neither can be compared the UK in 1946, when there were 3 million motors, and in 1974, when there were 17 million. We must have some comparative rate, and if this is improving we are entitled to claim that we are making progress. The large number of deaths is at least partly due to the enormous number of motors. It is also remarkable that your profession, who are in the best position to know, should neglect the large saving in lives made by the motor in enabling you to get to your patients more quickly and to get them to hospital promptly, in enabling the fire brigade to reach fires early, and so on.

This mistake has been made twice, if not three times, with tragic results. Between 1946 and 1956 the number of deaths rose slightly, although the "Smeed rate"—which allows for the population and number of motors—and the deaths per 100 million vehicle-kilometres both fell markedly. The rise in deaths, slight though it was, was blamed wholly on the drivers, though the number of motors had risen from 3 million to 6½ million. An Act increasing penalties was passed, the trend of the deaths rose sharply, and both rates rose. This was again blamed on the drivers and another Act, much increasing penalties, was passed in 1962. The deaths then rocketed upwards to the highest they have ever been, almost 8000, the rise being as much as 1100 in one year. When they fell again in 1967 the fall was claimed for the alcohol regulations in spite of many other measures taken at the same time which would reduce the deaths. The rises were ignored. The deaths then rose again and nearly reached the "Marple's" summit. The probability is that all three Acts increased the deaths.

I agree with you about the recording of accidents and strongly condemn the popular use—once again even by the RRL—of the word "casualty" for minor bruises and cuts. Worse still is the use of the word "maim" for these, though I think I heard—at 77 my hearing is not 100%—a prominent member of your Association do it on TV recently.

Unfortunately, however, it does not seem possible to get the full information about the human factors. I have tried it. You must remember that the object of accident investigation at present is to find out if a driver—and a driver only—can be prosecuted, and once that has been decided the armour-plated door clangs to and nothing more can be done. I even tried to find out whether drivers concerned were local and knew the road—important information—in my studies. The chief constable refused to ask this question on the grounds that it might produce prejudice. I could not argue with him. God knows there is enough prejudice already. I think you will find that to get the information needed would need the total reform of the law, though this is badly overdue. You must, however, remember that we engineers know how to stop the accidents. We have done it many times. I have done it. What we need is the money.

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Former County Surveyor of Dorset

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Clinical integration

SIR,—Your leading article (23 October, p 964) does not mention the vast financial saving to the NHS which would result from co-ordination of hospital and general practitioner services. The present arrangement of large outpatient follow-up clinics in hospital duplicates much of the GP's work and is wasteful of scarce NHS resources. The four common disorders of dyspepsia, stroke, hypertension, and diabetes which you mention are far better cared for in

general practice; I do not think that reliable readings of blood pressure and blood sugar can be obtained in the hospital outpatient clinic. However, the problem of long-term follow-up and chasing up of defaulters is one which has not yet been solved in general practice and is an area which could well benefit from hospital experience.

Integration should also involve the social services. A great deal of the work in general practice would be done better by a social worker attached to the practice as a member of the primary health care team. Pooling of information and resources would again make an enormous financial saving.

GEORGE STRUBE

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Survival at sea

SIR,—May I draw attention to an error in your leading article on this subject (30 October, p 1026)? The first step in improving naval lifesaving equipment after the second world war was the inflatable lifejacket, not the liferaft.¹

May I also comment on the statement that the survivor's need is for water rather than food, except in extreme cold? Lest it be inferred that water is not important in cold climates it should be noted that many seafarers in antarctic seas have reported to the contrary—for example, Sir Ernest Shackleton, "Thirst took possession of us. . . . Lack of water is always the most severe privation that men can be condemned to endure,"² Commander F A Worsley, RN, "All hands were suffering from the sensation of thirst. . . . Our raging thirst prevented us from eating,"³ and more latterly Dr David Lewis, "Chronic thirst remained a constant preoccupation. Two fingernails came off today."⁴ Wartime survivors in arctic seas likewise reported their craving need for water; one stated, "No one ate very much, nor complained of being hungry, but we all craved for a drink."⁵

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¹ Holt, W J, *Transactions of the Institution of Naval Architects*, 1955, **95**, 332.

² Shackleton, E H, *South*. London, Heinemann, 1919.

³ Worsley, F A, *Shackleton's Boat Journey*. London, Hodder and Stoughton, 1940.

⁴ Lewis, D, *Ice Bird*. London, Collins, 1975.

⁵ Lee, E C B, and Lee, K, *Exposure at Sea*. Proceedings, Studies Section, International Radio Medical Centre, Rome 1968.

Diets for diabetics: no added sucrose

SIR,—My recent letter (23 October, p 1011) contained a mistake about the sucrose content of Professor J W Anderson's diabetes diet. The sugars in the US diet average 20-25% energy and in the diet of the American Diabetes Association are about 20%. Dr Anderson had reported that the proportion of "oligosaccharides"—that is, sugars—in his diet was 20%.¹ A colleague pointed out that I should not regard these as sucrose, but by then it was too late to prevent publication of my letter. I wrote to Dr Anderson in Kentucky for more details of his diet, previously not published. He replied very kindly and promptly (27 October) that "our diets contain about 25% of total carbohydrate as simple sugar." (From previous letters and articles I had misinterpreted this to signify "simply sucrose"). But

the letter continued "no added sucrose . . . less than 20 g per day". I also noted that fat had with safety been increased from 9% to 15%, thus increasing palatability. There are each day 13 servings of wholemeal bread and five servings of starchy vegetables. After two weeks' hospital treatment over 20 diabetics have been able to discontinue sulphonylurea; also those receiving 15-25 U of insulin each day have been able to discontinue it, but not those requiring more.

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¹ Kiehm, T G, Anderson, J W, and Ward, K, *American Journal of Clinical Nutrition*, 1976, **29**, 895.

Hypotension during angiotensin blockade with saralasin

SIR,—Sodium depletion has been commonly recommended to identify angiotensinogenic hypertension with the competitive angiotensin antagonist saralasin.¹ However, the decrease of blood pressure obtained after saralasin infusion in a severely sodium-depleted state may give more information about the extent to which the renin-angiotensin system was stimulated than about the true angiotensin-dependent nature of the hypertension itself. Moreover, saralasin infusion in a severely sodium-depleted subject may lead to a dangerous fall of blood pressure, as was demonstrated by Dr R Beckerhoff and his colleagues (9 October, p 849). In addition to their findings we would like to report our experience with saralasin infusions in a hypertensive patient before and after six days' treatment with chlorthalidone 100 mg daily.

The patient was a 43-year-old man with a blood pressure of 175/120 mm Hg. Renal arteriography showed a severe proximal stenosis of the left renal artery. The patient received no medication. After three hours of recumbency saralasin was infused at increasing rates (0.5, 5, and 10 ng/kg/min) while the patient was on moderate sodium intake (urinary sodium excretion 93 mmol(mEq)/24 h). Blood pressures were recorded automatically by an Arteriosonde. Only a small decrease of blood pressure, from 160/110 to 150/108 mm Hg, was recorded after 45 min of saralasin infusion (see figure). A short initial rise of blood pressure was noted within 5 min after the beginning of the lowest infusion rate. After six days chlorthalidone 100 mg/d, resulting in a 2.8 kg decrease of body weight, an immediate fall in blood pressure from 136/108 to 108/87 mm Hg was observed at the

Blood pressure recording during saralasin infusion before and after sodium depletion with chlorthalidone 100 mg daily for six days.