reduced to 3 μg min, and blood sugar two hours later was 8.9 mmol/l, and 10 hours later 4.5 mmol/l. Urine tests returned to normal four hours after the reduction and remained normal despite continued high doses of corticosteroids. A later glucose tolerance test while 15 mg day of prednisone was being taken was normal.

The ketosis and hyperglycaemia only during the period of high salbutamol dosage suggests this as the cause, rather than corticosteroids. The case of Drs Leslie and Coats required as much as 32 U/h of insulin to prevent ketosis with 10 μg /min of salbutamol, and we speculate that a rise in plasma glucagon with beta-stimulation³ may perhaps contribute to this "insulin resistance,"⁴ though is unlikely to be the only factor involved.

The dose of salbutamol we used was higher than that usually recommended for asthma, but the use of such doses in many very ill patients has been permitted by the remarkable freedom from serious (particularly cardiac) toxicity to date. We think that regular monitoring of blood glucose is now indicated if high doses of salbutamol are used, at least until the frequency of the hyperglycaemic reaction can be assessed.

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¹ Thomas, D J B, *et al*, *British Medical Journal*, 1977, **2**, 438.

² Leslie, D, Coates, P M, *British Medical Journal*, 1977, **2**, 768.

³ Kaneto, A, *et al*, *Endocrinology*, 1975, **97**, 1166.

⁴ Müller, W A, *et al*, *American Journal of Medicine*, 1973, **54**, 52.

Seat belt legislation

SIR,—Like Mr P A M Weston and Dr D J Paynton (8 October, p 955) I work in a casualty department, but I cannot support their contention concerning seatbelts. I am opposed to any legislation for the following reasons. Firstly, any reasonable concept of freedom includes the ability to hazard your own health. If this is denied, then legislation must also be passed forbidding smoking, cream cakes, and sexual promiscuity, as respiratory disease, obesity, and venereal disease also cause much distress and suffering. Yet no one has, as yet, advocated these measures on the grounds of health. Humanity is entitled to live in such a way as to hazard its own welfare without interfering legislation based on somebody's opinion of what is "good for you." Secondly, freedom cannot be measured in purely economic terms. To argue that legislation is good and necessary because it saves the NHS money has an unpleasant dictatorial tang, out of place in a society that values individual freedom. But this is part of a larger issue. Coercion has no place in health care.

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SIR,—The letter from Mr P A M Weston and Dr D J Paynton (8 October, p 955) has again raised, possibly unintentionally, another issue where the politicians could assist in reducing accident and emergency departments' work loads. In their first paragraph they suggest those persons opposed to the compulsory wearing of seat belts should attend accident and emergency departments late at night and

at weekends. In the rest of the letter they do not confirm whether these were the times when the majority of the 41 patients attended. If indeed they have found that many of the patients attended at these times, then their recent alcohol consumption would be of interest. As presumably some of the patients were passengers, it is not simply a question of fitness to drive. It could be that attitudes to wearing seat belts are affected by blood alcohol levels.

There are, possibly, ethical and legal problems in measuring blood alcohol levels as a routine in all such patients, but ways must be found of doing so. Then the evidence to politicians and other interested parties could be so presented that legislation would follow to reduce the heavy morbidity in all its forms that is caused unnecessarily by road accidents.

S M LORD

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Acute gastric dilatation in anorexia nervosa

SIR,—In reply to Dr O P N Grüner (17 September, p 774), mesenteric obstruction was considered as a cause for acute gastric dilatation but was not discussed because of space limitations. Mesenteric obstruction seems to be recognised more commonly in the USA than in the UK. The anatomical structure causing the obstruction remains in doubt, though more authors agree that it is due to a loss of fat padding. The case for mesenteric obstruction is supported by Dr Grüner's references and by the common finding of duodenal ileus in anorectic patients without gastric dilatation,¹ and by the association of duodenal dilatation with acute gastric dilatation from a variety of aetiologies.¹⁻³

I dispute, however, Dr Grüner's claim that the obstruction is cause rather than effect of the psychological illness. Our patient had severe psychological problems before organic symptoms and the dilatation occurred during the recovery phase of her illness.

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¹ Scobie, B A, *Medical Journal of Australia*, 1973, **2**, 932.

² Makkowski, B, *British Medical Journal*, 1947, **2**, 128.

³ Wallace, R G, and Howard, W B, *Radiology*, 1970, **94**, 307.

⁴ Berk, R N, and Coulson, D B, *Radiology*, 1970, **94**, 303.

⁵ Paul, J G, *et al*, *American Journal of Surgery*, 1973, **126**, 658.

Medical hazards of air travel

SIR,—The cardiovascular emergencies with which Dr I Drummond Rennie (20 August, p 515) had to deal while travelling on various air routes in the USA leads one to consider whether the illnesses were merely untimely exacerbations of pre-existing disease or were actually related to air travel itself. Many individuals with extensive health problems are safely transported by air lines without incident and the value of screening such travellers must remain doubtful. It is to be expected, however, that the stresses of even a relatively short flight, coupled with minor hypoxia, immobility, and not inconsiderable fluid loss, could at times affect even healthy passengers.

Our recent report¹ of eight passengers who developed features of pulmonary thromboembolism after travel draws attention to this problem. All had been in normal health before their journeys, which were made by aircraft (3), car (3), rail alone (1), and rail/ship combined (1). Six of this group had a previous history of venous disorders in the legs and by the time of presentation three had clinical evidence of calf vein thrombosis and one of active superficial thrombophlebitis. The term "economy class syndrome" has been coined to describe the venous problems which develop as a consequence of the relative immobility associated with air travel. The velocity of venous blood flow in the lower limbs in the recumbent position is reduced by half when standing and by two thirds when sitting.² It seems probable, therefore, that the somewhat cramped seating conditions of modern aircraft can reduce blood flow further, making the risk of venous thrombosis and its thromboembolic sequelae more likely.

Whether or not the patients in Dr Rennie's experience were suffering from such thromboembolic complications as a direct result of air travel will presumably remain unresolved but it would seem prudent that intending travellers, and particularly those with pre-existing venous disease, should be advised to take appropriate exercise during the course of their journey.

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¹ Symington, I S, and Stack, B H R, *British Journal of Diseases of the Chest*, 1977, **71**, 138.

² Wright, H P, and Osborne, S B, *British Heart Journal*, 1952, **14**, 325.

Population control

SIR,—Dr A T Coleman (24 September, p 835) asks why chastity is not discussed as an important means of population control. I think the answer is three fold. Firstly, no sensible person could believe that chastity could ethically be required in marriage: it cannot, therefore, make a large contribution to the population control. Secondly, Kinsey showed what every person of common sense knows—namely, that the realities of human life have always included sexual activity far beyond the hypocritical malaise of puritan society. Finally, "the value of chastity" is a false value. It is not ethical to support a "value" that is wasteful, destructive, and blasphemous.

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Surgical treatment of trigeminal neuralgia

SIR,—Your otherwise admirable leading article (17 September, p 718) on the treatment of trigeminal neuralgia ends on a probably false note of optimism. When new avenues open up faster than opportunities to assess their merits the choice of treatment is best determined by a few simple principles, adapted to individual circumstances, as you yourself have indicated. The mortality of treatment must not be higher than that in the natural history of the disease and not even a single death is acceptable. There should be no morbidity beyond the inevitable

sensory deficit of varying degree in the trigeminal territory. The denser the anaesthesia, the lower the recurrence rate, whichever the technique used. Henderson's results after alcohol injection are a perhaps unique exception in this respect.

Microsurgical techniques are mostly aimed at reducing the morbidity from facial sensory loss either by fractional rhizotomy, dividing only the "portio major," or by relieving presumed arterial compression. It will be surprising if in the long run these procedures find any more general acceptance than Taarnhøj's decompression.¹ Surgical treatment is unlikely to reduce the recurrence rates unless it produces complete anaesthesia at least in the affected division of the trigeminal nerve and should, therefore, be confined to those patients willing to accept the sensory loss in return for a more or less permanent cure.

We feel that on most occasions percutaneous radiofrequency thermocoagulation has more to offer than any other form of therapy because sensory deficit can be controlled and confined to the distribution of the pain. As the aim of this technique is to obtain selective loss of pain sensation only in the affected area, with minimal injury to the nerve, the chance of delayed recurrence is relatively high in comparison with any other method of surgical treatment. This recurrence, however, can be treated by repeating the technique more swiftly and simply than by intracranial surgery. The treatment is tolerated best and the incidence of facial dysaesthesiae lowest if as with other procedures under basal sedation thermocoagulation is carried out when the pain is at its height, and not during a remission.

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¹ Taarnhøj, P, *Journal of Neurosurgery*, 1954, **11**, 299.

The urethral syndrome

SIR,—We read with interest the recent leading article on "The urethral syndrome" (3 September, p 593), in which our recent paper on the treatment of this condition by the Richardson urethroplasty was criticised. In answering these criticisms we would like to emphasise the points which we made, because it would appear that they have been missed by your leading article. That we failed to distinguish between bacteriuric and abacteriuric patients is not correct. All cases were examined for evidence of infection and in only eight out of 38 cases was this detected, the point being that infection in this series was an uncommon aetiological factor.

Perhaps it was the simplicity of the urodynamic data which we used to diagnose the bladder outlet obstruction—namely, flow rate, residual urine, if it was present, and trabeculation—which caused you to opine that our urodynamic data were inadequate. We must point out that we used these data not only to detect bladder outlet obstruction—we also used the flow rate and residual urine measurements to test the success of the operation. In that context we contend that our urodynamic data were adequate.

In your leading article you state in the second paragraph, "Two prospective trials of treatment of proved urinary tract infection in

this age group have failed to show any benefit from either urethral dilatation or internal urethrotomy." You then state in your last paragraph, "When all else fails (use of anticholinergic drugs, a course of local or systemic oestrogens, elimination of vaginal infection, voiding after intercourse, cessation of bubble baths, etc) urethral dilatation or urethrotomy may succeed in relieving symptoms in both bacteriuric and abacteriuric patients." We think that most readers would have shared our surprise at these inconsistencies.

Nevertheless, we emphasise that the patients who were referred to one of us (AJS) were referred because all other forms of management had failed. As an aetiological factor, we offered the positive findings of fibroelastosis in contradistinction to the nebulous one of "the possibility of reversible muscle spasm" as the result of a "local irritative urethral or bladder lesion." We think that non-compliance of the urethra as the result of fibroelastosis can cause, in the initial stages of compensatory detrusor hypertrophy, strong but ineffective and uncoordinated detrusor contraction, which might result in muscle spasm at the vesicourethral junction.

Although we do not agree with your concepts on the aetiology and management of the urethral syndrome, we would like to congratulate you on the thought given to this problem, which causes so much unnecessary suffering in women, and, because it is not life threatening, receives scant attention from many urologists.

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Soft contact lenses

SIR,—In your excellent leading article (10 September, p 655) on the relative merits of soft contact lenses you omitted to mention the special cases of uniocular aphakia. When a patient has a cataract removed from one eye and is still able to see reasonably well with the other, spectacle lenses will produce double vision, whereas a contact lens (either hard or soft) will avoid this unpleasant complication.

F J CURTIS

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Patients referred to community psychiatric nurses

SIR,—The variation in the number of patients referred by different practices in a health centre to an attached community psychiatric nurse described by Dr C M Corser and Mr S W Ryce (8 October, p 936) is of great interest and may be compared with the results of an experimental attachment of community psychiatric nurses to two health centres in Salford in 1975. The length of the experimental attachment was three months and during this period, and indeed for long afterwards, a psychiatrist attended each health centre on one

afternoon each week providing consultant support for the psychiatric nurses. There were 15 general practitioners in the two health centres and they referred a total of 56 patients to the psychiatric nurses. Three doctors made no referrals and one referred 12 patients, the remainder occupying intermediate positions in the table.

B E MARKS

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Doctors and the global population crisis

SIR,—It was precisely because of the deviation of some doctors from the traditional code of ethics and the abdication from responsibility of the GMC following the 1967 Abortion Act that led to the setting up of the British section of the World Federation of Doctors Who Respect Human Life. Our members are a witness to the Declaration of Geneva 1948, article 8, which states: "I will maintain the utmost respect for life from the moment of conception . . ."

PEGGY NORRIS
Honorary Secretary,
British Section,
World Federation of Doctors
Who Respect Human Life

Huyton,
Merseyside

Pruritus as a presentation of myelomatosis

SIR,—I read with interest the report by Dr J G Erskine and others on pruritus as a presentation of myelomatosis (12 March, p 687). I would like to comment on the reference to our communication.¹ The three cases described by us were initially diagnosed as benign monoclonal gammopathy (as mentioned in the report). I should like to emphasise that in the same communication we emphasised the point that one of the three patients subsequently developed a typical clinical picture of Waldenström's macroglobulinaemia. Thus macroglobulinaemia as well as myelomatosis should be considered in the differential diagnosis of generalised pruritus.

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¹ Zelicovici, Z, *et al*, *Israeli Journal of Medical Sciences*, 1969, **5**, 1079.

Estimating bowel frequency

SIR,—A report by Dr A P Manning and co-workers (24 July 1976, p 213) revealed that patients who had estimated their bowel frequency to be six motions or less a week had a consistent tendency to underestimate their frequency. However, only 13 of 81 patients were wrong in their predictions by as much as three motions a week. We asked 120 healthy

Doctor No:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
No of patients referred . . .	1	7	7	0	2	0	0	1	6	4	5	12	1	2	8