with safety, without the help of anaesthetists, in many thousands of administrations in the recent past when they undertook this treatment themselves.

Undoubtedly ventilation is more easily carried out through a tracheal tube when the likelihood of apnoea lasting 30-90 minutes is probable, but in most hospitals an anaesthetist can be called to employ his expertise with a laryngoscope at his early convenience if the obstetrician thinks it necessary and fails to pass a tube himself, bag and mask ventilation being maintained until he arrives.

There may be good reasons why extradural analgesia in labour should remain in the hands of the anaesthetists, but the very rare risk of death from apnoea through the inability of the obstetrician to intubate is not one of them.

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Disseminated histoplasmosis in diabetes

SIR,—Dr D W R Mackenzie's letter (14 May, p 1281) has recently come to our attention. He is to be thanked for his interest in our case (16 April, p 1002) and for finding a reference not covered by the number of excellent reviews available in the more widely read English language journals¹⁻³ and the anecdotal book.⁴ Some clinical points are, however, worthy of reply, particularly as they reflect his divergence of opinion from experienced writers in endemic areas.

(1) *Serological studies.* Both complement fixation tests and precipitin tests are negative in up to 40% of patients with disseminated histoplasmosis, possibly reflecting a state of immune anergy to the overwhelming infection.^{2,3,5}

(2) *Opportunistic infection.*⁵ As judged by conversion to positive skin tests, some 500 000 patients per year receive primary exposure to histoplasma antigen in endemic regions of America.⁶ Of these only 1-2 per 1000 present as the disseminated form,³ and of these one series recorded factors which diminish host resistance in 65%.³ With reference to the patient reported this change in host resistance may be related to the onset of his diabetes mellitus, and with cases referred to elsewhere^{3,5} this picture may hope to explain the "latency" which Dr Mackenzie cites for systemic mycoses. Presumably in the other cases exposed to the antigen the fungus is either overwhelmed by host resistance or lives as a saprophytic commensal awaiting immune paresis. In this it shares features with both accepted commensals (monilia) and accepted pathogens (*Mycobacterium tuberculosis*).

(3) *Endemic histoplasmosis in the United Kingdom.* Not having studied the soil of the north-west, we are in no position to comment on Knight's interesting speculation that histoplasmosis is potentially endemic in the United Kingdom as it is in Norway.⁷ Perhaps in denying Knight's data Dr Mackenzie will be able to comment on other possible endemic United Kingdom cases, including the cotton-mill worker in the Manchester area who had two colleagues with positive skin tests.⁸ Since the Manchester region has been the port of entry for thousands of tons of cotton, including cotton from the histoplasma-infected Mississippi and Ohio River valleys, Dr Mackenzie will no doubt be able to help in confirming the absence of *Histoplasma capsula-*

tum from the starling roosts near the Stretford City Hall, where the patient reported works as a doorman.

(4) *Reviewing.* Finally, it would seem appropriate to observe that the choice of referees must be the prerogative of the editor of the journal concerned. Perhaps such decisions are influenced by experiences in the past such as those published in a recent *BMJ* article.⁹

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¹ Goodwin, R A, and Des-Perz, R M, *Southern Medical Journal*, 1973, **66**, 13.

² Smith, J W, and Utz, J P, *Annals of Internal Medicine*, 1972, **76**, 557.

³ Reddy, P, et al, *American Journal of Medicine*, 1970, **48**, 629.

⁴ Symmers, W StC, *Curiosa*. London, Baillière Tindall, 1975.

⁵ Furcolow, M, *Laboratory Investigation*, 1962, **11**, 1134.

⁶ Broome, W, Hutchinson, R, and Mays, E J, *Periodontics*, 1976, **47**, 95.

⁷ Knight, R K, *Guy's Hospital Reports*, 1968, **11**, 309.

⁸ Miller, A, Ramsden, F, and Geake, M R, *Thorax*, 1961, **16**, 388.

⁹ Horrobin, D R, *British Medical Journal*, 1974, **2**, 216.

Starting on the pill

SIR,—Dr Nancy B Loudon's letter (20 August, p 521) should, I believe, produce a much-needed change in the routine advice given to patients starting on oral contraceptives. Some of us have, in special cases where low motivation and intelligence would combine to cause complex instructions to destroy the patient's confidence, already discarded the "traditional" instruction to use additional contraception for the first 14 days of pill-taking. Was this folk-lore? Was it based on a very small number of early failures which, in the light of more recent knowledge, could perhaps have been due to drug interaction? Whatever the reason, we have probably wasted tons of rubber and thousands of pounds sterling (as well as deterring many timid potential pill-users) over the past 15 years. I would endorse a massive effort to ensure that this practice is quickly discarded by all doctors and nurses advising on birth control.

ELIZABETH H GREGSON

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Acute gastric dilatation in anorexia nervosa

SIR,—I was interested in Dr G K Brooks's report of acute gastric dilatation in anorexia nervosa (20 August, p 499) and would like to make some observations as to its possible causation.

Case 1—A 16-year-old girl was admitted to hospital in November 1972 with a diagnosis of anorexia nervosa. She was treated with chlorpromazine and a high-calorie diet and told that discharge would be entertained once she had gained a certain weight. On 23 December, realising that she would not be discharged for the Christmas holiday, she hoarded food and secretly overate. Early next morning she vomited, collapsed, and assumed a catatonic state. She was found to have acute gastric dilatation, aspiration pneumonia, and some pulmonary oedema. Seven litres of fluid were aspirated from the stomach and after treatment

with antibiotics and hydrocortisone she recovered fully.

Case 2—A 19-year-old girl admitted shortly before Whitsun 1973, having realised that she would not be discharged for this holiday period, undertook a similar gastronomic excess and soon complained of severe epigastric pain. Four litres of fluid were aspirated from the stomach before vomiting started. She later used overeating and impending acute gastric dilatation as a means to achieve hospital admission on several occasions.

It would appear that acute gastric dilatation occurs in anorexia nervosa, that it may result from attempts to gain weight quickly, sufficient to warrant discharge, and that similar episodes may be consciously provoked to gain hospital admission when external social pressures prove too great.

I would like to thank Dr H C Hamilton for allowing me to report these two of his patients.

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Anxieties and fears about plutonium

SIR,—I hesitate before accusing Dr R H Mole (17 September, p 743) of the bias he so dislikes in others, but I fear that in his attempt to allay fears about plutonium he has himself fallen into this trap. Probably he was not intending to do so, but he has implied that those who object to its use are over-reacting to misrepresented and misunderstood evidence of its likely effect on the outside population.

As a member of one of the environmental organisations I have heard many arguing against the use of nuclear energy but very few of them using arguments so obviously distorted as those quoted. Most base their opposition on the known facts—Dr Mole himself states them—that plutonium is a long-lived α -particle emitter capable of causing cancer, especially of the lung, and that any radiation can cause genetic damage.

I disagree with his implication that because environmental radiation exists more will not do harm. If this were the case we would not need to be concerned about the effect of repeated exposure to x rays. Any increased radiation, whether from a nuclear power station or an x-ray machine, increases the risk of genetic damage. Neither do I agree that the natural occurrence of the long-lived potassium-40 in any way proves plutonium less dangerous. The importance of the long half life of this α -particle emitter is that any which escapes into the environment will be there for a long time—not a pleasant prospect if the amount released, whether by accident or terrorist activity, is large.

Basically Dr Mole and I disagree not so much on the facts as on the importance we place on them as compared with the benefits of nuclear energy. Whether the benefits outweigh the risks is obviously a matter of opinion, but this must be well informed. It is in this context that the Windscale inquiry is so important as it is the first time in my recollection that there has been a chance for all interested parties to put their views before an impartial judge. Naturally it will take time: there is a great deal to be said on both sides. It is to be hoped that it will result in an objective assessment of both the advantages and dangers involved in nuclear technology. It may be a mistaken belief that "the only experts to be trusted are those not

paid by the Government or commerce," but it is sometimes equally difficult to avoid the impression that the Government is reluctant to give as much publicity to facts which weaken its case as to those which enhance it. It is a sound principle that justice must not only be done but must be seen to be done, and this is not the case when the Government appears to be advised only by those with a vested interest in nuclear technology.

JACQUELINE ORMAN

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Surgical emphysema during dental treatment

SIR,—A 31-year-old housewife visited her dentist, who drilled a cavity in her left upper seven. As he used the compressed air drier she suddenly experienced severe pain in the left side of her face to the temporal region and down into the left anterior triangle of her neck.

On his advice she consulted me within 30 minutes, when she had marked surgical emphysema extending from the left temporo-parietal region down the side of the face and into the subcutaneous tissue of the left anterior part of her neck. The only abnormal finding in the mouth was a small ulcer in the gingival sulcus lateral to the offending tooth. This presumably could have arisen as a friction burn during drilling and was presumably the site of entry of the subcutaneous air. The condition was extremely painful and tender, but with penicillin cover it subsided completely within 48 hours.

I can find no precedent in the literature and should be interested to learn whether this has been previously reported.

JOHN B WILLIAMS

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Advisory Committee on Borderline Substances

SIR,—Professor Barbara E Clayton (24 September, p 834) draws attention to the Advisory Committee on Borderline Substances (ACBS) and states that it is always ready to reconsider any of its decisions in the light of new evidence. I would like to ask whether it will reconsider some of its decisions in the light of long-existing evidence or alternatively explain how they came to be made in the first place. I give just a few examples.

(1) Casilan for biochemically proved hypoproteinaemia. Hypoproteinaemia is due either to excessive loss, as in nephrotic syndrome, or deficient manufacture, as in liver disease. It does not occur in ordinary starvation. Whatever the cause, no amount of Casilan or other protein given by mouth can raise it unless that cause can be cured. It follows that Casilan can have only a nutritional effect in such cases and indeed in others. What line of reasoning decides that it may automatically be considered a drug in hypoproteinaemia and presumably not in others?

(2) A list of gluten-free products for gluten sensitivities and other foods for cystic fibrosis, malabsorption of protein, steatorrhoea, etc, may automatically be regarded as drugs—but not carbohydrate-free (or -reduced) foods for diabetics. Is diet considered less important for the treatment of diabetes? Or has the committee arrived at its decision, not on grounds of sound medical reasoning, but on cost to the Health Service? Will it please say why diabetics suffer this kind of discrimination?

(3) Corn oil for familial hypercholesterolaemia. Has corn oil some totally different action in other

kinds of hypercholesterolaemia—or are the familial cases less likely to fry fish and chips in it?

I have always thought that the chief object of the ACBS was to give guidance not so much to manufacturers as to the prescribing practitioner. It has always been understood that the general practitioner, unlike the hospital doctor, cannot prescribe food (including special diets), clothing, heat, light, household disinfectants, or detergents even if these are necessary to save the patient's life. If the patient cannot afford any of these things he is expected to apply to such public resources as are available to assist him. By departing from this principle in a series of decisions, through which no thread of logic can be detected, in an apparently arbitrary selection of conditions and foods this committee, far from providing guide lines, has merely confused the issue still further.

I would strongly advise the prescribing practitioner in doubt to apply not to the ACBS but to his local medical committee. The secretary will often be able to give on-the-spot advice. Alternatively, he can prescribe a limited amount of the doubtful substance and argue his case personally before the LMC, whose decision is subject to appeal, when the referees will not only give a decision but also their reasons for arriving at it—which is more than the ACBS or any of its predecessors have done. Your estimable journal used to publish some of these decisions, which, unlike the ACBS, did give the prescribing practitioner some kind of guidance. Fortunately neither the prescribing practitioner nor the local medical committee is obliged to take any notice of the advisory committee's recommendations. I sincerely hope they won't. That committee's usefulness is, to say the least of it, doubtful.

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Whole-timers and the new consultant contract

SIR,—There are a number of aspects of the present negotiations between the Central Committee on Hospital Medical Services and the Department of Health and Social Security about the new consultant contract that I find disquieting, but one particularly which I think should be brought to the notice of whole-time consultants.

The original CCHMS proposals as published (11 September 1976, p 655) proposed the abandonment of the 2/11ths differential between whole-timers and maximum part-timers, but I had assumed that the DHSS would strongly resist this proposal. The Linkman letter of 17 August about the negotiations, however, says that "the Government takes the view that the maximum number of notional half days which a consultant can be expected to work should be higher if he does not propose to do private practice. The professions do not consider that such a proposal would be fair to the individuals concerned and they expressed complete opposition to the concept."

It seems, therefore, that the DHSS negotiators have already partly accepted the CCHMS line in that whole-timers would be able to receive their differential only if they did extra work and that this has given a peg for the CCHMS to "protect" us—a protection which we could well do without.

If other whole-timers believe as I do that it is the whole-time consultant who is the back-

bone of the NHS and that an increase in the proportion of whole-time consultants will be achieved only via an increase in the differential, then this watering-down of the current opposition by the DHSS is a retrograde step and one of which all whole-time consultants should be aware.

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SIR,—The latest BMA Linkman letter reports progress in the new consultant contract negotiations. The Government view, stated in the appendix, is that the maximum number of notional half days which a consultant can be expected to work should be higher if he does not propose to do private practice, a differential which has existed for nearly 30 years. Where has the statement that the professions do not consider such a proposal to be fair and express *complete* opposition to it come from? Many whole-time consultants, academic staff, community physicians, etc, if asked, might disagree.

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*.*The Secretary writes: "The financial differential between the 'whole-time' and 'part-time' consultant has been carefully preserved by the availability in the basic contract of two unscheduled notional half days which the previous whole-timer can work and be paid for. All that the CCHMS is seeking to eliminate is the enforcement of a legal restriction upon what a consultant does in his free time."—ED, *BMJ*.

Deputising services: charges to subscribers and pay of deputies

SIR,—Although considerable publicity has been given to the medical and ethical implications of commercial or BMA-sponsored deputising services, one aspect which in our opinion has attracted inadequate debate is the cost to the subscriber in relation to the payment of the deputy.

We note that more and more doctors find the cost of night and weekend cover so attractive and the thought of actually working for the service so unappealing that they choose to opt out of on-call work entirely. Surely this is to the detriment of themselves as general practitioners—but that is another story. The sombre fact is that tired GPs can set aside the cost of providing emergency cover as an "expense" against taxation while their less fortunate surrogates may be braving wintry storms or facing distraught patients only to find that their well-earned pittance is further diminished by income tax.

For five hours' work on a Sunday morning, seeing, for example, 10 patients, a deputy would collect £14.25, which gives an hourly rate of £2.85. If he manages to cope with 20 calls he will have earned £20.85, a rate of £4.17 an hour, although some patients may reasonably wonder whether they have been "seen" at all. Fees and costs are, we believe, fixed by negotiations between the Central Advisory Committee of the BMA and the various commercial firms involved. It is some indication, if nothing else, of how badly some doctors are paid if they are prepared to sacrifice their free time "moonlighting" for such