cloxacillin (M.I.C. 5–20 $\mu\text{g./ml.}$). No details were given of the case itself or of the quantity and frequency of methicillin administered. The conclusion, however, was that methicillin treatment failed because the culture was resistant. Furthermore, the culture was also reported to differ from staphylococci normally encountered in its ability to destroy the isoxazolyl penicillins oxacillin and cloxacillin.

At the time of this fatal septicaemia at Carshalton we received two cultures of the staphylococcus in question from Dr. Stewart. One culture was an isolate from the patient before death and the other after death. In all our tests these cultures appeared identical, but the results we obtained are not entirely in agreement with those reported by Dr. Stewart.

On solid media, after incubation for 24 hours, significant inhibition of growth was apparent even with a concentration of methicillin as low as 5 $\mu\text{g./ml.}$ (The usual M.I.C. for methicillin with staphylococci in this test is 2.5–5 $\mu\text{g./ml.}$) At a concentration of 12.5 $\mu\text{g./ml.}$ inhibition was virtually complete. The overwhelming majority of the staphylococci present in these cultures therefore showed normal sensitivity to methicillin. Highly resistant variants were present in these cultures, however, but only as minority populations. This could be demonstrated by incubation of the tests for a further 24 hours. Isolated colonies could then be seen, growing with concentrations of methicillin even as high as 250 $\mu\text{g./ml.}$ However, these highly resistant variants represented less than 1 in 100,000 of the total population. Consequently the strains as received from Dr. Stewart were essentially mixed cultures with respect to methicillin sensitivity and therefore do not appear to differ from those already reported by Jevons.¹

Tests were also carried out in our laboratory with cloxacillin. Both cultures received from Carshalton were completely inhibited by a concentration of 1.25 $\mu\text{g./ml.}$ of cloxacillin. This figure is within normal limits for the sensitivity of staphylococci to this drug, and is well below the levels normally obtained in the body. It should also be pointed out that methicillin and cloxacillin do not necessarily stand or fall together with respect to resistance, as your leading article suggests (February 2, p. 280). Strains naturally resistant to methicillin can still be sensitive to cloxacillin at levels readily attainable in the body.²

Regarding the destruction of the isoxazolyl penicillins it is known that the latter are not as stable as methicillin to staphylococcal penicillinase.² The degree of instability, however, is so slight that for all practical purposes the isoxazolyl penicillins can be regarded as stable compounds. Quantitative tests for cloxacillin stability were carried out with the cultures received from Dr. Stewart. With both cultures the rate of inactivation of cloxacillin was no higher than that with any other penicillinase-producing staphylococcus. We were therefore unable to show that the Carshalton cultures possessed any unusual ability to destroy cloxacillin.

On the broader question of resistance no one would disagree that staphylococci resistant to methicillin and capable of causing disease may well exist. For such staphylococci to become a clinical problem, however, they must exist in significant numbers and they must also be capable of causing cross-infection. So far, methicillin-resistant strains have only appeared as minority members of otherwise normal cultures of penicillin-resistant staphylococci. It is because these strains have not to our knowledge been encountered in infections as pure cultures that it is difficult to assess

their significance. The testing of staphylococci for methicillin and cloxacillin resistance is very desirable and it is important that reports are as fully documented as possible so as to avoid any misleading conclusions.—I am, etc.,

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- ² Nayler, J. H. C., Long, A. A. W., Brown, D. M., Acred, P., Rolinson, G. N., Batchelor, F. R., Stevens, S., and Sutherland, R., *Nature (Lond.)*, 1962, **195**, 1264.

Sheer Nonsense ?

SIR,—It was with growing amazement and indignation that I read "Without Prejudice" (February 9, p. 395). If this purports to be history it is indeed as Henry Ford said "bunk." I was a member of the Medical Planning Commission and can assure you that it is sheer nonsense to say that the report was the work of men whose "inspiration was socialistic and their goal a State medical service." There never was any hint of a proposal during the war for the B.M.A. to "come out in favour of a whole-time salaried service." Indeed all the efforts of those who represented the Association in discussions at the Ministry of Health were directed towards the prevention of such a catastrophe.

Mr. Ernest Brown's proposal for a salaried service met with such opposition from members of a B.M.A. deputation that he dropped his suggestions at once with the words, "Well, that can go in the discard." Mr. Willink's proposals shared the same fate as those of Mr. Ernest Brown.

It is poor reward for those who worked so hard for so many years to prevent the setting up of a State salaried medical service to be faced with such stupid and wholly inaccurate statements as those set out in the article in question.—I am, etc.,

Birmingham 29.

J. A. BROWN.

Treatment of Hiccup

SIR,—Persistent post-operative hiccup is extremely rare, but troublesome when it occurs; it baffles, seemingly inevitably, all the measures of the resident and nursing staff, yet its relief can be guaranteed immediately by the intravenous injection of "methedrine" (methylamphetamine). Some 15 years ago I observed some of my anaesthetist colleagues using this drug for controlling hiccup under anaesthesia, and resolved to try it in the conscious patient should need arise. I have done so on perhaps a dozen occasions since then with similar dramatic results.

The trouble usually presents on a ward round, and the residents and other patients are only too conscious of this persistent noisy disturbance. After counting the number of hiccups per minute, 15–30 mg. of methedrine is injected slowly intravenously, and it can be confidently predicted, even in such public circumstances, that there will be no further hiccup after two minutes.

I feel that this sure and apparently safe method of controlling hiccup should be more widely known, as none of the resident staff have ever been familiar with it. The patients have usually been stout people with cardiovascular degeneration, and have had some major abdominal or pelvic operation, yet no untoward effects have been encountered. The dose can be repeated if

trouble should recur, but two or three times is all that has ever been required. I hope this note may be of use to those faced with this problem. Its rationale is out of my province, but its efficacy is not in doubt.—I am, etc.,

Wolverhampton, Staffs.

HENRY B. YOUNG.

Errors in Operating Theatres

SIR,—Recently an article appeared in a newspaper for a proposed meeting of senior theatre staff to discuss errors in the theatres, resulting in the wrong patients being operated on, or the wrong operation performed. That such a meeting need be called is deplorable; more so that it should be published, thus suggesting to the public that a negligent attitude might exist in our surgical teams.

We are all liable to errors, but when they occur they are our own, and must not be blamed on to willing assistants. I have committed the offence in theatre once, in performing a hernia operation on the wrong side—this was because of a clerical error in placing the hernia on the wrong side in the out-patient notes, ward notes, and operating list. Nevertheless the final blame becomes the surgeon's in not checking pre-operatively, and cannot be attributed to anyone else.

The blame rests fully on big names and small names in the profession who fail in what should be a standard routine in all hospitals—namely, to check patients themselves, pre-operatively in the ward, instead of delegating responsibility to a minor member of the profession or placing the onus on a member of the nursing profession.

Surgeons may eliminate these operating-theatre errors by the following logical principles: (1) Examination of operation area pre-operatively by the operator himself in the ward; (2) courtesy greeting to patient in anaesthetic room; (3) simple procedure for listing patients going to the theatre, and the change over of cases during a list.

Closer attention by senior members to smaller details would make the above principles easy to follow. Everyone follows this procedure for private patients, so it is a disgrace to our name as a profession that few follow it for public hospital patients. Let us be more practical and shoulder responsibility that is justly ours.—I am, etc.,

London W.2.

W. J. ORAM.

Detection of Glaucoma

SIR,—The correspondence relating to the detection of glaucoma has become so wide that it is necessary to put the whole of the ophthalmic services in their proper perspective.

There are several facets: the eye hospitals and the eye departments in general hospitals, the consultant ophthalmologist, the ophthalmic medical practitioner, the ophthalmic optician, and the dispensing optician. The ophthalmic optician's main purpose being the correction of refractive errors and the referral of suspected pathological conditions to the patient's general practitioner, it is hardly possible to call a person so qualified a layman.

His course of training takes four years. He is then subject to rules and regulations of the General Optical Council, the opposite number of the General Medical Council. A medical student spends perhaps one or two half-days per week for three months in an eye department. How many medical students have to answer a question on eyes in a written paper, and how many are

given an eye case during the clinical examination? One ought to remember there is such a thing as systemic ophthalmology. Most opticians know far more than general practitioners do about eye conditions. This, of course, puts the ophthalmic medical practitioner in a different class.

Having said all this it does not mean that everything is satisfactory. Far from it. The consultants should allow ophthalmic optics students into their departments and so make available to them more clinical material. They should also open the doors for the pre-registration year of experience.

As regards the ophthalmic optician he has much to do to establish himself. He should begin to realize he is no longer a shopkeeper. Furthermore, the pernicious practice of consultants or ophthalmic medical practitioners working on a sessional or fee basis for either ophthalmic or dispensing opticians ought to be abolished. It would be of advantage if the principle applicable to the general practitioner—one principal, one assistant—were adopted. This would go a long way towards the status of the ophthalmic optician being raised.

The ophthalmic services have come to stay. The sooner everybody realizes this the better. It is no use entering the field of recrimination; a *modus vivendi* has to be established.

To revert to the original point, ophthalmic opticians do an ophthalmoscopy on all their patients. Many opticians are also now doing field checks on patients over the age of 40. This by itself is not enough. Glaucoma clinics must be established under the supervision of consultants in their hospitals. Has the Ministry of Health realized the urgency?

The question of cost should be of secondary consideration.—I am, etc.,

London N.W.2.

MAX SORSBY.

Airways

SIR,—It is customary in most anaesthetic rooms to have a supply of Guedel airways; these usually have a metal sleeve with a flange inserted into the upper end of the airway (see illustration, *right*). However, it does not appear to be realized that there is also a type of airway with a hidden metal sleeve and without a visible metal flange at the upper end of the airway (*centre*). A member of the theatre personnel, not realizing there was a hidden metal sleeve, decided to insert a metal sleeve with a flange; this forced the partly hidden metal sleeve further down the airway, leaving a small gap in the airway between both metal flanges (*left*). On removal of the airway at the end of operation through clenched teeth,