(N - methyl - 1 - (3,4 - methylenedioxyphenyl) - 2 - butanamine) instead of ecstasy. Mixtures of these substances with ecstasy as well as with unrelated drugs such as amphetamine, caffeine, and l-phenylethylamine are also encountered. In addition, tablets have been found to contain other, less common, ring substituted amphetamines instead of ecstasy. These analogues may well differ in their neurotoxic potential. Finally, there have been reports of mixtures of ketamine and ephedrine, as well as other substitutes such as mixtures of lysergide (LSD) and amphetamine or of lysergide and ephedrine, being sold as ecstasy.

This diverse pharmacological content of tablets may go some way to explaining the variety of symptoms reported among and within users. Not only does it mean that users are exposing themselves to unknown long term effects but it leaves researchers with a problem. Neither the user nor the researcher can be certain what the ingested tablet contained until later analysis. Adverse symptoms, both short and long term, will depend on the interaction between the drug and the individual, which cannot be safely predicted.

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...such as ketamine

EDITOR,—There is increasing concern over the toxic¹ and neurodegenerative² effects of ecstasy, and further research is clearly required. Potential hazards can also, however, arise through use of tablets sold as ecstasy that contain substances other than ecstasy, such as ketamine. Ketamine is an anaesthetic agent with a rapid action that has medical and veterinary applications. Drug users who have taken ketamine illicitly say that it induces a profound change in consciousness, involving a feeling of dissociation from the body, and invokes visual hallucinations. These users have reported the need for precautions when taking the drug, emphasising that the intensity of its effects could lead to problems such as psychological distress or accidents due to lack of physical control, particularly if it was taken in a public setting (such as a club) and if used unwittingly or by novices.³ There have been no reports of any serious toxicological or neurodegenerative problems arising from the illicit use of ketamine.

Until a few years ago illicit use of ketamine mostly entailed small scale diversion of injection ampoules from clinical supplies. Since 1993 in Britain, police seizures of ketamine notified to the Drugs Intelligence Laboratory at Aldermaston have increased considerably, from 21 in 1993 to 183 in 1995. In nearly all cases the ketamine was in tablet form, often resembling tablets commonly sold as ecstasy. The ketamine in these illicit tablets had often been mixed with ephedrine, but some tablets also contained selegiline or procaine. Recently a single police

seizure yielded almost 100 000 tablets containing ketamine and ephedrine, about one third of which carried an impression of a bird ("white dove"). Ecstasy tablets bearing this design have been common for some years.⁴

The recent trend in seizures of ketamine indicates an appreciable increase in the availability of tablets that are intended to mimic the effects of ecstasy and the appearance of ecstasy tablets. While it is important to note that ecstasy has never been found mixed with ketamine, illicit manufacturers seem likely to be targeting a market in which ecstasy is widely available; the potential for the problems described above is therefore considerable. The availability of tablets of ketamine mixed with ephedrine will continue to be monitored, but systematic research on the interactive effects of taking ketamine in conjunction with ephedrine may also be needed.

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γ-Hydroxybutyrate is a new recreational drug that may lead to loss of consciousness

EDITOR,—We were interested in A Richard Green and Guy M Goodwin's editorial on ecstasy and neurodegeneration.¹ We wish to draw attention to another recreational drug, which is taken in similar circumstances to ecstasy, whose use can lead to acute neurological effects.

γ-Hydroxybutyrate—also known as GHB, sodium oxybate, GBH, and liquid ecstasy—has been available in Britain since 1994, mostly in night clubs around London. It has recently become more readily available, and the National Poisons Information Service (London) has received calls regularly since 1994. It produces a state of relaxation and mild euphoria, which may be followed by drowsiness, epileptiform seizures, and coma. We have recently seen several cases of symptomatic toxicity; four patients presented in coma.

γ-Hydroxybutyrate was first reported as a drug of misuse in North America in 1990. That year the Food and Drug Administration banned over the counter sales of it, and in 1991 the Centers for Disease Control issued a warning about its side effects.² In Britain it is not controlled under the Misuse of Drugs Act, and so possession is not considered to be illegal. There have, however, been a few prosecutions under the Medicines Act, which forbids unauthorised manufacture and distribution. The police currently have little power to control the spread of its use, and it will probably become more widely available in Britain.

All accident and emergency staff need to be aware of the use of γ-hydroxybutyrate and its effects and modes of presentation. The drug is commonly sold as a clear, salty liquid in a bottle similar in size to the bottles used for type correction fluid, and the usual dose is one or two cap-

fuls. Side effects may include mild headache, vomiting, and drowsiness, which can be followed by seizures, loss of consciousness, and hyperventilation. Most patients maintain their airway well, and consciousness is usually regained within a few hours, although cases requiring ventilation have been reported. The effects may be worsened by coingestion of alcohol and other psychoactive drugs. The drug is not detectable with routine toxicological tests, and there are no clinically effective antidotes. Management is largely supportive.

Collapse after ingestion of γ-hydroxybutyrate should be added to the list of differential diagnoses for seizures and coma in patients presenting to accident and emergency departments.

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Recommendation to avoid all drugs during first trimester is unrealistic

EDITOR,—The message of Patrick Vallance's editorial on drugs and the fetus is rather academic and far from practical experience¹; exaggeration of the teratogenicity of drugs causes anxiety in women of childbearing age and increases the likelihood that doctors will practise defensive medicine.

Drugs are probably regarded as the most important of the supposed hazards during pregnancy. Of about 3000 drugs used in Hungary, only 20 are proved teratogens in humans.² Contrary to supposition, only a small proportion (about 1%) of congenital abnormalities is traceable to teratogenic drugs in humans.³ In 102 women who attempted suicide with extremely large doses of drugs in the first trimester of pregnancy the observed rate of congenital abnormalities was no higher than the expected population figure after women who were dependent on alcohol were excluded.⁴ In a Swedish study no congenital abnormality was found in 70 infants born to mothers who had taken an overdose of psychoactive drugs during the period of fetal development in which the organs form.⁵

In Hungary 91% of pregnant women use drugs during pregnancy³ and 8% need long term drug treatment for chronic disorders. Thus Vallance's recommendation that "all drugs should be avoided if possible during the first trimester" is unrealistic because drug treatment is necessary for many women. Because of inflexible application of this recommendation, however, necessary drug treatment is sometimes not given during pregnancy; this exacerbates disorders such as epilepsy, hypertension, and genitourinary infections. In the early 1980s the number of induced abortions in Hungary was about 80 000, of which about 16% were for medical indications. Analysis indicated, however, that about 5000 pregnancies were terminated for no truly appropriate cause—most were terminated because of the supposed teratogenic effect of drugs and defensive practice by physicians. Vallance mentions griseofulvin as an example of a teratogenic drug taken by men. The dataset of

the Hungarian case-control surveillance of congenital abnormalities, however, was unable to confirm that griseofulvin used during pregnancy has a teratogenic effect.⁶

In my opinion, the anxiety and fear created by the notion that nearly all drugs cause congenital abnormalities may be more harmful than the drugs themselves.

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Medic Alert UK should start new section for patients with a difficult airway

EDITOR,—The Medic Alert Foundation is a worldwide charitable and voluntary organisation dedicated to disseminating information to doctors about potential hazards for individual patients. In anaesthesia its greatest contribution is to warn anaesthetists that a patient has a life threatening reaction to a drug, so that the drug can be avoided.

An unsuspected difficult airway can be life threatening in patients presenting for general anaesthesia. According to one survey, almost one third of all adverse anaesthetic outcomes are related to respiratory problems,¹ and about 41% of all deaths attributable to anaesthesia are related to difficulties with endotracheal intubation.² Unfortunately, preoperative tests on the airway have poor predictive value: nearly half of difficult intubations are not predicted preoperatively.³ Knowledge of previous problems with a patient's airway is of paramount importance. Generally, however, patients have only a vague idea of problems that occurred when they were given anaesthetics in the past. Usually, and especially out of hours, efforts to get the details of the previous incident and its management are futile, and so the patient is at risk of a further critical incident.

With patients' full consent, Medic Alert keeps relevant data, which can be obtained by authorised medical staff on a 24 hour basis. I propose that a national "difficult airway register" should be established (which could be based at St George's Hospital), to which all anaesthetists could supply relevant information on a standard form. Registered patients would then be approached to become members of Medic Alert UK, so that their record giving details of their difficult airway could be stored with this organisation and the information retrieved, if required, at any time. General practitioners would have access to this information and could include it in their referral letter to the hospital.

In the United States a comprehensive system for disseminating information about patients with a difficult airway, which incorporates Medic Alert, has operated for the past few years. Preliminary results indicate that access to this detailed information leads to fewer techniques

being used by anaesthetists and a reduction in adverse outcomes.⁴

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Describing race, ethnicity, and culture in medical research

"White" populations also need to be accurately described

EDITOR,—Kwame McKenzie and N S Crowcroft's comments about the recording of race, ethnicity, and culture are sensible and sensitive.¹ Their choice of examples, however, may inadvertently reinforce the misconception—widely held in the health service and not helped by the classification of the Office for National Statistics (formerly the Office of Population Censuses and Surveys)—that "ethnic" equates with "non-white." There is enormous ethnic and cultural variability in "white" populations, with both political implications (as in Ulster and Bosnia) and medical implications (for example, heart disease and diabetes). When appropriate, similar precision should be used in describing white population groups. I speak as a professional Malta-born, polyglot, Catholic pasta eater of Maltese, Irish, and English extraction who has been resident in Britain for 35 years.

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Self defined ethnicity is unhelpful

EDITOR,—Kwame McKenzie and N S Crowcroft's editorial and recommendations on describing race, ethnicity, and culture are an important contribution to the debate on ethnic classification.^{1,2} While the authors discuss the complexities associated with ethnic classification of various non-white British groups, their recommendations fail to acknowledge the similar difficulties in describing what could be referred to as the indigenous population (that is, those who have been traditionally termed white). There is an implicit assumption in much of the work on inter-ethnic differences that this group represents an ethnic standard by which members of other ethnic groups may be judged.³ Our findings indicate that when people traditionally classified as "white British" are asked to define their ethnic background a range of complex responses is elicited.

As part of a larger study at Northwick Park Hospital examining psychosocial aspects of chronic disability due to low back pain, we attempted to determine the ethnic group to which patients felt they were affiliated. A question was designed that was based on five items (ethnic origin, religion, country of birth, length of time in Britain, and languages spoken); we thus used a similar approach to that recommended in McKenzie and Crowcroft's

Table 1—British patients' self defined ethnicity and country of birth

Ethnic identity	Country of birth	No
English	England (45), London (1), United Kingdom (3)*	51
British	Britain (2), England (20), United Kingdom (3), Wales (2)	27
White	Britain (2), England (7), Ireland (1)	10
White European	Ireland (2), United Kingdom (1)	3
Caucasian	England (1), Northern Ireland (1)	2
British Gibraltar	Gibraltar (1)	1
British White	England (1)	1
British/Irish parents	United Kingdom (1)	1
British Philippines	India (1)	1
English/Australian	United States (1)	1
English/Irish	England (1)	1
European	England (1)	1
Scottish	Egypt (1)	1
United Kingdom	United Kingdom (1)	1
White British	England (1)	1
White English	England (1)	1
Total		104

*Two patients did not state their country of birth.

guidelines² and used free text fields, because of the move towards the use of such fields in ethnic monitoring in the health service.⁴

Out of 297 patients, 235 (79%) responded to the question on self defined ethnicity. Analysis by χ^2 test indicated that this group was significantly younger ($P = 0.029$) than the 62 who failed to respond to this question. Altogether, 104 respondents were identified as "British" (table 1). Sixteen distinct responses fell in this category. The three most common responses were English, British, and white (total 88 patients); the 13 further groups comprised 16 patients.

Our data show the heterogeneity of this ethnic group—patients who were categorised as British. Thus, while use of the term "Asian" to describe people of Indian, Pakistani, Bangladeshi, and Sri Lankan origin is often said to lack specificity as the definition of an ethnic group,⁵ a similar case could be made for the ethnic term "British."

We conclude that it is more profitable for health service research to use a range of variables, such as language, religion, country of origin, and length of residence in the country, to investigate the impact of cultural differences. We recommend that ethnicity, even if self defined, should not be used on its own as a variable.

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