functions (that is, action and speech). There were no catatonic features other than mutism. The diagnosis of catatonic stupor therefore seems unjustified in both cases.

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- 1 Maxwell DL, Polkey MI, Henry JA. Hyponatraemia and catatonic stupor after taking "ecstasy." *BMJ* 1993;307:1399. (27 November.)
- 2 Taylor M. Catatonia: a review of the behavioral neurologic syndrome. *Neuropsychiatry, Neuropsychology and Behavioral Neurology* 1990;3:48-72.
- 3 Fisher CM. "Catatonia" due to disulfiram toxicity. *Arch Neurol* 1989;46:798-804.
- 4 World Health Organisation. *The ICD-10 classification of mental and behavioural disorders*. Geneva: WHO, 1992.
- 5 Fink M, Taylor MA. Catatonia: a separate category in DSM-IV? *Integrative Psychiatry* 1991;7:2-10.

Funding family planning

EDITOR,—Brian Harradine calls for an end to "population control programmes" funded by, among others, the International Planned Parenthood Federation "because of their coercive nature and the negative effect they have on women's health."¹ The aim of the International Planned Parenthood Federation is to provide women and their families with information and services that will allow them to live healthier and longer lives. Through its worldwide network of autonomous national family planning associations the federation responds to family planning needs and reproductive health needs expressed by local people, particularly women.

Currently more than 120 million women in the developing world are not using contraception although they say that they want to avoid pregnancy.² As many as 500 000 women die every year from causes related to pregnancy.³ An African woman has a 1 in 22 likelihood of dying from a cause related to pregnancy.⁴ These figures are well known to those working with reproductive health issues. On paper, however, they do not necessarily reflect the suffering and ill health that each of those women may encounter in her desire to practise the right to regulate her own fertility.

The International Planned Parenthood Federation agrees with Harradine's hope that family planning programmes will continue to concentrate on the individual needs of users. It enjoys a close relationship with the Australian International Development Assistance Bureau and hopes for the bureau's continuing support in its work.

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- 1 Harradine B. Funding family planning. *BMJ* 1994;308:64. (1 January.)
- 2 Robey B, Rutstein SO, Morris L, Blackburn R. The reproductive revolution: new survey findings. Baltimore: Population Information Programme, Johns Hopkins University, 1992. (Johns Hopkins University population reports, series M, No 11.)
- 3 Royston E, Armstrong S, eds. *Preventing maternal deaths*. Geneva: World Health Organisation, 1989.
- 4 Tinker A, Koblinsky MA. *Making motherhood safe*. Washington, DC: World Bank, 1993.

Cystoscopy in bladder cancer

EDITOR,—R R Hall and colleagues¹ support the Medical Research Council's proposals for changes in cystoscopic follow up of patients with bladder cancer and adjuvant intravesical chemotherapy.² We wish to add some words of caution. One of us (DAT) was a coauthor of the Medical Research Council's paper and recognised that the population with superficial bladder cancer on which the conclusions were drawn was biased in favour of

Effect of using Medical Research Council's criteria on number of cystoscopies performed in patients with bladder cancer

Risk group	No (%) of patients	No of cystoscopies (% positive)			
		Actual	According to MRC protocol	Yielding positive result	Rate of positive cystoscopies*
Low	68 (42)	430 (14)	279 (22)	62	1 every 3.0 years
Intermediate	57 (36)	372 (33)	450 (28)	124	1 every 1.7 years
High	34 (22)	275 (55)	372 (41)	152	1 every 0.9 years
Total	159	1077 (31)	1101 (31)	338	

*Excluding recurrence at first check cystoscopy.

disease with a good prognosis, based on tumour recurrence rates of 40% compared with a generally accepted rate of 70% in other series.³ This led us to examine what would have happened if this approach had been adopted in our own department with an unselected group of patients (annual meeting of British Association of Urological Surgeons, 1993).

The table shows that our patients were overall at higher risk of recurrence than those in the Medical Research Council's study, in which 60% were classified as at low risk, 30% at intermediate risk, and 10% at high risk. Possibly as a consequence of this, our audit of prospectively recorded data on 159 patients with superficial bladder cancer treated in our department suggested that the adoption of such a policy, far from reducing the number of check cystoscopies, would entail a 2% increase in the frequency of cystoscopy overall. This, however, would be the result of increasing the frequency of cystoscopy in the intermediate and high risk groups, for whom the benefits would be greater; thus our resources would be better used.

We strongly agree that, if such a policy was generally implemented, high grade tumours that are already invading the submucosa (G3T1) should be excluded and treated aggressively since all four patients from this study population who progressed to muscle invasive bladder cancer had a tumour of this type at diagnosis. One of them would have been placed in the group at low risk of recurrence if the Medical Research Council's criteria had been strictly applied.

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- 1 Hall RR, Parmar MKB, Richards AB, Smith PH. Proposal for changes in cystoscopic follow up of patients with bladder cancer and adjuvant intravesical chemotherapy. *BMJ* 1994; 308:257-60. (22 January.)
- 2 Parmar MKB, Freedman LS, Hargreave TB, Tolley DA. Prognostic factors for recurrence and follow up policies in the treatment of superficial bladder cancer: report from the British Medical Research Council subgroup on superficial bladder cancer (urological cancer working party). *J Urol* 1989;142: 284-8.
- 3 Gilbert HA, Logan JL, Kagan AR. The natural history of papillary transitional cell carcinoma of the bladder and its treatment in an unselected population on the basis of histological grading. *J Urol* 1978;119:488-92.

Murder in the NHS

EDITOR,—In his editorial on the murder by nurse Beverley Allitt of four children in hospital W J Appleyard states that one of the two consultant paediatricians at the hospital, Dr Nanayakkara, "sought the opinion of a paediatric pathologist but this request was persistently denied."¹ Readers might infer that my department was at fault, and I strongly refute this. Appleyard may not be aware that it was the coroner for Grantham who decided not to call in a specialist paediatric pathologist to perform the postmortem examinations on the children. Instead he instructed the local pathologists (who were employed in a locum capacity) to carry out the examinations. Dr Nanayakkara was concerned about the pathologist's diagnosis in the initial case and discussed the case over the telephone

with our paediatric pathologist, who readily agreed to comment on any tissues or tissue sections preserved from the postmortem examination. He was unable to give a firm opinion on the limited material made available at that time.

The chain of events initiated by Beverley Allitt was extraordinary, and, as is evident from Appleyard's editorial, many lessons are being learnt from it. Perhaps what needs to be emphasised is that it is the coroner's responsibility to ascertain the cause of death, often using information obtained by the pathologist. In the case of children the coroner should employ a pathologist with a record of skill in paediatric work, particularly when the circumstances of death are ill defined.

Finally, making the correct diagnosis in the cases in Grantham would have been extremely difficult for anyone since the interpretation of biochemical variables after death is unreliable. Not only biochemical tests but careful evaluation of the clinical records were ultimately required to reach the correct diagnoses.

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- 1 Appleyard WJ. Murder in the NHS. *BMJ* 1994;308:287-8. (29 January.)

Treatment of heroin users

EDITOR,—It is unhelpful for John Marks to continue to force an artificial polarisation of the debate on prescribing.¹ In distancing ourselves from the suggestion that we are "pandering to American prohibitionist fundamentalism" we do not wish to be forced to embrace a similarly extreme opposite position of, for example, providing insufficiently controlled supplies of the "drug of choice" or "state-rationed drugs"^{2,3} or becoming "a dealer by appointment to Her Majesty's Government."⁴ We wish to be allowed to continue to explore the more fertile intermediate terrain.

In our original letter we expressed concern that excessive reliance on individual clinical judgment may jeopardise British doctors' privileged autonomy in prescribing—especially if the manner in which this freedom is used or exploited seems excessive.⁵ There is little in Marks's response that reduces our concern. The choices of drug, form, and dose each stretch the bounds of clinical freedom to their limits. In all three of these aspects, the prescribing that we described previously is extraordinary: neither heroin nor cocaine can be prescribed to drug users in any country in the world other than Britain. Likewise, the prescribing of injectable drugs to users has long been an exclusively British behaviour (with the minor exceptions that we outlined previously).⁵ We disagree fundamentally with Marks's statement on dose conversion between methadone and heroin: considering a prescribed daily dose of 900 mg of diamorphine to be about equal to 80 mg of methadone is so far off the mark to beggar belief since the more usual conversions are around parity.

Marks's "defence" of the right to offer treatment to drug users temporarily resident in

Britain is a red herring. We agree that we should provide continuity of treatment to drug users from abroad, and we have done so for patients on American maintenance programmes who are taking oral methadone, for example (although these patients' right to care under the NHS is far from clear). But to propose, under the mantle of continuity of treatment, that 80 mg of oral methadone should be changed to 900 mg of injectable heroin (even setting aside the supplementary cocaine at weekends) is surely not within the spirit of continuity of treatment. Furthermore, far from curbing the spread of HIV infection such eccentricities of practice could well provoke a migration of drug users from the United States and elsewhere, with consequent mixing of HIV pools.

Marks's allegation that "London might be a safer and healthier place with fewer addicts" if only we would use "the doses of drugs allowed under the Dangerous Drugs Act" requires robust rebuttal. As Marks must know, there are no dose limits in the legislation: the only controls that prevent Marks or us from prescribing a wheelbarrowful of heroin and cocaine each day are initially peer influence and ultimately a Home Office tribunal.

Those of us who prescribe injectable drugs and other formulations with similarly high potential for misuse and a high resale value on the black market (as in the case we described previously⁵) are surely obliged (professionally and morally, even if not in law) to make efforts to reduce the misuse of these prescribed drugs.

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- 1 Marks J. Clinical freedom and drug dependence. *BMJ* 1993;307:1565. (11 December.)
- 2 Police lobby for maintenance. *Druglink* 1992;7(4):4.
- 3 Marks J. State-rationed drugs. *Druglink* 1987;2(4):14.
- 4 Self W. Drug dealer by appointment to HM government. *Sunday Observer* 1992 Sep 13.
- 5 Strang J, Farrell M. Drug regimens that break a country's drug laws. *BMJ* 1993;307:1010. (16 October.)

Adult epiglottitis

Heightened awareness saves lives

EDITOR,—M J Stuart and T J Hodgetts draw attention to the fact that epiglottitis is just as life threatening in adults as in children.¹ I am aware of two adults who died of epiglottitis in the past seven years. Both presented with severe sore throats but no symptoms of upper airway obstruction until sudden and fatal occlusion of their airways. One had been discharged home and the other was in hospital.

Stuart and Hodgetts also point out that cricothyrotomy may be lifesaving. This is illustrated by a third case. A 20 year old man presented with a sore throat and stridor, which worsened rapidly as he was transferred from the casualty department to the intensive therapy unit. Cricothyrotomy was performed urgently with a Mini-Trach (Portex). His symptoms were rapidly relieved, and oxygenation was improved by passing 6 litres of oxygen/minute down the Mini-Trach tube by an 8 gauge suction catheter. Subsequently he underwent uneventful general anaesthesia and a formal tracheostomy.

Adult epiglottitis is serious but curable. Hopefully, with increased awareness of its presentation and treatment, it will claim fewer lives.

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- 1 Stuart MJ, Hodgetts TJ. Adult epiglottitis: prompt diagnosis saves lives. *BMJ* 1994;308:329-30. (29 January.)

Causative organism may be elusive

EDITOR,—M J Stuart and T J Hodgetts recommend that antibiotics effective against *Haemophilus influenzae* should be given to adults with epiglottitis.¹ I take issue with this. Although the recommendation is reasonable for the disease in children, which is almost always due to this micro-organism, I do not believe that it is sufficient in adult epiglottitis.

I recently helped to manage acute epiglottitis in an adult who required emergency intubation. The patient deteriorated during the first two days of antibiotic treatment with the anti-haemophilus agent cefuroxime, developing both local and systemic complications. The patient had further neck swelling and developed the sepsis syndrome, which was confirmed by haemodynamic measurements with a pulmonary artery balloon flotation catheter; the systemic sepsis resulted in acute renal failure. Because of clinical deterioration benzylpenicillin was added empirically to the antimicrobial regimen. The patient improved over the next few days and was extubated. A group A streptococcus was subsequently cultured from a supraglottic swab and proved sensitive to benzylpenicillin but resistant to cefuroxime. The patient returned home a fortnight later; repeat fiberoptic laryngoscopy showed a normal airway, and renal function recovered spontaneously after conservative fluid management.

Although the organism most commonly identified in acute epiglottitis is *H influenzae*, positive bacterial cultures have been obtained in at most a third of the cases in all large series of the condition, making recommendations on the likeliest causative organism limited.^{2,3} In a study by Mayo-Smith *et al*,⁴ in which a large number of pharyngeal swabs were taken, the commonest pathogen found was group A streptococcus (five of 11 positive cultures), followed by *H influenzae* (three of 11); the other pathogens were *Streptococcus pneumoniae* and *H parainfluenzae*.⁴ Thus organisms other than *H influenzae* are important causes of this serious condition, and the case I describe serves as a lesson that giving broader spectrum antibiotic cover in adult epiglottitis is prudent.

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- 1 Stuart MJ, Hodgetts TJ. Adult epiglottitis: prompt diagnosis saves lives. *BMJ* 1994;308:329-30. (29 January.)
- 2 Yenson AC, Zeeb ZE, DeFries HO. Acute epiglottitis in the adult. *Laryngoscope* 1985;95:289-91.
- 3 Navarrete ML, Quesada P, Garcia M, Lorente J. Acute epiglottitis in the adult. *J Laryngol Otol* 1991;105:839-41.
- 4 Mayo-Smith MF, Hirsch PJ, Wodzinski SF, Schiffman FJ. Acute epiglottitis in adults: an eight year experience in Rhode Island. *N Engl J Med* 1986;314:1133-9.

Establish an airway early

EDITOR,—Having recently admitted a patient with acute epiglottitis who had had a cardiorespiratory arrest before admission and who later died, we endorse the views of M J Stuart and T J Hodgetts¹ that epiglottitis may affect people of any age and that the occasionally fatal complication of upper airway obstruction is not restricted to children.² The authors advocate conservative management of the airway in adults in whom respiratory distress is not evident at presentation. We would argue, however, that an elective, "prophylactic" artificial airway should be established at diagnosis in all adult patients (as is routine in paediatric patients) as the risk of airway obstruction is high, there are no reliable early markers of compromise of the airway, and progression to complete closure of the airway may be rapid.

Acute epiglottitis is relatively rare in adults,^{2,3} and consequently the experience at individual centres is limited. Although estimates vary, one study has shown that the mortality from this

condition in adults is similar to that in children before the policy of securing a prophylactic airway in all cases was introduced.² This policy is thought to have reduced the mortality from acute epiglottitis in paediatric patients from 6.1% to 0.9%.⁴ We believe that as airway obstruction is the main cause of death in acute epiglottitis, irrespective of age, it is logical to advocate the same management for adults as for children.

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- 2 Mayo-Smith MF, Hirsch PJ, Wodzinski SF, Schiffman FJ. Acute epiglottitis in adults: an eight year experience in Rhode Island. *N Engl J Med* 1986;314:1133-9.
- 3 Trollfors B, Nylen O, Strangert K. Acute epiglottitis in children and adults in Sweden 1981-3. *Arch Dis Child* 1990;65:491-4.
- 4 Cantrell RW, Bell RA, Moriaka WT. Acute epiglottitis: intubation versus tracheostomy. *Laryngoscope* 1978;88:994-1005.

Don't waste time with radiography

EDITOR,—Partial upper airway obstruction is a common adult emergency presenting to accident and emergency departments. The commonest cause is a reduced level of consciousness. Other causes include foreign bodies, trauma, burns, anaphylaxis, angioneurotic oedema, and tumours. Infections, including epiglottitis,¹ acute bacterial tracheitis, and acute hypertrophic tonsillitis, may occur. In all of these, life threatening complete airway obstruction may be precipitated quickly and sometimes by minor iatrogenic actions or procedures.

Airway obstruction is a clinical diagnosis, and sometimes a high index of suspicion is needed. I do not recommend radiography of the soft tissue of the lateral neck in the management of patients because the high false negative rate and diagnostic inaccuracy may lead to a false sense of security. The journey to and from the x ray department may precipitate deterioration, and facilities for resuscitation may not be immediately available. Staff experienced in advanced airway management, including anaesthetists and ear, nose, and throat surgeons, should be informed urgently.

Phlebotomy and intravenous access may precipitate acute obstruction of the airway. The patient should be nursed in whatever position he or she finds most comfortable. An oxygen mask may not be tolerated and should not be forced on the patient. A calm and a reassuring approach by all staff is essential to relieve anxiety. Indirect laryngoscopy should be performed only by experienced staff, and facilities for creating a surgical airway should be immediately available if necessary.

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Consider underlying malignancy

EDITOR,—M J Stuart and T J Hodgetts highlight the need to include acute epiglottitis in the differential diagnosis of adults presenting with symptoms of acute pharyngitis with or without respiratory distress.¹ Fear of missing a case in children is akin to the fear of missing a case of meningitis, and consequently most doctors remain alert to the possibility of the condition. I suspect, however, that epiglottitis is more likely to be missed in adults.

Not only is it critical to diagnose acute epiglottitis early but the possibility of serious underlying