matters to the professional competence of caring and concerned doctors.

T J HAMBLIN

Royal Bournemouth Hospital,
Bournemouth BH7 7DW

1 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)

EDITOR,—It would be impossible to produce a satisfactory law allowing euthanasia: experience of the abortion law should have convinced most objective people that this is the case. Abortion law is suffering wholesale abuse, despite the safeguards written in that depend on the integrity of doctors and the supervisory responsibility thought to reside in the General Medical Council, BMA, and law enforcement agencies. Though aware of the situation, parliament—the author of the act—has not allowed amendments to be made that would correct matters.

This taken together with information coming from the Netherlands shows that we dare not permit legislation on euthanasia. Unfortunately, powerful pressure groups have perfected techniques to take our society into things that as a whole it does not approve of.

Richard Smith's editorial is a standard gambit.¹ I think it was David Owen who, in a moment of candour, admitted that royal commissions can be set up to produce the result wanted by those who set them up. This would be followed by a private member's bill (with government help, probably) with specious promises of proper safeguards, which would be passed, implemented, and put into practice with benign "Nelsonian" supervisory neglect, tranquillity being marred only when some troubled person protested about a specific case that could not be hushed up.

In view of Smith's revelations that a group that met at Leeds Castle was determined to circumvent "moral" opponents,² we should not be deluded into thinking that any debate that takes place in journals like the *BMJ* is free of management. This aspect of so called press freedom—complete freedom of action for editors—is perhaps more worrying than the antics of the editors of the tabloid press persecuting erring public figures.

J FINDLATER

Silverdale,
Carnforth,
Lancashire LA5 0TT

1 Smith R. Euthanasia: time for a royal commission. *BMJ* 1992;305:728-9. (26 September.)

2 Smith R. Promoting sexual health. *BMJ* 1992;305:70-1. (11 July.)

EDITOR,—The case of Dr Nigel Cox is a sad indication of the failure of transmission of accurate information on pain relief. Apparently the patient was considered no longer able to "absorb the amounts of diamorphine that Dr Cox was giving her"—up to 50 mg an hour.¹ That amazed me. I was working in a hospice 12 years ago, and I remember that, even then, a young woman with an inoperable carcinoma was stabilised on 500 mg diamorphine orally ever three hours, and on that dose she was able to go home and care for her baby. She was completely pain free and had a reasonable quality of life for several months.

Nowadays we tend to use oral morphine instead of oral diamorphine, and the equivalent dose would be 750 mg every three hours. Any amount of diamorphine can be used in a syringe pump as diamorphine is extremely soluble in a tiny volume of fluid. Patients should receive the amount needed to control their pain, and there is no ceiling. This simply is not appreciated by most medical and nursing staff. If patients' pain is properly treated the dose received will not impair their respiration and certainly will not kill them. This patient was receiving a totally inadequate amount, in my view.

Another misapprehension is that treating pain effectively always shortens life. Paradoxically, if pain is adequately relieved the quality of life is so much better than patients often live longer. Many doctors do not seem to realise that morphine can be used just as effectively for symptoms of chronic degenerative conditions and for the intractable dyspnoea of terminal heart failure or chronic respiratory disease as for cancer.

Why should patients in hospices be the only ones to have their symptoms relieved effectively? In the case of frail elderly people, tiny doses such as 1-2 mg every four hours may be adequate.

I think it would be a tragedy if euthanasia was legalised, and a total abrogation of our responsibility to care for patients with chronic sickness and terminal disease. Elderly people and those with chronic sickness already feel threatened by the reversion of responsibility for their care from health authorities to local authorities next year, which is a complete reversal of the National Health Service Act of 1948. They would feel even more threatened if they thought that doctors had the power legally to terminate their existence at any time that they wished. Our duty is to care to the end and not to duck out of the challenge of chronic suffering and pain. It will be expensive in terms of time, money, and compassion, but ultimately it is the only truly compassionate way.

LESLEY A M WILLIS

Trinity Hospital,
Taunton,
Somerset TA1 3JL

1 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)

Propofol infusion in children

EDITOR,—I wish to correct inaccuracies in T J Parke and colleagues' paper and to comment on their conclusions.¹

Two of the cases—cases 4 and 5—were treated in the intensive care unit in which I work. The patient in case 4 received propofol for a total of 64 hours and died almost three days after the infusion was stopped, a fact not emphasised in the report. In case 5, at the time of his acute deterioration the patient had all the features of septicaemia with a core temperature up to 41°C and a core-periphery deficit of 14°C. He showed considerable vasoconstriction, had rigors, and was developing early renal failure with oliguria, granular cast formation, and rising blood urea concentrations. His acute deterioration occurred in relation to the intravenous injection of the first dose of ceftazidime.

These deaths were reported to the Committee on Safety of Medicines, and we decided to look formally at the metabolic effects of propofol infusion in children. This was organised jointly by the intensive therapy unit and the university department of paediatrics under Professor Aynsley-Green. Ethical committee approval was given for such a study. We have now looked at several children and can find no evidence of a direct effect of propofol or its vehicle on any aspect of metabolism in these patients. Details of the study are being prepared for publication.

Since Parke and colleagues' paper was published our hospital's solicitor has advised us that we cannot continue to use propofol in this way without fully documented informed consent, which will now be difficult to obtain. We do not know whether propofol played a part in the reported deaths, but it will now be almost impossible to establish. The inaccuracies in the reports of two of the cases lead me to wonder if there are similar inaccuracies in the other cases. If propofol was implicated, all of the studies in adults and our studies in children suggest that this is a rare idiosyncratic reaction. It is a sad day when our use and assessment of drugs (both their value and their adverse effects, if any) is

governed by events such as these. This report has brought forward the time when we must practise medicine in a transatlantic manner, with use of agents being controlled by fear of litigation and not by scientific investigation.

S COOK

Intensive Therapy Unit,
Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

1 Parke TJ, Stevens JE, Rice ASC, Greenaway CL, Bray RJ, Smith PJ, et al. Metabolic acidosis and fatal myocardial failure after propofol infusion in children: five case reports. *BMJ* 1992;305: 613-6. (12 September.)

EDITOR,—T J Parke and colleagues' paper and the ensuing coverage in the lay media have led to confusion regarding the use of propofol in children.¹ In the United Kingdom propofol is licensed for anaesthesia in adults and in children aged over 3 and has been used extensively in such cases. It is also licensed for the sedation of ventilated adult patients requiring intensive care, for up to three days. This indication was approved in the United Kingdom in 1991 as our clinical programme with propofol continued and the range of indications was extended. Experience in these licensed indications has not raised similar concerns to those that Parke and colleagues report.

Propofol is not licensed for sedation of children receiving intensive care, and the cases reported by Parke and colleagues are clearly of concern. Though no causative association between the adverse events and propofol was established, we wish to draw attention to our earlier communications to the medical profession.^{2,3} We agree with Parke and colleagues' conclusion that "until further data delineating the appropriate dose range are available, propofol should not be used in paediatric intensive care."

K G EDWARDS

B D C ARNOLD

ICI Pharmaceuticals,
Alderley Park,
Macclesfield,
Cheshire SK10 4TG

1 Parke TJ, Stevens JE, Rice ASC, Greenaway CL, Bray RJ, Smith PJ, et al. Metabolic acidosis and fatal myocardial failure after propofol infusion in children: five case reports. *BMJ* 1992;305: 613-6. (12 September.)

2 Rodgers EM. 'Diprivan' intensive care sedation in children. *Br J Anaesth* 1991;67:505.

3 Edwards KG. 'Diprivan' ICU sedation in children—unlicensed use. *ICI communication to UK anaesthetists and hospital pharmacists*. Macclesfield: ICI Pharmaceuticals, 1992.

EDITOR,—T J Parke and colleagues suggest that the new intravenous anaesthetic agent propofol should not be used for sedation in paediatric intensive care.¹ This drug is licensed for induction and maintenance of anaesthesia in adults and children over the age of 3 and for sedation of ventilated adults receiving intensive care. It is not clear from their paper whether or not Parke and colleagues were using the drug with a clinical trial exemption certificate. The manufacturers have repeatedly informed the medical profession of the age limitation.

The authors report that lipaemic serum was observed after three or more days of propofol infusion in all five children who died. Our recent work and that of others has shown that even induction doses of propofol (2.5 mg/kg) are associated with appreciable adrenocortical depression.^{2,3} This cortisol suppression is likely to be more important when infusions of propofol are used for sedation in intensive care as the provoking stimulus of surgical trauma is absent. We speculate that cortisol depression induced by propofol may be a mechanism for the development of lipaemic serum as the normal cortisol stress response would increase lipolysis and oxidation of fat. The clinical manifestations of these underlying biochemical abnormalities are more evident in children than