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 Six hours after all the antiarrhythmic drugs had been withdrawn further attacks of VT and VF stopped and the patient was free of cardiac arrhythmias during the next 10 days' stay in the coronary care unit.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.

C YATES

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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

carried out before extubating patients in the intensive care unit.¹ Although we might have to be more selective in Britain there is little doubt that patient management would be improved by the greater use of this instrument.

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¹ Sackner, M A, Hirsch, J, and Epstein, S, *Chest*, 1975, **68**, 774.

² Sackner, M A, *et al*, *Chest*, 1976, **69**, 164.

³ Sackner, M A, *Chest*, 1972, **62**, 70S.

⁴ Kenkichi Oho, personal communication.

Physicians in training

SIR,—Our surgical colleagues recently set up an association aimed at representing the views of surgeons in training to the royal colleges, DHSS, and the various bodies concerned with postgraduate education. The question of a similar association representing physicians in training was discussed by the Standing Committee of Members of the Royal College of Physicians of London. For many years this committee has been privileged to represent the views of members to the college and to receive copies of all major documents for comment. Although it is concerned with all members, not just those in training, it is always willing to consider suggestions and recommendations from physicians in training for transmission to the college or the Joint Committee on Higher Medical Training. In recent years the committee has initiated study and discussion of topics of current interest—for example, its recent lead in the care of the elderly. It intends to continue to do so. While it will continue to represent the views of all members it would welcome the opportunity to act as a forum for those who are still in training. Matters of concern can be sent to the chairman or honorary secretary at this address.

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Related ancillary staff in general practice

SIR,—I was most interested to read the recent report by Dr B L E C Reedy and others on nurses and nursing in primary medical care in England (27 November, p 1304). It contains one statistic which particularly brings itself to my attention.

In a letter to Dr David Owen in January of this year I wrote: "I have never come across a comprehensive survey either of the number of people (related ancillaries) involved, nor of the estimated cost to the NHS of paying related ancillaries who actually work in their husbands' practices on the same footing as other ancillary staff who currently attract 70% of their salaries into the practice. . . . What I suspect, you see, is that there are relatively few wives who work in their husbands' practices, apart from normal wifely (non-qualifying) duties, which I agree with you have to be excluded. I think this has come about for a variety of reasons. . . . Anyone arriving in general practice

since 1966 would have seen the financial disadvantages of getting involved. . . . Some of those who were involved before 1966 have left."

I do not therefore find it tremendously surprising that "very few nurses were the wives of general practitioners," but even to me the figure is small. What is surprising, and appalling, is that so much time, energy, and money can have been expended over the past 10 years by the BMA in discussing and by the DHSS in resisting the claims of some 145 women, all of them trained nurses, to be paid for doing a legitimate job in the field of primary medical care. I am told (Dr David Owen, 5 April 1976) that "we have always feared abuse if doctors could employ members of their own family, and we have never so far been able to find any way of completely avoiding this unless we had a disproportionate system of inspection." Might I suggest that what is "disproportionate" is the amount of concern and fear present in the DHSS about the moral standards of 145 professional women?

While I accept that the figure of 145 will probably be augmented by a certain number of women who are not qualified nurses but hold other legitimate qualifications and by a few who did not reply to the survey, the cost to the NHS of paying currently employed relatives would be very small. Is it not now time for the Elephant and Castle to withdraw gracefully from their intransigent position and allow reimbursement of currently employed related ancillary staff?

Incidentally, I think that I should voice my disagreement with the conclusions reached by Dr Reedy and his colleagues concerning the reasons for employment of practice nurses. In my own experience attached nurses are perfectly adequate and the two categories can and do complement each other. District nursing sisters are better geared to carry out nursing procedures on the district, while other activities such as nursing tasks on surgery premises, screening, and supervision of record keeping within the practice can be more efficiently undertaken by a practice nurse. The only field in which, through no fault of their own, attached nurses are "inadequate" is the small one of immunisations, which the bureaucrats have decided is a highly dangerous procedure which must be supervised by a registered medical practitioner.

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Points from Letters

Liver damage due to paracetamol

Dr F E DE W CAYLEY (Bevendean Hospital, Brighton) writes: I am continually attending clinical meetings on liver damage due to paracetamol and I wonder if the time is ripe to consider whether this drug should be obtainable only on a doctor's prescription as it seems a much more dangerous drug than was originally thought.

"Nurse consultants"

Dr D M BOWERS (Neasham, Darlington) writes: . . . This situation is completely out of hand. The Salmon scheme was instituted specifically to grant nurses the illusion of "professional equality" with doctors and at

the same time doctors are conventionally required to practise a complex ritual of flattery and self-abasement in order to "maintain a good relationship" with nursing staff. In many hospitals "reporting on medical staff" is part of a nurse's duty, and in the event of a dispute between a doctor and a nurse it is absolutely inconceivable that the nurse would not be officially upheld, even though it might be privately admitted that the doctor was right. In casualty departments it is a bigger crime to be disliked by a nurse than it is to kill a patient. We can read in a handbook that "procedures outside [the nurses'] general training remain the responsibility of medical staff, but nevertheless they are done to a standard which often exceeds anything that medical staff are capable of."¹ No less an authority than my own medical defence organisation once advised me that "it is now generally accepted that casualty officers work under the clinical supervision of nursing staff." . . .

¹ Hardy, R H, *Accidents and Emergencies—A Practical Handbook for Personal Use*, p 40. Oxford, Dugdale, 1976.

"Part-timer"

Dr ANNE SAVAGE and others (London N8) write: All publicity (they say) is good, so we are grateful to Minerva (4 December, p 1395) for her reference to the newsletter *Part-timer*. However, she does seem to suggest that our aim is to be a cross between Universal Aunts and a marriage guidance council, whereas it is much wider than that. Correspondence has already revealed a considerable interest in part-time appointments, and not only from potential employees. There is clearly much variation in different parts of the country. . . .

War service

Dr J SHAW (Cheltenham) writes: I see that your statement with regard to war service (27 November, p 1337) applies only to the 1939 war. While not wishing to make an issue of it in the present economic state of the country, shouldn't the volunteers of the 1914-18 war be considered?

Deputising services: GPs and consultants

Dr S J JACHUCK (Newcastle upon Tyne) writes: . . . Dr T F Davies (4 December, p 1376) questions the quality of primary care when one-third of the practitioners use a deputising service. He has lost his identity by being in the solitary confinement of the hospital. He has not even realised that all hospitals run a very efficient deputising service for all their consultants which has gained national acceptance. All patients are referred to or admitted under a consultant, but a good proportion of referrals and most emergencies out of hours are dealt with by deputies to the consultant who are often not even registered practitioners. I am sure Dr Davies must have acted as a deputy without realising that he was working with an organised deputising service for hospital practitioners. At least the doctors working for the general practitioners' deputising service are all qualified and fully registered medical practitioners. . . .