be readily swayed by the patient's own wishes regarding home or hospital treatment.

KENNETH EDWARDS

Herts

Are dietitians a luxury?

SIR,—In your leading article (20 November, p 1214), you urge dietitians to agree on the future of their profession.

Since reorganisation of the Health Service and with the appointment of district dietitians, whose brief is to co-ordinate the dietetic services in their district and advise on nutrition policy, dietitians now have the opportunity to use their valuable expertise in both hospital and community. A small but significant group of dietitians (and nutritionists who work outside the NHS) have been working for the past 20 years in the community with health and social workers and others who advise people on their nutritional problems. They work at the field level as well as acting as advisers. These dietitians are continually assured by the response that they receive that the support they offer is important if the community is to be influenced by the correct nutritional thinking of the day.

In the present economic difficulties of the NHS the importance of preventive medicine has been yet again underlined by the recent publication "Prevention and Health: Everybody's Business."¹ If this is to be our guideline in medicine today nutritional guidance by alert and well-informed dietitians and nutritionists is imperative and certainly not a luxury.

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¹ Department of Health and Social Security, *Prevention and Health: Everybody's Business*. London, HMSO, 1976.

*.*This correspondence is now closed.—Ed, BMJ.

Sodium valproate: dosage for children

SIR,—Attention has been drawn by Dr D A Winfield and his colleagues (23 October, p 981) to the case of a 6-year-old boy (which was originally reported at a symposium held in September 1975)¹ who developed thrombocytopenia while under treatment with sodium valproate. This patient, weighing 20 kg, had been receiving 400 mg of the drug four times a day, a dosage which is greater than the maximum now recommended, and a plasma level of 244 µg/ml was found. It was on the basis of this and other reports appearing at about the same time²⁻⁵ that the recommended maximum dose for children was related to body weight rather than age.

The purpose of this letter is to draw attention to the revised recommended children's dosage for sodium valproate. The initial dose for children over 20 kg should be 400 mg/daily irrespective of weight, in divided doses with spaced increases until control is achieved (usually within the range 20-30 mg/kg daily). Children under 20 kg should receive 20 mg/kg daily, and in severe cases up to 50 mg/kg daily may be given. A dose of 50 mg/kg daily should be exceeded only in patients in whom

plasma levels are measured; plasma levels of 200 µg/ml should be exceeded only with caution and with monitoring for haematological function.

It is also recommended that pending investigation sodium valproate should be withdrawn if spontaneous bruising and bleeding are observed and that patients receiving sodium valproate should be monitored for platelet function before major surgery.

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¹ Espir, M L E, et al, in *Sodium Valproate (Epilim)—Some Clinical and Pharmacological Aspects*, Proceedings of a Symposium, Nottingham, p 145. MCS Consultants, England, 1976.

² Sutor, A H, and Jesdinsky-Buscher, C, *Medizinische Welt*, 1974, 25, 447.

³ Sutor, A H, and Jesdinsky-Buscher, C, *Fortschritte der Medizin*, 1976, 94, 411.

⁴ Voss, H von, et al, *British Medical Journal*, 1976, 2, 179.

⁵ Stolzis, L, and Scheffner, D, *Bibliotheca Psychiatrica*, 1975, 151, 161.

Survival at sea

SIR,—Your interesting leading article on this subject (30 October, p 1026) states that the recommendation adopted by the Royal Navy was that "the most economical and least risky way of providing water within limitations of weight and space was to take it as such, supplemented by lightweight plastic solar stills."

Recent RAF trials¹ show that the output of the most modern solar still in good sunny weather will be about 750 ml per day. Each still weighs 920 g and occupies 2750 cm³. The same space occupied by chemical desalination kits will produce 12 700 ml of water. It would therefore take 17 good, sunny, distilling days to get more water to drink. On a weight basis, 920 g of chemical desalination kit will produce 3689 ml of water—or five days' output from a solar still.

Desalting apparatus is therefore now the main source of water in RAF liferafts, and solar stills are being withdrawn. Canned water is also supplied to supplement the desalinated water, especially for seasick or injured survivors as the desalted water, though quite safe, is unpleasant to drink on account of its metallic taste. The only real disadvantage of desalination apparatus is that it is expensive—one six-pint (3.4 l) kit costs as much as two solar stills.

However, by far the greatest number of deaths occur from the effects of cold and exposure and the greatest contribution to the preservation of life will be made by the prevention of these dangers following shipwreck or aircraft crash.

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¹ Heald, M A R, *Water Sources in Liferafts—a Comparison*. Royal Air Force School of Combat Survival and Rescue Trials Report SCS 24/75, 1975.

D-Penicillamine

SIR,—Following a brief article in the *Daily Mail* (2 December, p 19) there appears to be consternation among patients being treated with D-penicillamine. As doctors have no way of assessing the facts, I wish to explain. On 18 November Dr D M Geddes, Professor

Margaret Turner-Warwick, and I presented a paper to the Heberden Society in which we reported six patients with obliterative bronchiolitis, a condition rarely diagnosed in adults. Five of the six patients had undoubted seropositive rheumatoid arthritis, and it was this interesting association that was the main purpose of our paper. Four of the rheumatoid patients have died of their lung disease without evidence of vasculitis or other systemic features of rheumatoid disease. Since two of the rheumatoid patients developing this rare syndrome had never received penicillamine, clearly this drug alone cannot be held responsible. Nevertheless, extensive inquiries are being conducted throughout Britain and elsewhere to learn whether there have been other examples of obliterative bronchiolitis in patients treated with D-penicillamine, and the results will soon be available. Also, physicians hope to study the position prospectively, forewarned of the difficulties in diagnosis.

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Preoperative skin preparation

SIR,—It has been stated¹ that shaving the operation site on the day before surgery may encourage the growth of skin organisms in the minor abrasions caused and that shaving immediately preoperatively in the vicinity of the operating theatre is preferable. This hypothesis was apparently not originally based on any experimental data but has nevertheless become an accepted statement in standard medical² and nursing³ textbooks and a journal.⁴ Another report,⁵ quoted in your recent leading article (2 October, p 773), provides some experimental evidence of an increased rate of wound infections in cases in which a longer time had elapsed between shaving and the operation, but the numbers in the study were small and no bacteriological data were recorded.

We were therefore interested in the paper by Mr S J A Powis and others (13 November, p 1166) in which bacterial skin counts are compared from two groups of patients who had been shaved a mean of 20 h and 3.3 h previously respectively. Skin pathogens were present in a much higher proportion of the patients who were shaved earlier. This contrasts with the findings⁶ of a study, supervised by one of us (AHL), in which 65 patients had paired bacterial skin counts recorded immediately after shaving and again the following day before surgery. In 77% there was a decrease in bacterial count in the second culture, while there was an increase in only 9%. The remainder showed no significant change or could not be counted owing to overgrowth of *Proteus* sp. The decrease was in most cases considerable, and Wilcoxon's matched pairs test showed a highly significant difference ($P < 0.001$). The trend was independent of sex, site of operation, hairiness, or whether the patients bathed between the two measurements.

The reason for the difference between these results and those of Mr Powis and his colleague is not clear. In their paper the groups are not strictly comparable as patients were not randomly allocated to early or late shaving, and this was carried out on different wards

and presumably by different people. The study we have referred to, carried out by one investigator, avoided this criticism by using paired data from the same patients and this may explain the contrasting results. Also it is possible that sampling the skin immediately after shaving gives rise to the very high counts which were noted in the data we present owing to the exposure of viable organisms from the deep layers of the skin. Certainly our evidence would not support a policy of shaving the operation site immediately before surgery, and more evidence is needed before this becomes widely adopted. Perhaps the answer lies in abandoning the practice of preoperative shaving and using depilatory creams. The results of Mr Powis and his colleagues and of previous work⁵ certainly support this suggestion.

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¹ Altemeier, W A, in *Infection in Hospitals: Epidemiology and Control*, ed R E O Williams and R A Shooter, p 207. Oxford, Blackwell, 1963.

² Bocock, E J, and Parker, M J, *Microbiology for Nurses*, 4th edn, p 168. London, Baillière Tindall, 1972.

³ Williams, R E O, et al, *Hospital Infection*, p 224. London, Lloyd-Luke, 1966.

⁴ Parker, M J, *Contact*, 1973, p 13.

⁵ Seropian, R, and Reynolds, B M, *American Journal of Surgery*, 1971, 121, 251.

⁶ Linton, J, *Nursing Times*, 1974, 70, suppl, pp 33, 37, and 41.

Antibiotic use in general practice

SIR,—Dr J G R Howie's conclusions from his study (30 October, p 1061) are interesting and might perhaps be paraphrased as showing that the doctors did not rate antibiotics highly in the treatment of sore throat and that they were prepared to give the patient the benefit of the doubt if there were sufficient reasons to do so. The usual reasons seemed to be that there was an important engagement in the near future or the patient was already under stress before the illness started.

It seems to me from studying the figures that apart from these two considerations (that is, excluding patients B7-12) there was remarkable consistency in the rate of antibiotic prescribing by the doctors: nearly all the figures lie between 22% and 44% of doctors, and I believe that this is not a significant difference. It would seem therefore that the appearance of the throat does not affect the rate of prescribing.

Can Dr Howie tell us from his data whether selection of cases for antibiotic treatment is random by individual doctors or whether doctors prescribe as individuals consistently frequently or consistently infrequently?

J B METCALFE

Telford, Salop

*.*We sent a copy of this letter to Dr Howie, whose reply is printed below.—ED, BMJ.

SIR,—Dr Metcalfe is right to look at the influence of doctor-behaviour on prescribing. There were indeed, as stated in the paper, doctors who prescribed antibiotics for all patients or for none of the patients and the distribution of range of individual doctors was

closely similar to that previously reported in a study involving doctors recording details of patients seen in their own practices.¹

The illustrations used in the study to which Dr Metcalfe refers were selected because they appeared to represent the type of throat abnormality over which there is the maximum of present disagreement on prescribing. The fact that most of the figures in the "A" group of patients fell within the range 22%-44% was thus expected. However, at one extreme the abnormality presented proved bad enough to make 93% of doctors decide an antibiotic would be necessary, confirming that there are, of course, occasions when appearance is the main consideration determining treatment.

The short answer to Dr Metcalfe is that the appearance of the throat is important beyond a certain level of abnormality but that below this point all points on the prescribing spectrum are represented, from doctors who prescribe consistently highly, through those whose prescribing patterns appear random, to those who prescribe consistently infrequently. The findings of this study have suggested that patient characteristics of a non-physical nature are yet another potential influence on prescribing habits.

J G R HOWIE

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University of Aberdeen,
Aberdeen

¹ Howie, J G R, *Journal of the Royal College of General Practitioners*, 1973, 23, 895.

Sectional strife

SIR,—I am sad and dismayed every time I pick up the medical journals these days as I read one pundit after another denigrating some section of the profession's activity and, in the name of economic necessity, proclaiming that we can do without that section or cut its activity to the bone.

Over the past few weeks I have read that we need to cut down the money to our "centres of excellence" so that a fairer share of the financial cake may go to the outlying areas. Then the general practitioners are attacked, both for their prescribing habits, their sinful alacrity to delegate after they have been driven by financial incentives into impersonal health centres and enormous group practices, and their failure to give a preventive medical service in between, I presume, their 5-min consultation times. Then the junior hospital doctors are attacked for their ruthless devotion to cash, which has ruined the cash differential between consultants and themselves and thereby emptied the country of any applicants for consultant posts.

The list is endless as each section of the medical community, in despair at the disintegration of its own area of care, blames it on some other section of his profession. The situation is desperate because no one seems to realise that the fault for the economic crisis in the NHS is not ours but is due to the 300% increase in administrators while the overall increase in medical staffing is less than 10%. The population has not increased by 300% so we have roughly the same number of people to look after; thus the crisis is entirely due to overspending on administration, to what purpose?

As a profession we must stop pontificating on one or other section of medicine, which delights the administrators and gives them

the ammunition for endless cuts to the "doers" of this profession while allowing them to extend their own empires. Let us have a truce, let us analyse the others, and let our harassed colleagues get on with their work without any more well-meaning but devastating surveys/studies/critiques of our profession's work. When the administrators have been analysed and decimated then let us start to rebuild, not criticise, our NHS.

S BLACKBURN

Bradford, W Yorks

JHDA

SIR,—May I add my experience to that of Dr R A V Milsted (4 December, p 1391)? During four years in the BMA I have not once received notice of a BMA meeting to elect officers or delegates.

Perhaps if there were no feud between the Hospital Junior Staffs Committee and the Junior Hospital Doctors Association a higher level of interest in representation in the regions would prevent this state of affairs. I do not think this is possible at present. A fundamental difference between the two organisations was pointed up by HJSC officials in a recent letter to you (6 November, p 1136), when they indicated that consideration of the interests of one section of the profession should be subject to those of the others. The JHDA, however, makes no prior commitment on this, for that does not preclude an "adult relationship" between sections of the profession.

But can this difference of opinion be contained by the BMA framework? Doctors who, like Dr Milsted, are more than ready to participate in democratic medical politics should badger their organisations by asking them precisely the questions he asks of Dr Elinor Kapp.

J R SAMPSON

Stockport,
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Junior Members Forum

SIR,—May I make use of your columns to draw attention to the Junior Members Forum 1977? It is planned to hold this in the University of Newcastle upon Tyne during the weekend of 2 and 3 April. As usual, the meeting will have two phases. During the scientific part the subject will be "Positive health—idealism or realism?" which should afford opportunities to discuss the problems and possibilities of preventive medicine and health education. The second part will allow the forum to discuss matters of current and future importance to the profession and affords a chance to influence the policy of the Association.

However, it is hoped that, once again, an invaluable feature of the weekend will be the informal contacts and discussion arising with other members of the forum. Anyone interested in attending should contact their divisional secretary or, in the case of hospital junior staff, the honorary secretary of the Regional Hospital Junior Staffs Committee.

DAVID BELL

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