reported to arrest haemorrhage from oesophageal varices in a proportion of cases for periods ranging from hours to months,¹⁻⁶ but haemorrhage recurred in some patients when the cannula was removed.^{2,4,6}

The effectiveness of thoracic duct cannulation for bleeding oesophageal varices is still a controversial matter. In spite of this, I think that the policy that should be adopted is to perform cannulation of the thoracic duct in patients not fit for major emergency operation. If this minor palliative procedure succeeds in preventing further bleeding the patient can be better prepared for a portacaval shunt operation that can be conducted a few days after his general condition has improved.

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¹ Dumont, A E, and Mulholland, J H, *Annals of Surgery*, 1962, **156**, 668.

² Bowers, W F, et al, *Journal of the International College of Surgeons*, 1964, **72**, 71.

³ Cueto, J, et al, *Annals of Surgery*, 1967, **165**, 408.

⁴ Kessler, R E, et al, *Gastroenterology*, 1969, **56**, 536.

⁵ Dumitrescu, I, et al, *Chirurgia (Bucharest)*, 1973, **14**, 529.

⁶ Datta, D V, et al, *Gut*, 1971, **12**, 48.

Diabetic ketoalkalosis: a readily diagnosed non-entity?

SIR,—We have watched with interest the reaction to Drs K C Lim and C H Walsh's recent short report on this subject (3 July, p 19). While reluctant to perpetuate the correspondence, we feel that a challenge should be made to this new term.

We would suggest that in all the cases cited by Drs Lim and Walsh, Dr Elaine B Melrose and others (24 July, p 237), and Mr R Shirley and Dr Jennifer V Martin (16 October, p 943) to support this new entity of diabetic ketoalkalosis an alternative explanation on the basis of concurrent pathology is possible. Naturally the clinicians concerned must remain the final arbiters in a decision as to the validity of our alternative proposals.

In the prime paper Drs Lim and Walsh explain the metabolic alkalaemia on the basis of gastrointestinal losses and, in the second case, the additional factor of alkali ingestion.

In regard to the letter from Dr Melrose and her colleagues we feel that a closer examination of the case is required before it can be used as an example of the condition. While it was clinically similar to the two patients in the original paper, we think the biochemical results and interpretation may be erroneous. Recalculation of the results from the given P_{CO_2} and pH show that the standard bicarbonate should be approximately 25 mmol/l (assuming a normal haemoglobin concentration). Thus this is definitely not a metabolic alkalaemia and a respiratory cause is likely.

In the case reported by Mr Shirley and Dr Martin, unlike Drs Lim and Walsh's cases, the metabolic alkalaemia was not corrected on treatment of the diabetes. Our view is that this set of blood gas results may be shown by a patient with chronic obstructive airways disease whose normal compensated hypercapnic state has been disturbed by measures which reduce the P_{CO_2} . Unfortunately we are given no details of this aspect of the case.

We are delighted to see the encouragement of acid-base investigation in all cases of diabetic ketosis and appalled by its absence on occasion. These patients illustrate how mixed and unexpected acid-base disturbances can

present and the fallacy of assuming single pathology which may dictate inappropriate treatment. However, we feel that such cases are the exception rather than the rule and wonder whether the new term "diabetic ketoalkalosis" may not be best avoided in favour of an accurate description of the individual patient's problems, lest it become the latest popular diagnosis.

We would like to end by observing that an alkalosis was not demonstrated in any case, only an alkalaemia.

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Safety for children

SIR,—Apropos your sensible leading article (9 October, p 833) in which you point out that Britain has the worst child pedestrian casualty rate in Western Europe, could I suggest that when a motorist who runs over a child says that the child did not give him a chance the reply should be that he should not have taken or needed one. Surely it is the business of adults to avoid injuring children as they go about their business rather than that of children to be taught prematurely that life is a matter of safety first rather than exploration of the environment.

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Continuous fetal monitoring in the ambulant patient

SIR,—Dr Anna Flynn and Mr John Kelly (9 October, p 842) state that "until now, because of technical limitations, continuous fetal monitoring in labour has meant confining the patient to bed." This is not strictly true, as the technical ability to use telemetry for signals of this nature has been available for quite some time.^{1,2} The real limitation is financial, since a commercial system will cost in the region of £1500 for the telemetry alone, while home-made devices, though low in component cost, absorb considerable resources in terms of technical expertise.

It is not denied that mobility may confer certain advantages to patients in the first stage of labour and that a technique of monitoring which allowed ambulation might encourage obstetricians to keep their patients ambulant. However, we do suggest that the system described is not necessary and because of its expense may be counterproductive to encouraging ambulation. We have developed and are currently evaluating a small battery-powered warning monitor under a grant from the Equipment, Research, and Development Fund of the Scottish Home and Health Department. The fetal heart is detected by electrocardiography and, in its present form, the device is designed as a low-cost portable bedside monitor which has the advantage of not producing large quantities of paper to prove that progress is normal. However, we intend to evaluate a simplified version which could be worn by an ambulatory patient.

While this device simply gives warning of the presence of abnormal fetal heart rate patterns, which then require more detailed

study on a recording fetal monitor, we feel it may be a more cost-effective approach towards extending surveillance to ambulatory patients not in "at risk" categories.

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¹ Weller, C, and Manson, G, in *Biotelemetry*, ed H P Kimmich and J A Vos, p 13. Leiden, Meander, 1972.

² Manson, G, *Electroencephalography and Clinical Neurophysiology*, 1974, **37**, 411.

Is the cholera pandemic waning?

SIR,—Your leading article (14 August, p 390) on the waning of the cholera pandemic notes its involvement of "Africa south of the Sahara (probably for the first time in history)." Lest this suggestion that it is the first time trans-Saharan Africa has been affected is taken as correct, evidence to the contrary should be noted. Richard Burton experienced the ravages of cholera on the East African coast at Kilwa. James Christie in his classic work¹ described the cholera epidemics of East Africa, including their extension to the remote inland parts of Central Africa,² while Pankhurst³ has recorded the many epidemics of cholera in Ethiopia, which must have extended more widely. Finally, for West Africa, which Hirsch⁴ recorded has never been affected, Bowesman⁵ described the epidemic of cholera in Senegal and Gambia in 1869. This was referred to *The Times* while it was raging and Bowesman notes other mentions of this epidemic which, till he wrote, was unrecorded in the *Index Catalogue* and other indexing and abstracting sources. Curiously enough Dr Bowesman's own note seems to have escaped attention.

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¹ Christie, J, *Cholera Epidemics in East Africa*. London, MacMillan, 1876.

² Davies, J N P, *East African Medical Journal*, 1959, **38**, 1.

³ Pankhurst, R, *Medical History*, 1968, **12**, 262.

⁴ Hirsch, A, *Handbook of Geographical and Historical Pathology*. London, New Sydenham Society, 1886.

⁵ Bowesman, R, *East African Medical Journal*, 1959, **38**, 621.

Computer interrogation of patients

SIR,—I wonder whether Dr A L Jacobs's letter (2 October, p 814) is based upon his own practical experience of using computers in this manner or merely an assumption of some fundamental medical ethic.

We have been experimenting with the use of computers in this mode for the past six years in attempting to discover what actually happens during the doctor/patient interaction. It is now being routinely used in one of our medical outpatient clinics. In one of our earlier experiments with bronchitis patients we interviewed the patients as to their opinion. All of them preferred the computer terminal asking the questions to the doctor. The reasons were clearly spelt out: (1) the atmosphere was relaxed and friendly; (2) the machine did not shout at them or become irritable; (3) they did not feel they were wasting the great man's time; (4) they could ask for the question to be repeated without feeling foolish; (5) they could