The occurrence of this incident in a well-run factory suggests to me that many industrial employees may be exposed to unsuspected dangers from inhalation of perchloroethylene as well as to unmerited social stigma from a form of intoxication very similar to that caused by alcohol.

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¹ Rowe, V K, *AMA Archives of Industrial Hygiene and Occupational Medicine*, 1952, 5, 566.

Prevention of hepatitis in travellers

SIR,—During the past six months I have seen six patients who developed acute hepatitis A within 2-6 weeks of their return from third-world countries. They were all young persons in their twenties and five of them had travelled overland to the Indian subcontinent.

In two patients the illness was severe and jaundice persisted for more than six weeks. One patient, a young man of 28 years, developed acute hepatitis A three weeks after his return from a climbing holiday in Nepal. One week later he died from fulminant hepatic failure. Although these patients had had inoculation against smallpox, cholera, and typhoid, none had had immunoglobulin prophylaxis for prevention of hepatitis. Normal human immunoglobulin (gammaglobulin) prevents clinical hepatitis A. Pollock and Reid¹ showed that a single dose of 750 mg of immunoglobulin protects persons working abroad against hepatitis A. Therefore immunoglobulin should be given to all prospective travellers intending to visit countries where hepatitis A is endemic.

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¹ Pollock, T M, and Reid, D, *Lancet*, 1969, 1, 281.

Disopyramide in ventricular fibrillation

SIR,—Reading the case report by Dr T D I M S De Lanerolle and others (2 October, p 795) reminded me of a 61-year-old woman admitted to the coronary care unit at this hospital recently with acute myocardial infarction. The patient developed primary ventricular fibrillation (VF) 6 h after admission and was successfully defibrillated. While she was on an intravenous lignocaine infusion she developed recurrent attacks of ventricular tachycardia (VT) and VF resistant to intravenous procainamide, intravenous alprenolol, and pindolol and quinidine sulphate by mouth. In the first 48 h after admission the patient had 18 attacks of VT and 15 attacks of VF which needed DC shock. Six hours after all the antiarrhythmic drugs had been withdrawn further attacks of VT and VF stopped and the patient was free of cardiac arrhythmias during the next 10 days' stay in the coronary care unit.

Ventricular rhythm disturbances, including VF, have been reported following the use of drugs such as lignocaine, procainamide, quinidine, and psychotropic agents such as phenothiazines.¹ The so-called "response to disopyramide" in the case reported might have been due to the omission of lignocaine and procainamide. Only by performing a controlled trial can one conclude that disopyramide could

be used as an alternative to intravenous lignocaine in acute myocardial infarction with ventricular arrhythmias.

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¹ Krikler, D M, and Curry, P V L, *British Heart Journal*, 1976, 38, 117.

"Babies for sale"

SIR,—The letter from Dr Christine Cooper (13 November, p 1193) was very timely, as this is certainly a matter which needs to be brought into the open. The fact that this "sale of babies" is probably more common in social class 1 or 2 than 4 or 5 does not by any means protect the babies in question from the results of ill-informed and inadequate adoption processes. Those responsible for the placings may be as unaware as the adopters of all the implications of the placement and, even more worrying, of what to do to safeguard the situation if things go wrong. That babies should change hands in the manner of merchandise is repugnant to all caring people, and at a time when by law the adoption process is being subjected to rigorous inquiry and raising of professional standards there is no possible excuse for such illegal exchange to continue. Penalties for so doing should be severe.

Another result of the current and probably continuing shortage of normal, straightforward young babies for adoption is the need for doctors in fertility and sterilisation clinics to look very clearly at the advice being given to their patients. The infertile couple can no longer be advised to apply to adopt a child and the sterilised man or woman can even less count on being able to have his or her family in this way. Far too many vasectomies in inadequately counselled men are followed by an application to adopt. In fact, increasingly this operation is being done after a man has one or two children and as a preliminary to adoption application. The reason given by the couple is usually the social one "to give a home to a child who hasn't parents without increasing the population themselves." This concept has considerable inbuilt hazards, of which those experienced in adoption may be unaware.

To all infertile and sterilised patients today the warning should be given that adoption of a normal, straightforward young baby is likely to be very difficult indeed and that sterilisation on social grounds should not be contemplated by any man who is uncertain that his family is complete.

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Pyorrhoea as a cause of pyrexia

SIR,—It was at the turn of the century that William Hunter introduced the concept of dental sepsis producing signs and symptoms elsewhere in the body. Quite rightly the extreme actions which these views provoked have since been abandoned, but as Drs E Berry and J Silver suggest (27 November, p 1289) perhaps the pendulum has swung too far in the opposite direction. A number of points arise from their article.

In presenting such cases it is vital that the oral examinations of the patients is as thorough and the write-up as meticulous as the medical aspects of the cases. In the paper the descriptions of the oral pathology are vague and the terminology confused. "Pyorrhoea" is scientifically meaningless. It is a lay term and at best implies severe, advanced, chronic periodontal disease. Similarly "periodontitis" is not clinically useful. Periodontal disease is not remotely related to dental caries or dental (alveolar) abscess, although these conditions are mentioned as relevant findings in each case history despite the title of the paper. Descriptions of periodontal disease should be comprehensive and include depths of pocketing around teeth, degree of bone loss, tooth mobility, etc.

The incidence of periodontal disease in the dentate adult population is such that if the authors' deductions are correct one would expect to see a great many cases in which chronic (as opposed to acute) dental sepsis had produced systemic manifestations. It may well be that we need to look again at this topic, and the authors are to be congratulated on drawing attention to this matter. To be convincing, however, such cases must be thoroughly assessed and documented in all respects and follow-up prolonged.

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Fibreoptic bronchoscopy in intensive care

SIR,—Artificial ventilation may markedly interfere with the normal protective mechanisms of the lung. The nasopharynx, which normally filters and humidifies the inspired air, is bypassed. Ciliary action can be impaired by both the presence of an endotracheal tube¹ and by high concentration of inspired oxygen.² These insults can only be made worse by blind suctioning procedures. Areas of mucosal oedema and erosion may be produced and often the left bronchial tree is sampled inefficiently.³ The fibreoptic bronchoscope is like a "suction catheter with an eye" and allows selective and highly efficient removal of secretions from all areas of the bronchial tree.

Dr J S Milledge mentions this use in the intensive care unit (11 December, p 1427). There are, however, further advantages in the use of the fibreoptic bronchoscope in this situation: (1) direct inspection of the airways is possible so that stenotic, traumatised, and inflamed areas can be recognised; (2) sterile wire loops or brushes may be guided into peripheral segments to obtain material selectively for culture; (3) transbronchial lung biopsy can be carried out under fluoroscopic control for definitive diagnosis in patients with bilateral "white-out"; and (4) the bronchoscope may be used to intubate difficult patients by sliding the tube over the shaft of the bronchoscope and guiding it under direct vision between the vocal cords.

Although a number of connections may be modified to allow bronchoscopy of the ventilated patient a commercial adaptor is available (modified 15-mm connector for fibreoptic bronchoscopy—Portex Ltd, Hythe, Kent). Provided the bronchoscope is lubricated (I use 2% lignocaine jelly) it can be manipulated easily without an air leak. In some centres in Japan fibreoptic bronchoscopy is routinely