cage usually reveals the true cause of the pain. The syndrome is not always self-limiting and may incapacitate the patient for months. The best treatment is a local injection of a corticosteroid plus an anaesthetic like lignocaine. Often one injection is enough to relieve the symptoms. Sometimes the injection must be repeated. Oral anti-inflammatory drugs have a very limited value in the treatment of Tietze's syndrome.

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Teaching first aid to children

SIR,—Dr D D'Auria (24 September, p 835) asks about educating children in first aid and he cites the splendid example of Norway, where this teaching has been done for many years. Safety and accident prevention should also be taught as part of the same package.

Unfortunately no national plan in the UK is yet forthcoming from any official source to require the teaching of safety and first aid in all schools, in spite of the obvious humanitarian and other reasons for doing so. However, an editorial and an article in *Burns*^{1,2} on teaching safety, accident prevention, and first aid in schools shows what can and could be achieved.

Do the hours devoted to literature, mathematics, languages, physical education, and the arts show that these subjects are, to the official mind, more important than the preservation of the lives and limbs of our children? It would seem imperative that all children should be enabled to survive free from injury so that they may enjoy the benefits of these other subjects. Or is the absence of interest and teaching simply a matter of lethargy and lack of compassion in our society?

A WARD GARDNER

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¹ Gardner, A W, and Foster, S, *Burns*, 1976, 2, 203.
² Gardner, A W, and Foster, S, *Burns*, 1976, 2, 204.

Place of chlormethiazole in treatment of alcoholics

SIR,—The risks of indiscriminate use of chlormethiazole should be widely known and, as stressed by Dr J J Bradley (17 September, p 774), Dr Joan M Horder's warning (3 September, p 614) is very timely. However, in contrast to Dr Horder's opening statement, chlormethiazole is not an antidepressant "widely used in the treatment of depression" and her concluding sentence, "In the depressed alcoholic it would seem wiser to avoid the drug altogether," misses the point.

Chlormethiazole is held in Sweden and Germany to be the best drug for the treatment of severe alcohol withdrawal syndromes, including delirium tremens. Experience in the routine use of this drug at the Alcoholism Unit at St Bernard's Hospital¹ over the past 13 years have fully confirmed that for such purposes it is an extremely valuable and safe drug. It is, however, not a "treatment for alcoholism"; as a rule it should not be used except under hospital conditions or (except in delirium tremens) for longer than about six to seven days because of the risks of psychological and, more rarely, physical dependence.^{1,2} Prolonged use in alcoholic patients outside hospital of course also carries the risks of

potentiation and of overdose, as rightly described by Dr Horder. Reactive depression in alcoholics during the alcohol withdrawal phase is very common (being present to a severe or moderate degree, for example, in 53% of over 100 patients in our 1965 controlled trial of chlormethiazole¹); under hospital conditions the drug can certainly be used for depressed alcoholics in the withdrawal phase.

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¹ Glatt, M M, George, H R, and Frisch, E P, *British Medical Journal*, 1965, 2, 401.

² Glatt, M M, "Alcoholism—A Social Disease," Teach Yourself Books. London, English University Press, 1976.

Surgical treatment of trigeminal neuralgia

SIR,—We are surprised that your leading article (17 September, p 718) makes no mention of peripheral branch injection or division as part of the surgical treatment of trigeminal neuralgia.

For several years now we have adopted this method as the first line of surgical management in those patients whose pain is no longer controlled by medical means and is essentially confined to one division of the trigeminal. In accepting the ultimate inevitability of pain recurrence we have nevertheless found that prolonged periods of remission are obtainable by injection, either with local anaesthetic or alcohol, or subsequent neurectomy. The success of the method depends firstly upon meticulous mapping of the distribution of the patient's pain so that, secondly, an anatomically accurate injection may be made. In the face of recurrent pain the injection can be repeated, often in the privacy and comfort of the patient's home, or appropriate neurectomy performed of one or more peripheral branches.

Before recourse is made to the destructive procedures on the ganglion or sensory root, with their inherent morbidity and mortality, we suggest that the simpler and safer peripheral procedures be tried.

E J R MORGAN

I P CAST

P J E WILSON

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Intravenous diazepam and Cyclimorph

SIR,—Dr A S Gardiner (10 September, p 701) attributes amateur status and inferior results to those who use intravenous diazepam and Cyclimorph as a substitute for general anaesthesia. I invite him to consider the example of the patient with a dislocated shoulder admitted to the casualty department after a recent meal who is presented with the alternatives of waiting several hours for general anaesthesia or having an immediate injection of diazepam and Cyclimorph followed by painless reduction of the dislocation. I also invite him to visit my fracture clinic and see fractures remanipulated immediately during the course of the clinic rather than enduring anxious waiting for the next anaesthetic session.

I am delighted to read the letter from Mr P

Sykes (24 September, p 832) and to learn that he can perform the most complicated dental extractions under intravenous diazepam and pentazocine. This confirms my expectations that the use of intravenous diazepam with or without intravenous analgesics will obviate the need for general anaesthesia in dentistry and thus eliminate the recurring tragedies of deaths in the dental chair. Mr Sykes claims that intravenous pentazocine is virtually non-nauseating. This is rather surprising in view of the reports which suggest that the emetic side effects of pentazocine are about half those of pethidine and plain morphine.^{1,2} Moreover, pentazocine is known to have a higher incidence of other side effects such as dizziness and light-headedness. When I started using Cyclimorph I thought that it was virtually non-emetic until I made careful follow-up inquiries as to what happened after the patient got home. I then discovered that in some cases the emetic effects of morphine outlasted the antiemetic effects of cyclizine. A comparative trial of intravenous diazepam with Cyclimorph and with pentazocine is clearly indicated.

I am surprised that Mr Sykes has not found much increase in tolerance to intravenous diazepam in patients taking long-term benzodiazepine medication. Last week, for example, I injected 80 mg of diazepam before getting adequate sedation in such a patient who required remanipulation of relapsed Colles fractures. However, I agree that adequate sedation can usually be obtained and there appears to be no danger in larger doses providing these are carefully titrated.

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¹ Mowat, J, *British Medical Journal*, 1970, 2, 757.

² Morrison, J D, et al, *British Journal of Anaesthesia*, 1969, 41, 987.

Barbiturates and fractures

SIR,—Drs J B and Elspeth T MacDonald (1 October, p 891) have not fully taken up the main point I was making in my letter (10 September, p 699), perhaps because I expressed myself badly.

It is to be expected that any hypnotic would increase the risk of falls and hence of femoral fractures in the elderly, especially in those whose balance is already impaired. The figures in their paper (20 August, p 483) support this, though the authors drew attention particularly to the association of barbiturate hypnotics and nocturnal fractures. Their figures, however, suggest that non-barbiturates are more prone to cause fractures than barbiturates and show an altogether unexpected difference in the two groups between night and day fractures.

Time distribution of fractures

	10 pm-6 am	Daytime	Total
Barbiturate hypnotic fractures ..	91	12	103
Non-barbiturate hypnotic fractures ..	5	216	221
Non-hypnotic fractures ..	2	64	66

I agree that hypnotics will not be prescribed as often in the elderly generally as in those referred to a geriatric clinic, but when they are prescribed it would be reasonable to expect the prescribing pattern to be similar to that in the geriatric clinic referrals in the same locality.

Their paper showed a surprisingly high proportion of barbiturate users (40-50%) compared with non-barbiturates (60-50%) in Nottingham. If this pattern was followed it must mean that non-barbiturates were more liable than barbiturates to cause fractures. It also appears to show that barbiturates tend to cause nocturnal fractures but not daytime fractures whereas non-barbiturates cause daytime fractures but not nocturnal fractures.

It is this difference that I find most puzzling. I wonder if non-barbiturate hypnotics might be more often associated with the use of daytime sedatives and tranquillisers and therefore more liable to cause daytime fractures.

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Sunlighting and medicine

SIR,—If taking on paid outside work during night-time hours is moonlighting then let us call doing outside work (though unpaid) during daytime hours sunlighting. Too many senior doctors in London, whether NHS or university paid, spend too many days like this: 8.30-9.30 in the hospital doing their primary job. 10-16.30 in central London sunlighting—at the DHSS, or their respective college, or Senate House (London University), or the regional health authority, or the AHA, or another hospital/medical school, or the BMA, etc; they may be a member of a committee, or on an appointments board, or chairholder of a working party, etc, often changing location and function at lunchtime; 17-18.30 back at the hospital. Our colleagues from outside London will too often have to start the day: 7.30 catch train to London.

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Whole-timers and the new consultant contract

SIR,—As a younger consultant who has held both whole-time and maximum part-time contracts and who has, since appointment, experienced every type of pay anomaly, I would like to express my appreciation and support for our negotiating subcommittee in its efforts to produce a new consultant contract which is both fair and properly priced. While, of course, anyone who wishes to retain his present contract must be allowed to do so, I would think that most younger consultants, representing as they do the future of the hospital service, view a new contract as a vital insurance for their own future in the NHS.

The suggestion by Dr S P Baxter (8 October, p 960) that it is the whole-time consultant who is the "backbone of the NHS" is of course arrogant nonsense and is totally unhelpful.

The consultant body as a whole is of vital importance to the NHS in general and to the hospital service in particular. To hear some people talk one might think that whole-timers are paid extra for restricting themselves to their 11-session NHS contracts. I have always understood that the whole-timer is simply paid fully for all his NHS sessions and that it is the maximum part-timer who, while continuing to honour the whole-time 11-session commitment to the NHS and usually more, is paid up to £162 per month less in return for the option, without any guarantee of success, of

doing additional private work of any type in his "free" time, and for the use of NHS facilities which are themselves now being unilaterally withdrawn by Government anyway.

Surely most consultants would support the aim to unify the consultant body rather than divide it and to produce a realistic and properly rewarded basic contract covering commitments common to all consultants which itself provides a living wage, but which is linked to a system which recognises financially the fact that many consultants of all types shoulder a greater and more onerous work load than is covered in the basic contract, and which also gives every consultant the option of undertaking additional work if he wishes to use his free time thus. In short, surely no NHS consultant would argue with the principle that all consultants should be properly paid for being a consultant and that those who are prepared to do extra work or whose specialty demands a more onerous commitment should be rewarded for such.

Following on with the concept of consultant unity, may I inquire who or what is a "junior" consultant? Certainly no NHS district general hospital consultant is professionally or clinically responsible to any other NHS consultant, and experience has shown that, so far as the NHS consultant work load is concerned, there is no rising scale of responsibility and this is, by contract, full and continuing from the outset. In fact, from the work load and responsibility points of view, a consultant is a consultant is a consultant.

I suspect the title must refer to salary difference and not to the post, coined, doubtless, by a bureaucratic mind only able to think in terms of seniority levels and anxious to divide up consultants into subgroups, to conveniently—and euphemistically—describe younger consultants who, though taking no less a share of the work or responsibility, are paid considerably less than their older consultant colleagues, and to identify those who are on an incremental scale for salary (though not for work load or responsibility), which itself has been interfered with by Government causing them to make far greater financial sacrifice than the "normal" incomes policy effects on older and better off colleagues.

If the title "junior" consultant is a salary-based definition and refers to those who are paid less for doing the same job, one wonders whether this now puts younger consultants below senior registrars in the bureaucratic order of things since in relation to senior registrars of some standing many younger consultants are paid less for doing a more difficult job. Perhaps, to be facetious, the difficulty here might be resolved by abandoning the title "junior" and describing younger consultants as "discount" or possibly "cut-price," for that is exactly what younger consultants are as far as the NHS is concerned.

In an era of political pressure when we are resisting the erosion of the status of the consultant in NHS hospitals and are attempting to unify the consultant body through a fair contract which puts right artificial anomalies and arbitrary salary differentials, it seems senseless to persist with an outdated consultant increment scale in its present meaningless form, particularly as it is itself divisive and is so vulnerable to political attack. We all know that a consultant is a consultant in the NHS and I for one believe he should be paid as such and be known as such without qualification. If one wishes to recognise long service as an NHS consultant—and this would only really be necessary if the pay of consultants in general are inadequate—then is not this a worthy use to put the contentious "merit" award system to?

For myself, I have had my fill of being a full-time salaried employee of a State monopoly whose employer has shown itself willing to renege on contractual obligations. Even though I shall be even worse off financially and my work load and responsibilities will be greater, I consider that the gaining of partial

independence which changing to a maximum part-time contract has given me is well worth the considerable financial sacrifice.

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Consultant contract and HCSA

SIR,—I understand that the BMA is currently negotiating consultant contracts with the Department of Health and Social Services. I very much regret that the Hospital Consultants and Specialists Association have been excluded from these talks. Apparently there has been much discussion on additional duties but no positive undertaking that these additional duties will not actually constitute the accepted consultant contract without additional payment for them. I must hope that our negotiators insist on pricing the basic contract before proceeding any further. In this basic contract one must define a notional half day (flexibly worked) and there must also be specific recognition for "on call" commitments. I regret also the exclusion of a "feeper-item-of-service" contract from the discussions, even though the principle of this type of payment is already accepted in the payments that are being made for family planning services.

I send you this letter to register my strong protest on the fact that the HCSA is not being included in these talks and my plea that the BMA will soon come to realise that there is a significant number of consultants in this country which wish to have the HCSA as its sole, or at least part of its, negotiating body. What we would all like to see is an early alliance between the BMA and the HCSA.

P H SETNA

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* * * Mr David Bolt, chairman, CCHMS Negotiating Subcommittee, replied to a letter from the HCSA about the contract in the *BMJ* of 8 October (p 971).—ED, *BMJ*.

Consultants' motoring costs

SIR,—I was interested to read about the discussions on the issue of consultants' motoring costs (1 October, p 904). I have researched this topic extensively and it will do no harm to reiterate some of the basic facts. Firstly, a survey I carried out in this typical district general hospital revealed that over 90% of consultants had commitments in other hospitals at some time in the week. The same number were compelled to run two cars, since their own car was in constant use for the NHS. When one excludes those consultants who are single, virtually every consultant is compelled to run two cars. Secondly, the amount of mileage which a consultant "wholly and necessarily" incurs in the course of his work and is therefore reimbursable is a poor assessment of his need to have a car available. The need to supply a car for limited periods of the working week can only imply ownership for the rest of the week. The widespread insistence on implementation of the rule that consultants must live within 10 miles of their base hospital indicates that the authorities recognise the need for rapid availability.