with the agent in question this is a price that must be paid.

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1 De Klippel N, Sennesael J, Lamote J, Ebinger G, de Keyser J. Cyclosporin leukoencephalopathy induced by intravenous lipid solution. *Lancet* 1992;339:1114.

Treating tuberculosis in developing countries

EDITOR,—Botswana's national tuberculosis programme has an impressive completion rate of over 90% using short course chemotherapy and daily supervised treatment.¹ Most developing countries could not, however, implement such a programme.

There are an estimated 17 million active cases of tuberculosis worldwide, 60% of which are in Asia. Nepal has a prevalence of active tuberculosis of 5/1000.² We accept that short course chemotherapy is the cornerstone of tuberculosis control and that although the drugs are relatively expensive it is a highly cost effective intervention at US\$1-4 per year of life saved.³ However, successful implementation of a national programme requires political commitment and government structure to provide for cost of drugs, training, secure drug supply, cooperation, and integration of tuberculosis control into the general health service; it also requires diagnosis based on smear microscopy, and proper recording and reporting of patients. All of these conditions have been met in Botswana, which has then been able to introduce short course chemotherapy successfully and go one step further with daily supervised treatment.

The situation in Nepal and many countries in southern Asia is very different. Firstly, the geographical terrain in Nepal is very difficult. Secondly, Nepal is one of the poorest countries in the world: the gross national product per capita was US\$170 in 1988 compared with US\$940 in Botswana.⁴ The health infrastructure is poorly developed. Many people live two hours to two days from the nearest health post. Each health post in Nepal serves 15 000-20 000 people. Government expenditure on drugs was 3.3 pence per person in 1991,⁵ hence annual drug supplies in health posts run out in a few months. Thirdly, social conditions are very poor in Nepal: 71% live below the poverty line (income below US\$150 per capita a year)⁶ and literacy rates are low, estimated at 36% in 1989,⁷ in comparison to Unesco's figure of >95% in Botswana.

Kumaresan and Maganu admit that the cost of their programme needs to be evaluated. If their programme proves cost effective, it may well be an ideal role model for tuberculosis programmes in the faster developing countries of south Asia—Thailand and Malaysia, for example—but for countries such as Pakistan, Bangladesh, and Nepal such a programme is unfortunately a long way off.

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King's College Hospital's A&E department

EDITOR,—We are writing to express our concern about John Warden's news article on the accident and emergency department at King's College Hospital.¹ The short title on the cover was inappropriate, the actual title was misleading, and the text contained several errors of fact. The net effect was a misrepresentation of the high standard of clinical care provided in the department.

Camberwell Health Authority, the region, and central government have long recognised that the physical environment of the accident and emergency service at King's College Hospital is unsatisfactory, and the long argued case for investment has at last been acknowledged. Our other main problem has been the potential for long delays for those awaiting inpatient admission, but several recent initiatives have led to improvements. The establishment of an emergency admission ward, coordination of bed management, reductions in length of stay in hospital, and increased efficiency of discharge planning now enable more than 90% of patients to be admitted from the department within four hours of a bed being requested.

The two patients specifically mentioned in Warden's report were both under the clinical care of on call medical teams. One of the patients was left in the accident and emergency department by ambulance staff without referral to the nursing staff, and we acknowledge that there was thus an unacceptable delay before clinical assessment. But his subsequent death occurred in the department only because inpatient admission was difficult to arrange and not because of any lack of care. The 75 year old patient was receiving appropriate nursing attention and frequent monitoring but fell from the trolley in the department while awaiting admission. His death did not occur "during transfer to Guy's Hospital" but four days later.

Accident and emergency care at King's College Hospital has an excellent reputation, and in neither case considered by the coroner was a causal link suggested between the unfortunate outcomes and deficiencies in clinical care. Indeed, the coroner's concern was not about the accident and emergency department itself but about the intolerable additional strain imposed on accident and emergency staff by the continuing long delays for admission from an already overcrowded department.

An accident and emergency service is only as good as its related facilities, and these need improvement. Unfortunately, however, reports about South East Thames Regional Health Authority's inquiry failed to acknowledge publicly the remarkable efforts made by many staff over many years in enabling a chronically under-resourced accident and emergency department to cope with the additional strain of long delays to admission. These efforts are now being supported by capital investment in the department and by improvements in staffing. This is not the "new casualty regime" suggested in the title of the article but a new regime in support of the department.

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1 Warden J. New casualty regime at King's College Hospital. *BMJ* 1992;305:437. (22 August.)

Partners in practice

EDITOR,—As a community health doctor working in child health I have greatly enjoyed the series on partners in practice; many of the articles have lessons for all in the new NHS.¹ I looked forward to

a discussion of partnership with community health doctors in the management of chronic disability, child protection, and health promotion in the child and adolescent population in the community, as well as the integration of primary and secondary care. To my regret these important topics were not mentioned although there was reference to partnership with hospitals, patients, the family health services authority, health visitors, and members of the primary health care team. I was surprised, too, that with regard to advising schools on pupils' smoking, the two main groups of health professionals with this skill already working in schools—school medical officers and school nurses—did not merit a mention.

Many community health doctors are based in health centres with general practitioners, and with their skill in developmental, social, and educational paediatrics they can serve the interests of children best by conducting a continuing dialogue with general practitioners. To give some examples, one in five children have special educational needs at some time during their school careers. Community health doctors have a statutory responsibility under the Education Acts 1981 and 1991 to collate medical factors and advise the education authority accordingly. General practitioners may become aware early on of families' anxieties about their children's difficulties at school, and discussion with community health colleagues would be helpful in this. Similarly, general practitioners could share with community health doctors their concerns regarding developmental difficulties or suspicions of child abuse in order to benefit from their specialist skills. We would welcome such a partnership with our general practitioner colleagues.

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1 Lawrence M. Caring for the future. *BMJ* 1992;305:400-2. (15 August.)

Reducing pain associated with injection of lignocaine

EDITOR,—J A H Davidson and S J Boom report that warming lignocaine reduces the incidence of pain on injection.¹ An alternative, simple method is to apply counter-irritation.^{2,3} The operator scratches the skin near the site of injection for one or two seconds before and during the injection. Bourke showed that this effectively reduced awareness of the needle and the pain associated with injection of local anaesthetic solution.¹

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EDITOR,—Dental surgeons collectively give many more local anaesthetics annually than are given in any other specialty in medicine, and it is disappointing that work in dentistry aimed at making the administration of local anaesthetics as painless as possible—for example, by warming the anaesthetic, which has been widely accepted in dentistry for many years—has been largely ignored by the medical profession.¹

In particular, the use of extra-short, ultrafine needles (30 gauge), which are strong enough for