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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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.^{1,3} 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.⁵

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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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