interests must take precedence over the pride of the local psychiatrist.

The fact that some psychiatrists have failed to keep abreast of advances in knowledge about schizophrenia is shown by Pelosi's statement that "treatment must be unsatisfactory and there is no knowledge base and no technical skills that could justify superspecialist opinions." That is no longer true. New developments in neuroimaging, neuropharmacology, and psychology have transformed our understanding of schizophrenia and the outlook for patients. Schizophrenia is a chronic illness, as Pelosi states, but that is no reason for the therapeutic nihilism that he espouses. Diabetes is also a chronic illness, but few would doubt that expert care can enable most diabetic patients to enjoy reasonably good health for many years. So it is with schizophrenia.

Prompt intervention with a combination of modern cognitive-behavioural treatments and the new generation of antipsychotic drugs can successfully abolish hallucinations and delusions in most cases. On the other hand, suboptimum treatment that allows patients to remain psychotic can render their illness much more intractable.

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1 Pelosi AJ, McGinnis EB, Elliott C, Douglas A. Second opinions: a right or a concession? *BMJ* 1995;311:670-2. (9 September.)

Taxi rank malaria

EDITOR,—Malaria contracted during travel to a malarious zone may develop only after the traveller's return to an area free of the disease. This has led to doctors' practice of asking febrile patients, "Where have you been and when?" Malarious disease may also occur in people who have never visited a malarious area or been exposed to blood products infected with plasmodium. In north western Europe most such cases occur in the vicinity of international airports. These cases of "airport malaria" are acquired through the bites of infected anopheline mosquitos inadvertently imported by aircraft from endemic areas.^{1,2} Infected mosquitos can survive for extended periods in aircraft cabins and holds that have been sprayed with insecticide, and even in the wheel bays of aircraft.⁴ Little attention has, however, been paid to outbreaks of malaria due to anopheline mosquitos in overland vehicles.³

Hendrina, a small farming town (population 20 000) in Mpumalanga Province, Republic of South Africa, is 1220 m above sea level and has a mild climate (the average maximum daily temperature is 26°C in summer and 15°C in winter). The town is about 140 km from the limit of the summer malarious zone, and no cases of indigenous malaria in the town or surrounding district have been notified since malaria became a notifiable medical condition in South Africa in 1957.

During January 1995 a 57 year old housewife and 19 year old female university student resident in Hendrina developed febrile illnesses with features typical of uncomplicated malaria within one week of each other. As the most recent visit to a malarious area by either patient had been over five years previously, malaria was not suspected and symptomatic treatment was started. Falciparum malaria was diagnosed by Giemsa thin blood smear (percentage parasitaemia 1.8% and 2.4%) and curative treatment was started three weeks after the onset of symptoms, when the patients were referred to a regional hospital because of concern about their clinical conditions. They responded to treatment with chloroquine and suffered no sequelae.

The women lived in neighbouring houses, and their homes were within 80 m of a taxi rank serving

commuters from Mozambique and the low lying Mpumalanga area, which is malarious. An entomological search for vectors, larvae, and potential breeding sites proved fruitless.

A large number of similar cases of malaria have been linked epidemiologically to commercial transport routes in South Africa in recent years (C F Hansford, Institute for Tropical Diseases, Tzaneen, South Africa, personal communication). The volume of commercial land transport between malarious and malaria free areas suggests that this route of importation of the vector may be of greater public health importance than airport malaria.

When confronted by a puzzling case of acute febrile disease, health workers in malaria free areas that are served by vehicles, including taxis, from endemic areas should maintain a high index of suspicion and investigate for malaria.

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- 1 Whitfield D, Curtis CF, White GB, Targett GAT, Warhurst DC, Bradley DJ. Two cases of falciparum malaria acquired in Britain. *BMJ* 1984;289:1607-9.
- 2 Isaacson M. Airport malaria: a review. *Bull World Health Organ* 1989;67:737-43.
- 3 Signorelli C, Messineo A. Airport malaria. *Lancet* 1990;335:164.
- 4 Russell RC. Survival of insects in the wheel bays of a Boeing 747B aircraft on flights between tropical and temperate airports. *Bull World Health Organ* 1985;65:659-62.
- 5 Kondrashin AV, Orlov VS. Migration and malaria. In: Service MW, ed. *Demography and vector-borne diseases*. Boca Raton, FL: CRC Press, 1989.

Should good Samaritans claim a fee?

EDITOR,—I have always thought that the calls for help on aircraft for a doctor to come forward were a summons to do one's best for a fellow traveller, taking into account one's training and the equipment available. I could never imagine asking the patient which company he or she was insured by (virtually all passengers in civil aircraft are insured by somebody) and then sending a bill. The good Samaritan never asked for recompense. Is this changing?

I recently saw an account submitted to an insurance company by a doctor who had escorted a patient across the Atlantic for a second company. One of the first company's customers had had a severe attack of angina. Valuable help and advice were given, but at what stage is it right to start charging for this help? Will we start checking at the roadside to see whether accident victims' general practitioners are fundholders? Should rail tickets, especially first class ones, include details of private medical cover in case of the holder's collapse.

If the ethic of the good Samaritan is replaced by that of Good Samaritan plc where will it all end?

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Managing in flight emergencies

Emergency kit will now contain fatal dose of lignocaine

EDITOR,—While we admire the way in which W Angus Wallace and T Wong dealt with a tension pneumothorax under the adverse circumstances of a long haul flight, some comments have left us confused and concerned.¹

The inability of both clinicians to calculate the percentage of lignocaine provided (1%) serves to highlight the findings of S Rolfe and N J N Harper that many doctors are confused by the varying presentations of the drug content of an ampoule.² Nevertheless, it seems that the lignocaine was

used, as the chest drain was inserted "under local anaesthetic." In the discussion the authors comment that "a suitable local anaesthetic would, however, have been a helpful addition." This implies that the 1% lignocaine provided, and presumably used, was inadequate. Finally, the plan to include a 20 ml multidose phial of 2% lignocaine in the M5 medical emergency kit in future is worrying. Such an ampoule would contain 400 mg of lignocaine, which is twice the current maximum recommended adult dose of 200 mg.³ This could lead to the administration of a toxic dose, especially when circumstances are less than ideal. We therefore question the need for such a concentrated solution of lignocaine, as 1% is adequate for most surgical and medical emergencies.

For future reference the volume, per cent concentration, and dose of a drug are simply related by the formula:

$$\text{Volume (ml)} \times \% \text{ concentration} \times 10 = \text{dose (mg)}$$

Thus if any two are known the third can easily be calculated.

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- 1 Wallace WA, Wong T, O'Bichere A, Ellis BW. Managing in flight emergencies. *BMJ* 1995;311:374-6. (5 August.)
- 2 Rolfe S, Harper NJN. Ability of hospital doctors to calculate drug doses. *BMJ* 1995;310:1173-4. (6 May.)
- 3 BMA and Royal Pharmaceutical Society of Great Britain. *British national formulary*, number 29. London: BMA, RPSGB, 1995.

Glove and cannula approach is easier

EDITOR,—I applaud W Angus Wallace's ingenuity, which upholds a long orthopaedic tradition of improvisation.¹ I suggest, however, that the next time he is confronted with this problem he uses the coat hanger to hang up his coat. Using a large intravenous cannula and sterile surgical glove, one can pass the point of the cannula through the end of the middle finger of the glove from within, with the hub of the cannula remaining in the glove. The tip of the cannula can then be quickly and easily inserted into the pleural cavity with the glove attached around the waist of the cannula; the glove will hang over the hub of the needle, acting as a flap valve.

I suggest that, having done this, Wallace returns the bottle of brandy to the nearest air hostess in exchange for a respectable malt whisky and returns to his seat to enjoy the remainder of the flight.

This technique is by no means new and has been used in outlying clinics in Africa, where coat hangers and brandy are, alas, at a premium.

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- 1 Wallace WA, Wong T, O'Bichere A, Ellis BW. Managing in flight emergencies. *BMJ* 1995;311:374-6. (5 August.)

Plane should not have left the ground

EDITOR,—I initially read about W Angus Wallace's adventure—in performing an operation on board an aeroplane flying from Hong Kong to London—in the British press and thought it a ripping yarn. When I read his own account of it I was aghast.¹

When the patient was first drawn to Wallace's attention the aircraft was still on the ground in Hong Kong; this detail was not made clear in the newspaper accounts. Wallace was called to

examine a woman who had been involved in a vehicle accident on her way to the airport. The accident was sufficiently violent to have fractured a long bone. Despite having "attended an advanced trauma and life support course" he failed to examine the patient properly—on his own admission he did not carry out a full primary survey of the patient at the outset. Nor did he insist that the patient be transferred from the plane for a proper evaluation, which would have been simple and taken only a few minutes.

Admittedly, the "Heath Robinson" chest tube drainage that he performed during the flight was ingenious, but what if she had had a ruptured liver or spleen? His Sellotape and coat hanger would not have helped then. Surely the best way of managing an in flight emergency is to avoid it if at all possible.

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1 Wallace WA, Wong T, O'Bichere A, Ellis BW. Managing in flight emergencies. *BMJ* 1995;311:374-6. (5 August.)

Professor Wallace's reply

EDITOR,—When I was first asked to examine Paula Dixon she was complaining only of pain in the right forearm. She told me that she had injured her right forearm when she fell off her bike on her way to the airport. I assumed, incorrectly, that she had fallen off a bicycle and had injured the forearm while breaking her fall. It was only later (during the flight) that we learnt that she had been a passenger on a motorbike and had been thrown from it when it was in collision with a car. I have found, since this episode, that it is fairly common for airline passengers to conceal the truth if there is any possibility that they might be taken off their flight, and it is important for doctors to be fully aware of this.

Paul D Buisseret is right in highlighting the fact that I had been on an advanced trauma and life support course and yet failed to carry out a primary survey. There were three reasons for this. Firstly, Ms Dixon had not told me about the motorcycle accident and reported no problems other than that with her forearm; secondly, she was seated at the rear of the aircraft, which had no empty seats and little space available, although I could have carried out an acceptable primary survey with her seated; and, finally, Ms Dixon could easily have construed a primary survey examination of her limbs, spine, pelvis, and chest as misbehaviour. Doctors often forget how much easier it is to carry out such examinations either at the scene of an accident or in hospital.

In retrospect, perhaps I should have transferred Ms Dixon from the plane (thereby causing her to lose her economy flight home), but I took the action that I believed was correct on the basis of the information available to me. Perhaps others will learn from my experience and be slightly more cautious when called on to give medical help.

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American cardiothoracic trainees want longer hours too

EDITOR,—We are currently visiting England from the United States and training as senior surgical registrars in paediatric cardiac surgery at Great Ormond Street Hospital. As interested external observers of the British system of medical training, we strongly support the letter from the British

senior registrars in cardiothoracic surgery.¹ Like them, we believe that "cardiothoracic surgery is by reputation, and often in practice, an arduous specialty."

We think that technically oriented subspecialties such as cardiac surgery are different from most subspecialties because the trainees have to learn certain skills by repeating tasks in highly supervised settings. Consequently, it is not logical to place the same constraints on hours on these advanced subspecialties as are placed on most postgraduate training programmes. Certain exceptions to the standard constraints on working hours are necessary to allow cardiac surgeons in training to acquire the necessary skills and to gain exposure to rare cardiac lesions. They must be exposed to this work if they are to be safe and productive cardiac surgeons.

We have done many years of training since leaving medical school. This year's workload has been by far the lightest. Nevertheless, we have been told that we may be working more hours than we should. Unfortunately, this comes at a time when increased exposure to operations would be useful.

Great Ormond Street Hospital has an international reputation for training the best paediatric cardiothoracic surgeons in the world; limiting the hours of exposure will dilute their overall experience and compromise their training. Similarly, placing severe restrictions on the working hours of cardiothoracic surgeons in general threatens their training. We agree with our British colleagues that "not all hospital based specialties are similar." Furthermore, not all hours on call are similar. Thus we agree that all junior doctors in all specialties should not be governed by the same regulations, because each specialty is unique.

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1 Alkhulaifi A, Allen SM, Anderson JR, Argano V, Austin C, Barlow C, *et al*. New deal not satisfactory for cardiothoracic surgery. *BMJ* 1995;311:953. (7 October.)

Continuing confusion over the eponymous possessive

EDITOR,—Despite discussion in the medical press for many years the use of the possessive form for eponymous syndromes and diseases remains as confused and inconsistent as ever. For example, some medical dictionaries, such as Black's, consistently use the possessive form whereas others, such as Jablonski's, equally consistently use the non-possessive.^{1,2} *Index Medicus*, which might be expected to be authoritative, is hopelessly inconsistent, listing some possessive forms (for example, Alzheimer's, Hodgkin's, Huntington's, Klinefelter's, and Turner's) and some non-possessive forms (Crohn, Down, Marfan, Parkinson, and Rett).³ Fanconi appears in the possessive form for the anaemia but not for the syndrome. Nor is current or recent use much help. A search of titles in the *Science Citation Index* for 1981-5 and 1991-5 shows that the use of the possessive has decreased for chromosomal syndromes—from 60% to 52% for Down's, from 74% to 62% for Klinefelter's, and from 64% to 42% for Turner's. Huntington's has also decreased slightly, from 82% to 76%.⁴ Alzheimer's and Hodgkin's, however, have remained steady at about 90% and 95% respectively, while Parkinson's has increased from 87% and is now (despite *Index Medicus* and Jablonski) almost universal at 98%.

I have no strong views about which form is preferable. The lack of consistency, however, causes needless complications when one searches the literature. Is it not time for the editors of the major medical journals to come to an agreed position and to issue firm guidelines on use?

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- 1 Macpherson G, ed *Black's medical dictionary*. 37th ed. London: A and C Black, 1992.
- 2 Jablonski S. *Jablonski's dictionary of syndromes and eponymic diseases*. Malabar, FL: Krieger, 1991.
- 3 National Institute of Health. *Medical subject headings, supplement to Index Medicus*. Vol 36. Bethesda, MA: NIH, 1995.
- 4 Institute for Scientific Information. *Science citation index*. Philadelphia: ISI, 1995.

Corrections

Asking patients to write lists

A typesetting error occurred in the first letter in this cluster, by Alejandro R Jadad (16 September, p 746). The P value given in the middle of the penultimate paragraph should read $P < 0.05$ [not $P \geq 0.05$, as published].

Volume and mortality in coronary artery bypass grafting

An authors' error occurred in this letter by Harold S Luft and Jennifer D Parker (11 November, p 1304-5). The y axis in the figure was incorrectly labelled and shows the ratio of observed to expected mortality [not mortality adjusted for risk, as published].

Differences in progression of HIV infection between men and women

Owing to a typesetting error the table was omitted from this letter by Matthias Egger and colleagues (8 April, p 941). The table, which is mentioned in the penultimate paragraph, is reproduced here.

Details of subjects with disseminated cytomegalovirus infection among participants in Swiss HIV cohort study who were infected by injecting drug use or heterosexual sex and were free of AIDS at entry to study

	Women (n=998)	Men (n=1469)	P value
Characteristics of patients at entry:			
No (%) of injecting drug users	534 (54)	1013 (69)	<0.001
Mean (SD) age (years)	28.9 (6.6)	31.0 (6.8)	<0.001
Mean (SD) CD4 cell count ($\times 10^6/l$)	504 (34)	446 (33)	<0.001
Disseminated cytomegalovirus disease:			
Total No of events	4	12	0.2
No of AIDS defining events	0	5	0.07
Relative rate (95% confidence interval)*	0.57 (0.18 to 1.83)		0.34

*From Cox regression, including all events; comparing women with men; and adjusting for category of transmission, age, and CD4 cell count.