distances and stay away from home as before.

I suggest that specialist societies should urgently consider amalgamation or combined meetings with the larger organisations. Unless something is done to reduce expenses I feel sure that resignations will inevitably follow non-attendance and many of these valuable professional activities will cease. Little help can be expected from employing authorities, whose funds are wholly insufficient to cover meeting expenses for most of their staff.

R A GOODBODY

Department of Histopathology,
Southampton General Hospital,
Southampton

Phenylbutazone, oxyphenbutazone and aplastic anaemia

SIR,—Dr W H W Inman's study on fatal bone marrow depression with special reference to phenylbutazone and oxyphenbutazone (11 June, p 1500) is interesting and important. It provides confirmatory evidence that phenylbutazone and oxyphenbutazone are now the drugs most often found as the cause of drug-induced aplastic anaemia and that in that respect they, at least in countries like Britain, Australia, and Sweden, have replaced chloramphenicol. A conference in Kyoto in the autumn of 1976, however, clearly demonstrated that in the Far East, for example, the latter drug was still frequently used and a common cause of fatal bone marrow depression.

The mortality figures reported by Dr Inman are virtually identical with those reported by myself.^{1,2} I found figures for phenylbutazone and oxyphenbutazone, together, of 1-3 cases per 100 000. Furthermore, my figures clearly—like Dr Inman's—demonstrate the dominating role played by age, not only for aplastic anaemia, but for drug-induced cytopenias of all types. Thus special caution should be used in all medication given to elderly patients, especially with drugs known to be potential bone-marrow depressants, like phenylbutazone and oxyphenbutazone.

L E BÖTTIGER

Department of Medicine,
Karolinska Hospital,
Stockholm, Sweden

¹ Böttiger, L E, and Westerholm, B, *Acta Medica Scandinavica*, 1972, **192**, 315.
² Böttiger, L E, and Westerholm, B, *British Medical Journal*, 1973, **3**, 339.

Making better use of our nurses

SIR,—Your leading article on this subject (21 May, p 1306) raises a number of points which are relevant to the organisation of primary medical care.

In primary medical care it is the usual practice for a patient to consult the general practitioner first, whatever the problem, and for the GP to refer the patient if appropriate to the nurse or elsewhere. This tends to perpetuate the nurse's "handmaiden" role both in the patient's eyes and in the eyes of the GP.

Although an expansion of the nurse's role to include primary consultation and decision-making has been permitted in some areas, it is by no means the rule. The possibility was explored recently in this locality but was rejected by those in authority, mainly on the basis of idiosyncratic decisions regarding what was "doctor's work" and what was "nurse's work." For example, it was agreed that ear syringing

could be nurse's work but not venepuncture, that nurses could administer cyanocobalamin but not cholera vaccine, that nurses could use a vitalograph but not an ECG. In no case would they be allowed to make a diagnostic decision (even though training was offered).

Two practical and legal obstacles to nurses taking on more clinical commitments within the NHS seem to be, firstly, that the GP has a legal contract with the family practitioner committee for this purpose and not the nurse (except in a delegated role), and secondly, the nurse's inability to prescribe even a limited range of drugs on FP10.

If, as I believe, the GP should endeavour to fulfil the role of our late colleague the general physician he will need more than an average 6½ minutes' consultation. A longer average consultation-time will entail either longer working hours or delegating more work to others, especially nurses, for both first-time assessment and follow-up consultations.

Certainly experiment is needed. There are grounds for believing that such experiment would be welcomed by many nurses, but the resistance of those in authority over them needs to be overcome. Maybe it would be helpful if the Department of Health and Social Security were to let it be known that they would not look askance on any properly designed proposal.

H W K ACHESON

Department of General Practice,
University of Manchester

Maintenance digoxin after an episode of heart failure

SIR,—Dr Sylvia M Dobbs and her colleagues (19 March, p 749) claim that their findings show the value of digoxin in the maintenance treatment of heart failure apart from the control of atrial fibrillation, but the data presented are inadequate for this conclusion. In particular, the composition of the groups of patients makes the results difficult to interpret. Thirteen of the 46 patients studied were in atrial fibrillation, but none of the 13 had a history of a ventricular rate greater than 120/min. Since all had been treated for heart failure it is remarkable that none had ever had heart rates faster than this; perhaps all 13 were "slow fibrillators," incapable of faster rates and at risk of serious bradycardia on digoxin. The number of patients with atrial fibrillation in the group who relapsed on placebo is not stated; it is not enough merely to say that there is no significant difference in cardiac rhythm between the groups, especially since the level of significance is not mentioned. With groups of 16 and 30 patients important differences in composition might fail to reach statistical significance at the 5% level.

The inclusion of 10 patients with cor pulmonale makes the interpretation of radiographic and spirometric data difficult. The mean values of FEV₁ and FVC were remarkably low, especially in the group who relapsed on placebo.

The authors suggest that shortening of left ventricular ejection time index (LVETI) after treatment with digoxin for one month is evidence for a continuing inotropic response to the drug. However, there is no indication whether the systolic time interval (STI) was measured under standardised conditions. LVETI is particularly susceptible to many influences other than inotropic effect, including ventricular volume, pre-load, peripheral re-

sistance, level of adrenergic stimulation, and time of day.¹⁻³ Furthermore, the STIs recorded while the patients were taking placebo were not significantly different from those of normal subjects, which is in contrast with the findings of Weissler *et al*⁴; this suggests that the patients in this part of the study may have had especially mild heart failure. Weissler *et al*¹ showed that pre-ejection period index (PEPI) was a more consistent indicator of inotropic effect than LVETI, but in the patients of Dr Dobbs and her colleagues PEPI did not change on digoxin therapy. Finally, any uncontrolled haemodynamic observations made at intervals as great as one month must be regarded with the greatest suspicion.

S J WARRINGTON
N A J HAMER

Department of Clinical
Pharmacology,
St Bartholomew's Hospital,
London EC1

¹ Weissler, A M, and Schoenfeld, C D, *American Journal of Medical Sciences*, 1970, **259**, 4.

² Lewis, R P, *et al*, *American Journal of Cardiology*, 1976, **37**, 787.

³ Weissler, A M, *et al*, *American Journal of Cardiology*, 1966, **17**, 768.

⁴ Weissler, A M, *et al*, *Circulation*, 1968, **37**, 149.

Health visitors and child health

SIR,—I have read with interest "Has the Court Report been misunderstood?" (11 June, p 1522) and I would like to make one comment and ask one question.

Vocational training is necessary for all doctors, but for those thinking of general practice it is essential. It is not enough to make a diagnosis and prescribe the correct course of treatment without fully understanding the causative social factors. It is less than useless to prescribe a daily bath for someone without hot water.

The question I would ask is, does Professor Court really think that the work in Sheffield has been carried out by health visitors without cost? I am pleased to hear that they have improved the statistics on child health without any increase in numbers, but as a health visitor myself I would guess that many other aspects of work have of necessity been abandoned to enable them to give enough time to this work.

The health visitor has been trained as a family visitor and while every health visitor in the country would, I am sure, agree that child health has to be a priority, it would be stupid and very wrong to assume that that is the only work requiring attention. Middle-aged people have great problems and elderly people have too many problems to mention in this letter. If we do not give the right level of care to preventing some of these problems we will have too many elderly in hospital beds and the child will have difficulty in gaining admission for the removal of its appendix.

I hope the health visitors in Sheffield will be able to afford a little time away from child assessments to inform Professor Court about some of their other duties. Time given to one aspect of community care is time taken away from another.

Health visitors want to continue to promote child health to its highest level, but it has to be understood that there is a cost involved. Unless there is a great increase in the number of health visitors there will inevitably be less time to give to other work. A lot of health visitors view this

prospect with regret and see the middle-aged and elderly as very important aspects of their work. The recommended increase of 6% will do nothing to help solve the ever-increasing work load.

E J MORTON

Retford, Notts

Chromium and diabetes

SIR,—In regard to the effect of yeast extracts on diabetes discussed recently in the *BMJ* (4 December, p 1366, and 2 April, p 905) I would like to add the following comments.

It has indeed been claimed that chromium-deficient diets result in mild carbohydrate intolerance in the rat.¹ Recently we have studied chromium-deficient rats with intravenous glucose tolerance tests² using the exact methodology of Mertz *et al.*¹ We found only an extremely mild degree of carbohydrate intolerance, which could not even be confirmed by means of analysis of the fractional rate (K).

The studies regarding the effect of supplemental dietary chromium on human diabetes are not by any means conclusive.^{3,4} However, very recently Jeejeebhoy *et al.*⁵ have reported on one patient on parenteral nutrition for five years and with negative chromium balance who developed mild carbohydrate intolerance and neuropathy. These changes were corrected by the addition of chromium to her infusate. This is, so far, the most direct evidence that chromium deficiency, probably of a degree much more pronounced than that induced in our experimental model,² can result in mild carbohydrate intolerance. In the light of these considerations the severity of diabetes in the patient described by Dr Herepath⁶ in 1854 seems hardly compatible with the carbohydrate intolerance of chromium deficiency.

J BARBOSA

Section of Endocrinology,
Department of Medicine,
University of Minnesota Hospitals,
Minneapolis, Minnesota

¹ Mertz, W, *Physiological Reviews*, 1969, **49**, 163.

² Wooliscroft, J, and Barbosa, J, *Journal of Nutrition*. In press.

³ Levine, R, Streeter, D, and Doisy, J, *Metabolism*, 1968, **17**, 114.

⁴ Sherman, L, Glennon, J, and Brech, W, *Metabolism*, 1968, **17**, 439.

⁵ Jeejeebhoy, K, *et al*, *American Journal of Clinical Nutrition*, 1977, **30**, 531.

⁶ Herepath, W B, *Journal of the Provincial Medical and Surgical Society*, 28 April 1854, p 374.

Rubella in early pregnancy

SIR,—I would like to draw attention to one means of reducing the incidence of the congenital rubella syndrome.

Two children born in December 1975 at two other hospitals in East Anglia have the clinical picture of congenital rubella—that is, microcephaly, mental retardation, heart lesions, failure to thrive, and in one case bilateral cataracts. Antibody levels are consistent with the diagnosis. Both mothers had experienced a mild febrile illness with rash, one at six and the other at nine weeks of pregnancy. One did not seek medical advice; the other did and was not investigated. Each was seen in the normal way at an antenatal clinic a few weeks later, when blood was sent for antenatal rubella examination and reported as showing evidence of immunity.

In neither instance was the mother asked about the occurrence of illness or a rash during

the preceding weeks of the pregnancy. Had a history of a rash been obtained the diagnosis of recent rubella infection may well have been supported by serological tests and a termination of pregnancy considered.

Should not all physicians and antenatal clinics introduce the question "Have you had a rash since your last period?" into their questionnaire for "booking in" patients and if the answer is affirmative get the laboratory to help? A history of "German measles as a child" is known to be misleading¹ and immunity assumed from any other unsubstantiated evidence would be best disregarded in favour of a proper serological examination.

J NAGINGTON

Public Health Laboratory,
Addenbrooke's Hospital,
Cambridge

¹ Public Health Laboratory Service Working Party on Rubella, *British Medical Journal*, 1968, **3**, 203.

Infantile acne

SIR,—Both my children within the first few weeks of life developed what, for want of a better description, is termed infantile acne. This was, as you can imagine, disturbing for the loving parents and led to considerable searching through dermatological texts. In common with many other skin disorders there appeared to be no effective treatment. The most popular explanation to explain the skin lesions was withdrawal of maternal oestrogen and progesterone at birth.

Both children were breast-fed and, to the delight of mother and father, the unsightly spots rapidly disappeared when the former resumed taking a low-dose oral contraceptive preparation. I have recently witnessed the same phenomenon with a neighbour's child.

This uncontrolled observation may lend weight to the "withdrawal of maternal hormone" theory. I wonder whether any of your other readers have had a similar experience.

D ROWLEY-JONES

Baldock, Herts

Treatment of mild hypertension

SIR,—In the preamble to the report of the MRC Working Party on Mild to Moderate Hypertension (4 June, p 1437) it is pointed out that the argument for considering treatment of mild hypertension depends on the beneficial results claimed in the treatment of severe hypertension, and in particular on the report of the Veterans Administration study of 1967.¹ If the working party is satisfied with that, as it appears to be, it follows that there should already be enough data available from its pilot study to render the £2m full-scale study superfluous. The VA study was based on 143 cases studied for just over two years. The MRC trial included 1849 persons, some studied for over three years. For some reason the incidence of cardiovascular episodes in this group was not disclosed.

The Framingham study ("the best available")² indicates that in the age group studied one would expect about a 4% annual incidence of cardiovascular episodes. The MRC pilot study should therefore contain about 100 events of this sort, even allowing for any reduced incidence from the treatment.

According to Peto *et al.*³ 100 events should permit an even chance of detecting a 50% benefit from treatment. Admittedly this is not as high as the 95% chance aimed at in the MRC trial (in my view unnecessarily high). However, if I were funding the MRC (which in a way I am) I would not be inclined to endorse a full-scale trial without information on the results of the pilot trial. It would be a colossal undertaking and likely to be of very dubious benefit according to the Harvard workers.¹

HARRY HALL

Exeter

¹ Veterans Administration Co-operative Study Group, *Journal of the American Medical Association*, 1967, **202**, 1028.

² Stason, C, and Weinstein, M C, *New England Journal of Medicine*, 1977, **296**, 732.

³ Peto, R, *et al*, *British Journal of Cancer*, 1976, **34**, 585.

Cranial arteritis: atypical presentation

SIR,—Further to the correspondence regarding cranial arteritis (21 May, pp 1348 and 1355; 11 June, p 1534), I feel that an illustration of an atypical presentation might be of interest, partly because the typical clinical picture is usually so marked and also to prove that lightning can strike twice in the same place.

In 1967 a previously fit 78-year-old man presented with pain in the tongue on eating or rapid repeated protrusion of the tongue but not on drinking or repeated jaw movements alone. Biopsy confirmed the diagnosis of arteritis and corticosteroid therapy was started. The tongue pain and malaise had disappeared one week later.¹ Recently a female patient aged 77 presented with identical symptoms and signs and a raised erythrocyte sedimentation rate. A dramatic improvement was obtained on starting steroid therapy. It is interesting that this obviously uncommon presentation should have occurred twice in one practice and it exemplifies the fact that other arteries than the temporal can be affected.

I feel that note should also be taken of the complaint of general malaise which is commonly associated with the severe headaches described by Dr R V H Jones (21 May, p 1355) and which is rapidly improved once steroid therapy is instituted.

K D LAWREY

Seaton, Devon

Control of blood glucose in labour

SIR,—We would like to reiterate what was said by Dr Judith M Steele and her colleagues (11 June, p 1537) about the use of continuous intravenous insulin and glucose administration in the treatment of diabetic labour. Over the past two years we have been using 10% dextrose with Actrapid insulin and potassium chloride added direct to the dextrose solution. When infused over five hours this provides insulin at 2 U/h, glucose at 10 g/h, and potassium at 2 mmol/h. This can be administered and monitored easily by nursing staff or with a constant infusion pump such as the IVAC. We have not added albumin or found the use of an insulin syringe necessary. If the insulin dosage needs to be changed another bag of dextrose can be made up with the appropriate amount of insulin added. This usually varies between 1 and 4 U/h. An intravenous infusion bag costs the health