Phenacetin and the Kidney

SIR,—In my letter on excessive consumption of drugs,¹ the hazard of phenacetin nephropathy resulting from self-medication with easily obtainable drugs was stressed. Now that the Pharmaceutical Society's statement has formally brought this danger to public notice it is even more important that clear, reliable, and not misleading guidance be officially given to practitioners and public alike.

Thus the statement by the "Medical Consultant" of a national daily newspaper asserted "... alternatives without the hazards of phenacetin are codeine, paracetamol or aspirin, or a combination" (actually printed spelling was paracetamol). Many will, not unreasonably, follow this advice, which with paracetamol and in the case of aspirin might be considered safe, apart from those who take aspirin to relieve their (peptic ulcer) indigestion.² However, "codeine" is on Schedule I, and the tablets customarily sold over the counter when codeine is requested are Compound Codeine which contain phenacetin; this surely imbues a false sense of security. The widely and valuably used M.I.M.S. lists some 120 analgesic substances, and, significantly, no less than 25% of these contain phenacetin.

Some insight into the extent of the problem was given by a survey in 1960³ which revealed that some two-thirds of the broadly representative group interviewed took some form of self-prescribed medication. In another series in 1965² the corresponding figure was 80%, and one-quarter of these were for chronic complaints.

Of the various "symptoms" so "treated" depression, insomnia, and requests for vitamins and tonics made up some 25% of the cases in females and 7% in males. (Most reported cases of phenacetin nephropathy were female.) This strongly suggests that a large number of psychiatric symptoms are so self-treated, likely over a lengthy period of time, with significant and probably increasing amounts of insidiously hazardous substances, and with the consequent minimizing of symptoms leading to the sufferers not availing themselves of proper and more fundamental medical treatment and support. In this context it is noteworthy that Relaxa-Tabs, Persomnia, and Yeast-Vite tablets all contain phenacetin, and, as not infrequently observed, these products, particularly the first two, may be "eaten just like sweets."

Panic prohibition is inadvisable, but limited and controlled medical usage is the logical and safe procedure. "Primum non nocere" remains the basic therapeutic principle both in our own prescribing and in permitting unrestricted sales by others.—I am, etc.,

Cheadle Royal Hospital, MONTAGUE SEGAL.
Cheadle, Cheshire.

REFERENCES

- 1 Segal, M., *Brit. med. J.*, 1964, 2, 942.
- 2 Lader, S., *Practitioner*, 1965, 194, 132.
- 3 Jefferys, M., Brotherton, J. H. F., and Cartwright, A., *Brit. J. prev. soc. Med.*, 1960, 14, 64.

Allergy to Flea-bites

SIR,—Allergy to flea-bites is of considerable importance in veterinary dermatology and it was therefore with particular interest that I read Dr. M. Beare's account of papular urticaria in his excellent article "Skin

Conditions of Infancy and Childhood, Part II" (23 January, p. 237). However, I should like to draw attention to two points. Fleas are not host-specific.¹ I have found human, cat, and dog fleas on dogs and have often been bitten by *Pulex irritans* transferred from dogs on the post-mortem slab. Dr. Beare states that dicophane (D.D.T.) should be also applied to household pets to kill fleas present. Whilst dicophane may be applied to dogs with safety it is contraindicated² for cats, 0.5% being definitely toxic: preparations containing derris are safer.—I am, etc.,

Department of Clinical Veterinary Sciences,
Veterinary College of Ireland,
Dublin 4.

K. P. BAKER.

REFERENCES

- 1 Lapage, G., *Veterinary Parasitology*, 1956, p. 587. Oliver and Boyd, London.
- 2 Roberts, F. H. S., O'Sullivan, P. J., Rumball, P., and McLauchlan, A. W., *Austr. vet. J.*, 1947, 23, 148.

Improving Ambulance Services

SIR,—I emphatically endorse the views expressed by Dr. E. F. D. Gawne (23 January, p. 247). In a highly technocratic age much more imaginative thinking than has hitherto obtained is required and must be demanded of any proficient Health Service. Towards the end of saving more lives in cases of grave accidental trauma we need a complete reorientation of our ideas of the status and, by corollary, increased delegated responsibilities of ambulance driver/attendant personnel. In future the selection and training of these men should raise them from mere stretcher-bearers, having some outmoded first-aid knowledge, to highly skilled technicians. To attract this element, who must receive commensurate emoluments, there should be established a progressive career with promotive grades in defined ranks on a national basis, from trainee-recruit to commandant. The present local-station ratings are purely arbitrary; in furtherance of a national service there must be co-operative consultation and continuous liaison between the National Ambulance Officers Association, regional hospital boards, and medical officers of health (representing local authority interests).

In the training it must now be recognized that the days of reliance on triangular bandages and wooden splints are over. There is needed more precise teaching in the appraisal of the varying degrees of surgical shock—the recognition of the near-irreversible state from the moderate. Methods of revival by the use of the Minuteman resuscitator (vital equipment in every stretcher-bearing wagon), both negative and positive flow, must be inculcated. Radiotelephony must be standard between every such wagon and the major accident unit hospital, each of which should have an ambulance substation. Thus every ambulance driver/attendant at the accident locus could speak directly to the hospital accident officer and so receive guidance and instructions.

For the standards of efficiency needed every trainee should be required to spend a period of not less than three months officially integrated on the staff of the hospital accident and emergency unit. Here he would be taught the techniques for countering the three most obvious causes that precipitate death in the badly shocked patient: excessive physical

disturbance, loss of blood volume, obstructed air intake. With such training having been given I advocate the employment of reconstituted blood plasma at the locus of the accident by intravenous infusion and before the sufferer undergoes transportation—this under permissive radiotelephonic agreement. It has been traditional in hospital convention that no one but a medical officer should put a needle in a patient's vein; the time is ripe for rethinking about this. A precedent in a comparable situation comes to mind with the fierce opposition some of us met when advancing the then revolutionary proposal that the skippers of fishing vessels be entrusted with the custody and administration of morphine for emergencies at sea—now standard practice of inestimable value.

In my training scheme there would be included not only meticulous airway cleaning with Minuteman evacuating suction but also actual intratracheal intubation of the unconscious patient; done early this can be life-saving.

In the use of splinting regrettably it is still customary to receive patients with major fractures having the legs tightly bound together by a multiplicity of triangular bandages. The manipulations in applying these fixatives can be extremely uncomfortable for any patient; indeed this can be one of the cumulative factors in augmenting shock.

The answer is that fractured limbs should be immobilized by the finest available method—stabilizing in the pneumatic appliances variously dubbed "sterile jet bandage splints" or "space-age splints." These are comfortable in application and give a gratifying sense of pain-relief when in position, along with the added advantage of bleeding control by uniformly distributed air-pressure (mouth applied). Any disinclination to equip wagons with these plastic supports on the grounds of expense must be dismissed as pusillanimous.

In the present system too much emphasis is placed on vehicle maintenance and the inadvisable dogma of "rushing to hospital." I would much rather see the entire emphasis placed on human maintenance.—I am, etc.,

Grimsby, Lincs.

DANIEL LAMONT.

The Murder of English

SIR,—Dr. Philip Jacobs (6 March, p. 661) provides a welcome diversion from the Review Body, the independent contractors—what a lovely phrase—and Uncle Tom Robinson and all, by drawing our attention to a letter by Dr. J. G. M. Hamilton (20 February, p. 526).

May I also refer to the latter's communication confirming that "clinical" is derived from the Greek, meaning pertaining to a bed or couch. I also agree that the adjective "clinical" nowadays frequently denotes "cold, sterilized, scientific," but surely such epithets are quite applicable to the hospital beds of this day and age?

May I also remind Dr. Hamilton that the expression "didactic teaching," though not exactly contributing to the "murder of English," is not correct. "Didactic" means "intended to teach," so that in the phrase quoted it is superfluous.—I am, etc.,

Liverpool 18.

S. GIBSON.