will be a multicentred special supervision service. One of the centres (probably at the postgraduate teaching hospital) will be a small inpatient unit giving a regional service for assessment of difficult patients, treatment of specially referred problems, consultation, teaching, and research. Each health area is joining the arrangements with a supervision service for its own patients providing both inpatient and outpatient facilities.

The Government has asked us not to concern ourselves with psychopaths, as the Butler Committee recommended prison developments for them. Our scheme will deal primarily with the mentally ill and it will provide flexible graded supervision all the way from maximum security to outpatient care in four tiers. Tier 1 exists already in the form of the special hospitals; we will provide tier 2 (the regional unit) and tiers 3 and 4 (the area arrangements). On 16 September we issued a publicity document "Secure but not Secured" setting out the proposal for the layman. I would be happy to let anyone have a copy; alternatively they could write to SETRHA at Randolph House, Wellesley Road, Croydon.

Finally, I would like to endorse the plea made by Dr Price for different regions to try different approaches to the problems confronting them. A uniform blueprint for the whole country is fine if it is the correct solution, but what if it is wrong? A variety of approaches introduced gradually will surely give us the best opportunity of maximising our experience. It will be interesting to see if the DHSS will approve the SETRHA scheme, which is distinctly different from other proposals they have already approved.

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Epidural analgesia in labour

SIR,—In 1970 a letter from this department¹ reported no effects from epidural analgesia on the rates of either caesarean section or combined forceps and ventouse deliveries during the years 1965-9. In the middle of 1969 20% of patients were receiving epidural analgesia in labour.

Since 1969 there has been an obvious change in the incidence of operative vaginal delivery and this can be readily seen in the accompanying figure. Ventouse-assisted deliveries account for less than 1% of cases in this unit.

During the last decade it can be seen that the forceps delivery rate increased sharply as the use of epidural analgesia changed from 20% to 40% of women. The only other policy change in the unit during these 10 years has been an increase in induced labour, but this has been a gradual change from 20.2% in 1966 to 39.2% in 1975.

The total forceps rate has fallen from 36% to 30% since 1970 and this is probably due to a better understanding of second-stage management when this form of analgesia is used. In 1974 35.0% of patients with epidurals had forceps deliveries and the total forceps rate for all patients was 28.5%. These would appear to be fairly typical figures for units using epidural analgesia as their main form of pain relief in labour.

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¹ Noble, A D, and de Vere, R D, *British Medical Journal*, 1970, 2, 296.

Thyrotoxic vomiting

SIR,—In addition to the seven cases reported by Dr D F Rosenthal and others (24 July, p 209) 13 other cases of this syndrome have been reported in your correspondence columns. Four patients had abnormal liver function tests and two of these had mild jaundice. Two others had associated hypercalcaemia. I report another example which was interesting.

A woman aged 35 had bilateral hilar lymphadenopathy and a negative Mantoux test in 1972. The infiltration had been present for some time because her serum electrophoresis was then normal. Her father had pulmonary tuberculosis and therefore she was considered to have sarcoidosis. Three years earlier she had had generalised arthralgia and probably had transient hyperthyroidism. A year ago she started to lose weight and had intermittent diarrhoea. Her symptoms worsened and she began to have vomiting attacks on 2 August 1976. Her serum thyroxine was then 164 nmol/l (12.3 µg/100 ml). She had hyperthyroidism and her serum thyroxine was 244 nmol/l (19 µg/100 ml) when I saw her for the first time in September. She therefore probably has sarcoid hyperthyroidism.¹

The unusual cases of this syndrome with liver involvement may have had undiagnosed sarcoidosis.

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¹ Karlsh, A J, and MacGregor, G A, *Lancet*, 1970, 2, 330.

Laxative effect of All-Bran

SIR,—We were surprised by your expert's insistence (12 June, p 1461; 24 July, p 236) that All-Bran is more effective than raw, unprocessed millers' bran. We know of no evidence to support this statement. We have carried out a controlled trial of All-Bran and uncooked millers' bran, given alternately and in equivalent amounts to 10 healthy subjects.¹ At the commonly given "dose" of 20 g per day raw bran of the kind used in the manufacture of All-Bran significantly increased dry stool weight and shortened intestinal transit time. All-Bran itself had no significant effect when given in the fibre-equivalent "dose" of 22 g per

day. There was, however, a trend in the same direction and doubtless a significant effect would have occurred if All-Bran had been given in larger amounts—a standard helping of this breakfast cereal is probably 30-40 g.

Nevertheless, our findings suggest that the cooking-malting process reduces the laxative effect of wheat bran and that, weight for weight, raw bran is more effective than bran breakfast cereals. In practice the latter may be easier to take in effective amounts because of their greater palatability.

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¹ Wyman, J B, et al, *American Journal of Clinical Nutrition*. In press.

Postoperative pain

SIR,—I very much enjoyed your leading article on this subject (18 September, p 664) but would suggest there was a notable omission as no mention was made of the use of long-acting local anaesthetics.

During my general surgical training I used locally instilled bupivacaine (0.5% plain) into herniorrhaphy wounds during closure with good relief of pain for up to 36 h. More recently I have been using a similar technique for certain orthopaedic operations with very gratifying results.¹ Our anaesthetic colleagues have also been using total lower limb blocks, administered under the anaesthetic for the operation, with good symptomatic pain relief for up to 24 h postoperatively.

The use of the "indwelling epidural cannula" for the relief of both post-thoracotomy and post-trauma chest pain is now also well established.

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¹ Dinley, J, and Dickson, R A, *Journal of Bone and Joint Surgery*, 1976, 58B, 356.

Oestrogens for menopausal flushing

SIR,—We are pleased that Mr E R Broadhurst (18th September, p 697) referred to our article¹ which questioned the rationale and efficacy of oestrogen therapy in menopausal flushing. We wonder if Professor A I Klopper would amplify several points mentioned in his original article (14 August, p 414) and in his subsequent letter (18 September, p 697)?

He says that "depending on which evidence you accept" the response of hot flushes to oestrogen "can be clearly distinguished from a placebo effect." We have been unable to find any double-blind cross-over studies which show that oestrogen is significantly better than placebo. Does Professor Klopper have any information that we have overlooked?

We do not agree that a flush count is an objective way of evaluating the effect of treatment. Hot flushes are subjective. However, there are associated objective components which include alterations in skin temperature and the other changes mentioned in our article.

Professor Klopper says that it is not a question of whether oestrogens should be

prescribed, as "we are already too far down that path to turn back." In "an issue in which there is more emotion than reason" we would make a plea for continued evaluation of therapy. If acceptable studies do not provide evidence of the superiority of oestrogens over placebo then we should stop prescribing them.

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¹ Mulley, G, and Mitchell, J R A, *Lancet*, 1976, 1, 1397.

Volvulus of the small bowel in a diabetic patient

SIR,—Following the recent description by Dr H Freund (11 September, p 641) of primary small-bowel volvulus in association with diabetes mellitus we wish to report a similar case.

A 60-year-old man was recently admitted with a 72-hour history of vomiting, constipation, and abdominal bloating. He had been a diabetic for 11 years and had noticed increasing polyuria and polydipsia in the week preceding admission. His compliance with insulin and dietary advice was poor. He was on no other medication but had a heavy brandy intake until 1972.

On examination he was icteric and moderately obese. His pulse was 90/min and regular and no bruits were audible. The abdominal girth was 112 cm and rigidity was absent. Bowel sounds were hyperactive and the rectum was empty. Blood sugar was 20.5 mmol/l (370 mg/100 ml), sodium 122 mmol (mEq)/l, potassium 3.7 mmol (mEq)/l, and chloride 103 mmol (mEq)/l. The blood pH was 7.34, P_{O_2} 11.8 kPa (89 mm Hg), P_{CO_2} 5.05 kPa (38 mm Hg), and standard bicarbonate 20.5 mmol (mEq)/l. Ketonuria was present. His diabetes was controlled, but the abdominal symptoms persisted and laparotomy was performed. A necrosed 17-cm segment of jejunum, which was resected, was thought to represent an untwisted volvulus. No other aetiology was apparent. A preoperative liver biopsy showed macronodular cirrhosis.

The "acute abdomen" of diabetic ketosis resolves rapidly with diabetic control and may occasionally mimic an upper intestinal obstruction. In addition, vomiting may further confuse the picture by rendering the patient alkalotic. Although conclusive proof of volvulus was absent in this case, it emphasises the importance of considering a mechanical cause for abdominal complaints which fail to respond to metabolic correction in the diabetic.

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¹ Goyal, R K, and Spiro, H M, *Medical Clinics of North America*, 1971, 55, 1031.

² Zitoner, B R, et al, *Metabolism*, 1968, 17, 199.

³ Lin, K C, and Walshe, C H, *British Medical Journal*, 1976, 2, 19.

Hyposensitisation with house dust mite vaccine in bronchial asthma

SIR,—Dr J Gaddie and his colleagues (4 September, p 561) were unable to demonstrate an improvement following hyposensitisation therapy in a group of patients with "asthma sensitive to house dust mite." Unfortunately,

the selection of patients and conduct of the trial make interpretation of the results impossible.

No definition of asthma or demonstration of bronchial lability was included and therefore some of the patients may have had fixed airways obstruction. Moreover, bronchial allergy to the house dust mite cannot be inferred from positive allergic reactions in other organs, such as the skin or nose. Up to 50% of patients with positive skin tests¹ and 14% with positive nasal challenges² show negative bronchial responses to the same allergen. The asthma in these patients would not be expected to "improve" with specific therapy.

The patients were reviewed on only five occasions over one year and the pretreatment period of observation is not given. No mention is made of the method of recording the symptoms and treatment. Only a continuous diary card record of symptoms, treatment, and twice-daily peak expiratory flow rates would be valid.³ The five spirometric tests in the year are of little value in a variable condition such as asthma.³ The forced expiratory volume in one second is abnormal only with moderate to severe asthma and obstruction in smaller airways may not be detected by this test. Maximum mid-expiratory flow, maximum expiratory flow volume curves, or thoracic gas volume (by plethysmography) are more sensitive indices of small airway obstruction and likely to remain abnormal more consistently.⁴

Trials of treatment in bronchial asthma are always difficult because of the heterogeneity and intermittent nature of the disease. Therefore careful selection and assessment of patients are necessary if reasonable conclusions are to be drawn on the efficacy of any therapeutic regimen.

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¹ Spector, S L, and Farr, R S, *Medical Clinics of North America*, 1974, 58, 71.

² Aas, K, *The Bronchial Provocation Test*. Springfield, Thomas, 1974.

³ Chai, H, et al, *Journal of Allergy*, 1968, 41, 23.

⁴ Hill, D J, et al, *Archives of Disease in Childhood*, 1972, 47, 874.

Pulmonary complications of measles

SIR,—The first two sentences of your leading article (2 October, p 777) imply that "disease in the respiratory tract" is invariably a cardinal feature "not only of wild measles . . . but also of the mild reactions occasionally encountered with modern attenuated measles vaccines." What evidence is there for this statement?

In 1962 and 1963, during studies¹ of Wellcome's early measles vaccines MV/16 and MV/20, a daily record was kept about the severity of malaise, loss of appetite, headache, disturbed sleep, coryza, running eyes, cough, sore throat, rash, and fever (taken 2-4 times daily) in each child for two weeks after vaccination against measles.

After MV/16 high fever (39.2-40.6°C) and a roseolar rash² invariably occurred, while malaise or headache or disturbed sleep also occurred in every child. In contrast respiratory symptoms or signs in the eyes, nose, throat, or chest just as invariably did not appear for the first time during the reaction phase from day 5 to day 12, even if recorded in a few children

once or twice before or after the reaction period; on most charts they were absent throughout the whole fortnight. MV/20, though less virulent than MV/16, was still far more reactive than the modern attenuated measles vaccines. Its use was followed by less malaise and less fever (37.6-39.2°C); rashes occurred less frequently. Like MV/16, this vaccine also produced no respiratory symptoms or signs. From these records I conclude that, even though the reactions to these earlier vaccines were otherwise far from "mild," no disease was caused in the respiratory tract.

The accuracy of this interpretation was underlined by the complete absence of respiratory symptoms and signs in home contacts of wild measles vaccinated early enough during their incubation period to prevent them catching the disease,³ even though their vaccine reactions were associated with fever and roseolar rash.

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¹ Watson, G I, *British Medical Journal*, 1965, 2, 13.

² Watson, G I, *Journal of the College of General Practitioners*, 1966, 11, suppl 1.

³ Watson, G I, *British Medical Journal*, 1963, 1, 860.

BMA representation in hospitals

SIR,—It may look from Dr E M Rosser's letter (25 September, p 760) as though my appointment as BMA recruitment officer for King's College Hospital (or, as I would prefer it, King's Health District, one of the three in the Lambeth and Southwark BMA Division) was to solve some of the problems set out in the letter from Dr J M Cundy (of the other BMA division in our AHA(T)) and myself (18 September, p 702).

But, of course, it merely clarified them. One can dragoon people into the BMA if one's temperament is right, with adequate data, but one cannot recruit. For recruitment one needs up-to-date data about the names, grades, specialties, and workplaces of one's existing members so that their subscriptions can produce for them things that non-members do not get—namely, regular local medicopolitical consultation and information as well as social and scientific activities which they may or may not want. The general practitioners seem to get this from their divisions, the presently most local BMA structures, but the hospital doctors do not, as many of their homes lie in other divisions. So no hospital recruits. My one constructive act has been to supply BMA literature to every new graduate (not previously done!) through the kindness of the medical school office.

My plea, therefore, is for the BMA to locate a willing hospital-based BMA member in every health district, to answer his calls for data promptly, to make sure that applications for membership go through him, and to help him to communicate easily with his constituents, who should really elect him (the unions object—so do I—to non-elected professional representatives). He should, of course, also be in touch with, if not on, his divisional executive.

Whatever the cost, this level of activity is what the BMA needs right now and not further spending on regional councils which must be almost as remote, psychologically, as Tavistock Square.

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