drug she noted a marked increase in libido, which she could only relieve by masturbation. She stopped taking the tablets and the effect dwindled within a day or two, but the whole episode led to a great deal of guilt and self-reproach in subsequent depressive phases (the patient being a devout Roman Catholic). At the time, however, it was considered that this might have been a purely manic symptom and not due to chlorprothixene. Her "manic" phases were later partially controlled with prothipendyl hydrochloride ("tolnat") 40 mg. t.d.s. In July, 1963, chlorprothixene 30 mg. t.d.s. was again prescribed and within a few days she noticed increased libido and she again resorted to masturbation. The effect dwindled rapidly once she stopped taking the drug, even though her manic phase continued for another week, hence one must conclude that it was an effect of the drug.

—I am, etc.,

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- Heer, H., *Z. Urol.*, 1961, 54, 519.
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Dental Anaesthetics

SIR,—Dr. W. G. Dawson is the sixth on record as providing tracheal intubation anaesthesia for ambulant patients in the dental surgery (August 31, p. 565). I applaud his adherence to the first principles of safe anaesthesia while disagreeing with him about policy and position. The sitting position has proved safe in thousands of cases, who benefit from reduction of blood loss. It is more physiological in cases of heart failure, emphysema, or obesity. Intubation soon becomes easier than in the supine patient.

The *laissez faire* policy he recommends has already failed to bring about general improvement in dental anaesthesia, progress in which has lagged far behind hospital practice.¹ I wrote, without contradiction, in the *British Dental Journal*:² "It is unfortunate that . . . dentists should appear to be largely uninterested in advances in dental anaesthesia which they themselves cannot administer."

When anaesthetic mishaps occur it is convenient to blame the machine, but the man is more important. Free choice of anaesthetist does not really exist for dentists, basically because of Ministry policy still based on the conditions of 1948, reflected in the regulations for anaesthetic fees. The best interests of the patient and the community are not being well served by restricting dental anaesthesia to non-specialist methods. Future anaesthetic mishaps will be followed by the question—could they have been prevented by intubation? The probable answer will be yes.

Progress in dental anaesthesia depends on closer co-operation between dentists and specialist anaesthetists. To promote this I recommend that:

1. The Ministry should regard dental surgery work by specialist anaesthetists

as nominally equivalent to "domiciliary consultations."

2. The extraction fee should be increased when the anaesthetic is given by a specialist, in recognition of the better standard of dentistry which will result.

3. The regulations concerning "special" — i.e., endotracheal — anaesthetics should be revised. In my opinion the extraction of 10 or more teeth indicates intubation.

4. The limitations of non-intubational methods of anaesthesia where multiple extractions are concerned should be clearly acknowledged and taught. At the B.D.A. Annual Meeting in Oxford on July 26 Dr. J. G. Bourne recommended a limit of one and a half minutes for "traditional" dental surgery anaesthetics.

5. The dentists should consider whether or not they wish to be trained to perform tracheal intubation.

The Ministry's policies have led to wilful neglect of the established principles of anaesthesia for the surgery of the mouth. The known results of this fall far short of what could and should be achieved. They are listed as follows:

(a) 132 dental anaesthetic deaths in 10 years (as reported by Dr. V. Goldman at the B.D.A. meeting held in Oxford on July 26).

(b) An unknown number of damaged brain and lung cases.

(c) Long queues at the hospitals for work which could be carried out in the dental surgery, but for professional and public concern about dental anaesthesia.

(d) A poor standard of dentistry for the anaesthetized patient because of the race against time imposed by non-intubational methods and the poor operating conditions they provide.

The existing specialist anaesthetists could easily improve on all these results but have not been asked to by most dentists.—I am, etc.,

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REFERENCES

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Cadaveric Renal Transplants

SIR,—In the recent papers on human cadaveric transplants by Dr. K. A. Porter and his colleagues and by Mr. R. Y. Calne and his associates (September 14, pp. 639 and 645) priority for a well-documented series of cadaveric renal transplants is assigned to Hume and his co-workers.¹

It is not clear, however, that they are aware of a Canadian report in 1954 of an apparently successful cadaveric renal transplant by Drs. G. Murray and R. Holden.² While Drs. Murray and Holden acknowledged the possibility that the patient in question might have regained her health independently, nevertheless they described a clinical course of events which makes this seem unlikely, and which leads one to attribute the

salutary outcome of the case to the transplanted kidney.—I am, etc.,

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REFERENCES

- Hume, D. M., Merrill, J. P., Miller, B. F., and Thorn, G. W., *J. clin. Invest.*, 1955, 34, 327.
- Murray, G., and Holden, R., *Amer. J. Surg.*, 1954, 87, 508.

Emergency Suprapubic Catheterization

SIR,—A common emergency admission to hospital is the elderly man with an acute retention of urine. When this is secondary to a benign prostatic enlargement some surgeons advocate immediate prostatectomy as the treatment of choice; Wilson Hey in 1945,¹ and others since, have shown that this is safe. Nevertheless a widely adopted procedure is first to catheterize the patient per urethram; next, to maintain closed bladder drainage for one or more days whilst a full pre-operative assessment is made; and then, if he is fit, to carry out a formal prostatectomy during a routine theatre list.

Urethral catheterization is uncomplicated and relatively simple on most occasions; but occasionally great difficulty is encountered and not even the finest plastic catheter (for example, Gibbon's) can be inserted. Repeated unsuccessful instrumentation traumatizes the prostatic urethra and causes oedema, if not frank haemorrhage. The passage is consequently narrowed still further and bacterial infection is encouraged. At this stage it is reasonable to employ a suprapubic approach to the bladder; an excellent modification is the method described by Riches,² but it requires a special trocar-introducer and catheter. Moreover Riches's technique is rather specialized and beyond the scope of junior medical staff—particularly when it is not used routinely, and therefore not demonstrated to them, by their seniors.

An alternative procedure is to drain the urine with a lumbar puncture needle inserted into the bladder from immediately above the symphysis pubis.³ This carries several disadvantages, however, and an important one is that the rigidity of the needle prevents its point from remaining safely inside the bladder as the latter empties and contracts. The method described below is a simple variation which can be used by a house-surgeon, although it should be emphasized that it is not intended as a substitute for urethral catheterization.

Only a minimum of readily available equipment is required. This includes an intravenous needle of reasonable size (e.g., size 16 B.W.G.) and a "polythene" catheter which is capable of being threaded through the needle (e.g., size 1 with an external diameter of 1 mm.). The catheter should be long enough to stretch from a position within the patient's bladder to a drainage bottle, or plastic bag, at the side of the bed.

Having shaved and prepared the suprapubic skin a little local anaesthetic is in-

jected subcutaneously one inch (2.5 cm.) above the symphysis pubis. One end of the catheter, with three or four side-holes cut in it, is threaded through the hub of the needle and partly down its lumen. The needle point is now thrust obliquely downwards through the anaesthetized part of the skin and into the distended bladder. Urine immediately starts to flow down the catheter, which is quickly threaded along the needle until an estimated four to six inches (10-15 cm.) lies inside the bladder. Taking care not to dislodge the catheter, the needle is now withdrawn from the bladder and abdominal wall. A piece of adhesive strapping will hold the catheter in position and its distal end is inserted into a drainage bottle.

After 24-48 hours of drainage, oedema of the prostatic urethra will have settled and a further attempt at urethral catheterization can be made; or a prostatectomy, if now indicated, can be performed.

—I am, etc.,

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REFERENCES

- 1 Hey, H. W., *Brit. J. Surg.*, 1945, 33, 41.
- 2 Riches, E. W., *Lancet*, 1943, 2, 128.
- 3 Aird, I., *A Companion in Surgical Studies*, 1949, p. 957. Livingstone, Edinburgh.

Standardization of Electrical Outlets

SIR,—Dr. J. H. Holland's letter (August 17, p. 445) calls for standardization of electrical outlets, a change which will take time. When a new hospital was built in this city and equipped throughout with the then new 13-amp sockets much irritation was caused to visiting doctors whose apparatus was invariably fitted with round-pin plugs. The difficulty was overcome by providing wards and departments with portable boards, each carrying one two-pin 5-amp, one three-pin 5-amp, and one three-pin 15-amp socket, all connected at the back to one cable carrying the standard hospital type of plug. Any type of apparatus could thus be connected to the hospital outlets without changing plugs. The cost was small and the convenience great.—I am, etc.,

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W. G. S. HOPKIRK.

Radiation Hazard to Patients

SIR,—Dr. A. C. Glendinning's letter (September 21, p. 745) draws timely attention to some of the difficulties of implementation of the second report of the Adrian Committee¹ which face the diagnostic radiologist.

Radiologists must carry considerable responsibility in ensuring the proper use of ionizing radiation in the departments they control, in the light of the mingled technical, administrative, and clinical recommendations contained in this report. Under ideal conditions of direct consultation between clinician and radiologist no great problem arises. In practice, as Dr. Glendinning points out, the initiation of x-ray examinations by so many who are not conversant with the report creates serious difficulties and often places the individual radiologist in an invidious position.

Although I do not agree that a *directive*, from any authority, could provide either a proper or an effective solution to this problem, undoubtedly there exists a need for a deeper awareness of the clinical aspects of the Adrian Committee's findings. The task of achieving this has, in the event, been left to the radiologist; I am sure that Dr. Glendinning is not alone in feeling the need for some support in this respect.

The British Institute of Radiology, through its Radiation Protection Committee, has maintained a deep interest in all the implications of the Adrian Report; it is pertinent here to mention that a publication by the Institute is envisaged, with the aim of promoting wider application of the recommendations than has hitherto proved possible.—I am, etc.,

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REFERENCE

- 1 Radiological Hazards to Patients; 2nd Report, H.M. Stationery Office. London, 1960.

Psychiatry and the Medical Curriculum

SIR,—Dr. C. J. Lucas's letter (September 28, p. 807) implies that medical students who have a psychological disturbance during their training are discriminated against in examinations and when they apply for pre-registration posts. It is suggested that there should be "appropriate mental health facilities" to which the distressed student could turn outside the teaching hospital. It is questionable whether these assumptions are true. Many students are distressed when they meet disaster, whether physical, mental, or social, in a patient for the first time. Some may have difficulty in learning not to become personally involved in the patient's problems, but the support and guidance a student receives from his teacher in overcoming emotional problems of that nature should not be underestimated. It is my experience as medical officer to a clinical school that psychological difficulties frequently are dealt with successfully by teaching members of the staff. Where specialist psychiatric help is needed, this is always given unreservedly and discreetly by other members of the staff. I believe it is doubtful whether a body outside the teaching hospital is necessarily better qualified to deal with these problems. The really important thing is that a student knows that he has easy access to help and that he can find somebody with whom he can discuss his problems. I have not found that the suggestion that an episode of psychiatric illness during his medical career is held against the student when he applies for a pre-registration post is true. If anything the staff falls over backwards to help a student who has had emotional difficulties, provided of course that his professional qualities are of the necessary standard. I have found that examiners without exception show great understanding if

they have been forewarned of emotional troubles in a candidate.

If a student persistently fails to adjust in spite of readily available help within the school, the probability is that he is in the wrong profession and that it would be better for him and for his patients if he chose another career.—I am, etc.,

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Protein Intake in Renal Failure

SIR,—In your report on the Symposium on Acute Renal Failure at the Royal Free Hospital (September 21, p. 739) my own contribution has been slightly misquoted, and I shall be grateful for the opportunity of correcting any wrong impression which may have been conveyed.

The work on ¹⁴C-labelled urea was carried out by Dr. Alan Robson of this department; he studied patients with stable chronic renal failure, but the results are probably applicable to acute renal failure in patients without massive trauma or infection.

We were not attempting in these studies to assess the value of anabolic steroids, which has already been extensively studied, but to decide the ideal protein intake in patients who were receiving these drugs. We found that an increase in protein intake above 20 g. per day resulted in an increased urea production rate in all of the five patients studied. It does not necessarily follow that 20 g. of protein is the ideal diet, since the maximum calorie intake we can achieve in our patients with this diet is about 1,350 calories. The advantages of a low rate of protein breakdown must therefore be weighed against an appreciable calorie deficit.

The results of Dr. Robson's experiments will be reported in greater detail in the report on the Second International Congress of Nephrology, Prague, 1963.—I am, etc.,

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POINTS FROM LETTERS

Postgraduate Training in Obstetrics

Mr. G. DALLEY (The West Hill Hospital, Dartford, Kent) writes: For the information of Dr. John Bush (September 28, p. 806) the above more or less local hospital is approved by the Postgraduate Federation for residential courses in obstetrics for general practitioners, a fact of which he is apparently unaware. This arrangement has only been in existence for about a year, but even so we have had surprisingly few inquiries. One wonders whose duty it is to publicize such things.

Hospital Manners

Dr. D. W. R. LYLE (Burgess Hill, Sussex) writes: Let us have one detailed and signed letter on the day of the patient's discharge from hospital, and not one or more interim reports followed weeks later by the information we require.