in preparing this report.

S G CLARKSON
A P GLANVILL

Gloucestershire Royal Hospital,
Gloucester

¹ Meadow, S R, and Leeson, G A, *Archives of Disease in Childhood*, 1974, 49, 310.

² Meadow, S R, *British Medical Journal*, 1972, 1, 512.

Problems of NHS planning

SIR,—It is interesting that your leading article on problems of NHS planning (23 July, p 214), which discusses many of the difficulties being encountered, perforce looks at the relative roles of the NHS tiers. As the article points out, the NHS structure is designed around the area health authority as the level which was to provide comprehensive services to a population in close conjunction with its corresponding local authority. The functions of the regional and district tiers have been added on to this basic concept. With 25 years of history behind them it is perhaps not surprising that the units represented by the old regional hospital boards and hospital management committees refused to disappear—after all, the NHS is still dominated by the hospital sector.

It is important to look carefully at con-

siderations of NHS planning during the current debates on a change in the management structure and to raise the level of discussion above assertions of "over-bureaucratisation," true though these may be. It seems to me that the aims of reorganisation—to integrate hospital and community services in an area which allowed the closest liaison with a local authority—were exemplary. We should beware of losing sight of this concept; at present it at least gives us some ideal at which to aim. The implication of your article is that for financial expediency we should give up and go back to pre-1974. Surely any further changes in NHS management should achieve more than this?

D M PARKIN

Area Headquarters,
Leeds Area Health Authority
(Teaching),
Leeds

Industrial action

SIR,—One cannot help having misgivings about the recent "sabre rattlings" at the Annual Representative Meeting. One-day strikes and other like mini-demonstrations will be petty, ineffective, and merely add to our already excessive work load.

Let us get down to a few basic facts. (1) The economic situation of the whole medical profession is rapidly deteriorating. Before long it will not be possible to remain in practice within the NHS without the risk of bankruptcy. (2) Our present contracts—both hospital and general practice—are unjust, punitive, and detrimental to good practice with fair remuneration. (3) Medical care is at present at the mercy of party politics. Like education, religion, and the law, medicine must be divorced from such influence. (4) Industrial action must be aimed at the establishment and not the patient. It must be effective enough to bring Government and the Department of Health and Social Security to their knees should they choose to ignore it. For it to be effective there must be complete professional unity; and effective security so that premature leakage of information cannot lead to its sabotage.

It is time as a profession that we showed our "muscle." For "muscle" we have if we have courage to use it. Let not the Government be complacent about this, for we have been trodden on enough. Not only is our personal welfare at stake but also the future of medical care in this country.

DAVID HOOKER

Truro

SIR,—It is a highly disgraceful state of affairs that leading members of the BMA should identify themselves with other groups in the life and industry of Britain who seem determined to break through the Government's pay policy at this critical time in our national affairs. By the control of rising salaries and wages since 1974 inflation is beginning to be reduced, but not nearly far enough. The medical profession now appears to be aiding and abetting some trade union leaders of our national life to bring the country to its knees once more. This action is both irresponsible and regrettable.

In a nation that has lived well beyond its income for many years all sections of the community must be prepared to make sacrifices to

achieve economic stability; those of us who have higher incomes than others have to accept a greater lowering of our standard of living while trying to ensure that the less well-off members of our community do not suffer unduly. No member of the medical profession is living on the bread-line and for members of our profession to be prepared to take a lead in destroying the whole basis of the Government's pay policy is grossly irresponsible.

The threat of industrial action by doctors in general practice and in the hospitals is disgraceful because there is no doubt that if such action were taken patients would suffer.

I cannot remain a member of an Association that is prepared to act purely in the selfish interest of the doctors regardless of the damage that this will do to Britain's economy.

D L CALDWELL

Wallasey, Merseyside

SIR,—May I celebrate the signing of an application to join the BMA by begging the hospitality of your columns?

I finally decided to apply for membership as a result of the deepening exasperation I feel at the muddled thinking that goes on in your (sorry, our) Association. (1) The country can only support the medical service that it can afford. (2) It can't afford a Rolls Royce; it will have to make do with a perfectly serviceable Ford. (3) One-day strikes are hardly an intelligent, effective, or dignified means of pointing the case.

Surely there is nothing wrong with providing a fully comprehensive service from 9 am to 6 pm five days of each week in general practice. This will meet 95% or more of the real needs of the populace. The populace themselves would see that it did, as they would be called on to pay a fee at the time for out-of-hours service. This service can be provided at the present level of remuneration. Perhaps the membership would feel that certification is an irrelevant impediment to efficient practice in an industrial practice (such as this one). Naturally, should prosperity ever return, we can consider replacing certification and the unrestricted out-of-hours access to the doctor back under the NHS umbrella (subject of course to the realistic pricing of these services).

Unless general practitioners take this line they will in effect be paying for a significant part of the NHS from their own pockets by working free of charge when other people are free to relax. This, in a society which pays more for the servicing of a car, a washing machine, or an animal than for an NHS patient. As far as our disgracefully hard-pressed consultant colleagues are concerned I can only commend Dr Denis Burley's letter (30 July, p 320).

MICHAEL JOHNSON

Eakring,
Newark, Notts

SIR,—Like other correspondents, I am appalled by the irresponsibility of the leaders of the medical profession in their decision on pay at the Representative Meeting.

I am not a member of the Labour Party nor, for that matter, of the Conservative Party, but present facts show that the present Government has made and is making a more successful effort to control inflation than has been made up till now by any government of any colour. Also it is only too obvious that, because