point: I went fresh to the literature on pressure groups that my own social science training had omitted, to discover why we should expect professional associations generally and the BMA especially to be unrepresentative. In reporting this conclusion (pp 25-26) I entered certain caveats. If Scrutator could direct me to references that suggest a contrary conclusion, I would be grateful.

The second possibility is conceded early in my report (p 7) where I discuss the problem of publishing "incidental findings of what ought perhaps to have been an unpublished pilot survey" and again later (p 24) when I remind the reader why I have endeavoured to use "our modest survey material . . . not so much as evidence in its own right but as pointers to a fuller consideration of the BMA's fears and CPAG's reactions."

Despite having been urged by colleagues in the medical and social sciences alike that I was too apologetic on this issue I still have some qualms about publishing an interim report on a pilot dozen. Nevertheless, I resent Scrutator's suggestion that this report was "pushed out." I resent it as a member of a group that has won a reputation for producing reasoned—and often well researched—evidence in support of its claims. And I resent it as a social scientist who spent a considerable time seeking an answer to the question: why were the doctors we interviewed so much more caring, with regard to sickness certification and other welfare interventions, than one might have expected from the published views of the BMA?

I hope it will prove possible to do further work on these interventions with a sample that would satisfy both Scrutator and me. Meanwhile, I have been urged by medical colleagues to seek interim publication in a medical journal. The *British Medical Journal* was among their suggestions, but that may be going a bit far. Perhaps I should settle for the more modest goals of asking you to publish this letter and of inviting Scrutator to read the enclosed copy of my report (*The New Sickness Certification: Panacea or Placebo?* 40p including postage from Child Poverty Action Group, 1 Macklin Street, WC2).

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Ketamine hydrochloride: a potent analgesic

SIR,—We note with interest the letter from Dr T R Austin on the use of ketamine hydrochloride in subdissociation doses for the control of pain (16 October, p 943).

We have been carrying out a study into the use of a controlled intravenous infusion of ketamine hydrochloride in patients following upper abdominal surgery. Although this study is not complete, we have found that ketamine hydrochloride administered in this way produces very variable results, particularly if one wishes to preserve unimpaired cerebral cortical function. In a number of patients clarity and co-operation have been achieved with a significant increase in the pain threshold, as measured by tibial pressure analgesimetry and peak expiratory flow rate measurement. However, the unpredictability of this method has led to clouding of consciousness, excitement, and non-cooperation in other patients despite very careful control of the rate of

administration of the ketamine. A number of patients who appeared to have a near normal level of consciousness complained afterwards of a bizarre feeling of detachment and requested that they should not be offered this form of therapy again.

However, we would agree with Dr Austin that in view of its respiratory sparing effect ketamine may have a role in relieving pain, particularly at the time of physiotherapeutic procedures.

We hope to publish detailed observations of our study in the near future.

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Management of appendicitis

SIR,—Delayed primary suture for cases of suppurative appendicitis, as suggested by Mr A W Clark (9 October, p 881), was in fact practised by Mr Ivor Lewis 30 years ago. In a paper entitled "The Packing of Abdominal Incisions in Peritonitis" Mr Lewis¹ described this method for use with transverse incisions. The peritoneum was sutured and the wound packed, with excellent results in 64 cases.

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¹ Lewis, I, *Proceedings of the Royal Society of Medicine*, 1946-7, 40, 652.

Depression on holiday

SIR,—On a recent "package" holiday abroad I was chatting with the tours representative about the problems of British holidaymakers who fall ill and have to be admitted to hospital. He told me that 50% of his clients in hospital are suffering from mental illness of a depressive nature and that it puts considerable strain on him and the English-speaking doctors to visit these patients and keep them in touch with their relatives. I asked him how this situation came about, and he told me that they are mostly women who have suffered nervous breakdowns and been advised by their doctors to "take a holiday."

Having seen the enthusiasm with which my fellow holidaymakers were enjoying the cheap local spirits, against which they would have been warned by their doctors were they on antidepressant chemotherapy, I concluded that these patients in hospital abroad had neglected their chemotherapy either deliberately in order to "enjoy their holiday" or through ignorance because they had imagined that a holiday abroad would do them just as much good as the treatment prescribed by their doctors. Also, patients on drugs of the monoamine oxidase inhibitor group are afraid that they might unknowingly eat food which they have been told to avoid, for example, synthetic meat flavoured with yeast extract, sauce flavoured with cheese, or soup made from a purée of dried beans.

The holidaymaker who falls ill and misses her package tour return flight is dependent on the good services of her tours representative to arrange a free flight home. The average holidaymaker might find it difficult to return home independently on a scheduled flight,

for in many countries overseas the bearer of a foreign passport has to pay for her flight in her own currency, and her traveller's cheques can only be cashed into the foreign currency. Most medical insurance policies do not cover clients for the expenses arising from illness which could have been avoided. For example, the insurance company recommended by British Airways specifically excludes claims made for the cost of a suicide or of intentional self-injury, or any expense which could have been foreseen from knowledge in the possession of the insured person before the holiday or journey began.

I feel that a great deal of stress and anxiety could be avoided if psychiatrists and general practitioners gave very specific instructions to their patients not on any account to discontinue their chemotherapy before being professionally advised to do so, particularly if they are planning to go away on holiday, either in Britain or overseas.

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Acute diabetic abdomen

SIR,—We were interested in the report on volvulus of the small bowel in a diabetic patient by Dr G A Fitzgerald and others (16 October, p 945) and their comment regarding the importance of considering a "mechanical cause for abdominal complaints which fail to respond to metabolic correction in the diabetic." Their patient was a 60-year-old man who although showing ketonuria was not severely acidotic. In our experience both the age of the patient and the absence of severe acidosis are indications that the patient had an acute abdomen causing the diabetic metabolic decompensation rather than vice versa. We found¹ severe abdominal pain and tenderness in 46 out of 211 (22%) episodes of severe diabetic metabolic decompensation. There was no association between the abdominal pain and the degree of dehydration or the initial blood glucose. In 17 instances the abdominal pain could be attributed to the precipitating cause of the metabolic decompensation. Those episodes of unexplained abdominal pain occurred in insulin-dependent diabetics of less than 40 years of age who were severely acidotic with a plasma bicarbonate of 10 mmol/l or less. The abdominal pain would thus appear to be attributed to the acidosis. Although it has been suggested that the acidosis may produce such pain via a vagal neuropathy,² a recent study of autonomic nerve function in ketoacidosis is against this.³

We would stress from the point of clinical management that where abdominal pain occurs in a diabetic of more than 40 years, irrespective of the plasma bicarbonate, or in patients of any age with a plasma bicarbonate of more than 10 mmol/l, then this invariably in our experience indicates a specific underlying cause.

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¹ Campbell, I W, et al, *Journal of the American Medical Association*, 1975, 233, 166.

² Scott, J, and Lloyd-Mostyn, R H, *Lancet*, 1976, 1, 590.

³ Campbell, I W, et al, *Lancet*, 1976, 2, 167.