- 2 Ross RB. Growth of the facial skeleton following the Malek repair for unilateral cleft lip and palate. *Cleft Palate Craniofac J* 1995;32:194-8.
- 3 Horswell BB, Pospisil OA. Nasal symmetry after primary cleft lip repair. *J Oral Maxillofac Surg* 1995;53:1025-30.
- 4 Brusati R, Mannucci N. Repair of the cleft palate without lateral release incisions: results concerning 124 cases. *J Cranio-maxillofac Surg* 1994;22:138-43.

Prefer diazepam for initial control of pre-eclampsic fits

EDITOR,—James P Neilson¹ draws attention to data from a recent trial comparing three anti-convulsant regimens for women with eclampsia.² He suggests that magnesium sulphate is the drug of choice, its main advantage being the lower rate of recurrent convulsions. He makes no distinction, however, between the control of an active convulsion and the prevention of further fits.

It is important to achieve rapid control of an eclamptic fit because of the risks of hypoxia (to the woman and fetus), inhalation of gastric contents, and physical injury. We believe that diazepam given intravenously is the best available agent for this. It is highly effective at stopping convulsions³ and can be given simply and quickly: it takes little more than a minute to obtain a syringe, needle, and phial of diazepam from the emergency trolley and to check, prepare, and start giving the drug. The convulsion generally stops within one minute of the injection being started. In addition, most doctors already have experience of using diazepam in status epilepticus. Magnesium sulphate has been used by some units to stop eclamptic convulsions,⁴ but the time needed to prepare the drug is longer, and most junior obstetricians will have had no experience of rapid intravenous infusion of magnesium sulphate when first faced with a woman having an eclamptic fit.

We suggest that eclamptic convulsions should be controlled initially with intravenous diazepam and that further fits should then be prevented with magnesium sulphate.

ROBERT FOX
Consultant obstetrician

Department of Obstetrics and Gynaecology,
Taunton and Somerset Hospital,
Taunton TA1 5DA

TIM DRAYCOTT
Obstetric registrar

Department of Obstetrics and Gynaecology,
St Michael's Hospital,
Bristol BS2 8EG

- 1 Neilson JP. Magnesium sulphate: the drug of choice in eclampsia. *BMJ* 1995;311:702-3. (16 September.)
- 2 Eclampsia Trial Collaborative Group. Which anticonvulsant for eclampsia? Evidence from the collaborative eclampsia trial. *Lancet* 1995;345:1455-63.
- 3 Crowther C. Magnesium sulphate versus diazepam in the management of eclampsia: a randomized controlled trial. *Br J Obstet Gynaecol* 1990;97:110-7.
- 4 Pritchard JA, Pritchard SA. Standardized treatment of 154 cases of eclampsia. *Am J Obstet Gynecol* 1975;123:543-52.

Amphetamine misuse in southern Italy

EDITOR,—Recreational use of amphetamines has always been widespread in drug misusers referred to our service. Recently 3,4 methylenedioxymetamphetamine (MDMA or "ecstasy") has been used in combination with other drugs, generally heroin, with a particularly powerful effect. Being new, these drugs are not familiar to our health workers, but our clients' willingness to talk has let us study the consequences of combining drugs.

We have also found an increase in the presence of amphetamine metabolites in urine specimens tested, especially in clients who have just come out

of prison or those from a district prison who have been put under our care. These metabolites have also been found in specimens from patients who are being treated and are not using opiates.

Thus there seem to be two distinct populations, with two different forms of drug misuse: those addicted to heroin, and those experimenting with various drugs.

Drug misusers who are not taking heroin most commonly use ecstasy, in tablets or as crystals (possibly this is metamphetamine), and secondarily amphetamines. Few young people not misusing heroin come to our service; mostly they use "designer drugs," especially in discos, where the effects are strengthened by particular sound frequencies and alcohol. There is misinformation about these new drugs: organised crime deliberately emphasises their "positive" effects (aphrodisiac effects, euphoria, happiness, disinhibition, lack of weariness), but negative effects are commonly reported by our clients: hallucinations, tachycardia, nausea, vertigo, panic, muscular pains, etc.

Recently a large quantity of ecstasy has been confiscated in Italy, and further study of the situation is necessary but difficult. To prevent drug misuse, the social aspects of young people's leisure should be analysed, and drug free lifestyles should be promoted. We should also study the use of amphetamines in drug users who are not taking heroin—even if these people are heroin free for the time being, they are not drug free.

LUIGI RECCIA
Biologist
ANDREA ROCCO
Physician

Territorial Addiction Service,
Naples 3 ASL, Regione Campania,
via Pitagora 13,
S Antimo,
80029 Naples,
Italy

MAURIZIO LIONIELLO
Physician
GIAMPIERO FICHERA
Physician

Medicine Division,
Capituli Hospital,
Capri,
80073 Naples,
Italy

- 1 Brown C, Osterlich J. Multiple severe complications from recreational ingestion of MDMA (ecstasy). *JAMA* 1987;258:780-1.
- 2 Perez-Reyes M, White WR, McDonald SA, Hicks RE. Interaction between ethanol and dextroamphetamine: effects on psychomotor performance. *Alcohol Clin Exp Res* 1992;16:75-81.

Deputising general practitioners' role in emergencies

Lessons for both doctors involved

EDITOR,—I read J N Rawlinson's letter about the care given to a neighbour by a deputising doctor with some concern.¹ We all have anecdotes that show doctors or departments to be less than perfect, but we are all trying to provide the best service we can despite the pressures we face.

I am not the doctor this tale was about, but, as a general practitioner in an inner city area, I have chosen to hand over my out of hours calls to a deputising service. In return I work two shifts a month for the service.

I would like to reassure Rawlinson that training in resuscitation is required before a doctor is allowed to become a principal in general practice. Sadly, these skills can become rusty. I have never been called on to provide cardiopulmonary resuscitation in the community in 16 years of practice, though I try to attend yearly update sessions. I greatly value the skills of paramedics, who should

be confident enough not to allow themselves to be held back.

The deputising doctor did not know Rawlinson's neighbour, and a sudden death in the community has to be reported to the coroner's officer. Only the coroner or the patient's regular medical attendant can issue a death certificate. A deputising doctor can only confirm that life is extinct so that the body can be moved.

I have no doubt that the woman's general practitioner would have provided comfort had he been on call, but perhaps he stopped doing his own calls for the same reason that the deputising doctor was in a rush: because he had so many calls to make to crying babies, adults with diarrhoea and vomiting, and well children with rashes.

Finally, Rawlinson seems to have been keen to take over the woman's care when the use of advanced skills was necessary but to have looked to a person who did not know the family to provide comfort afterwards. Perhaps all staff doctors specialising in accident and emergency should also be trained in providing comfort.

JOSEPHINE FLEMING
General practitioner

Charlotte Keel Health Centre,
Bristol BS5 0UA

- 1 Rawlinson JN. Deputising general practitioners' role in emergencies. *BMJ* 1995;311:394. (5 August.)

GPs do not have a monopoly on supporting the bereaved

EDITOR,—J N Rawlinson raises several important points about a neighbour's death.¹ They are particularly important because of the increasing number of deputising services and the increasing expectations of patients. What concerns me most, however, is Rawlinson's implication that it is a general practitioner's role to stay with a bereaved person in all cases of sudden death. There may well be occasions when this is appropriate, but what of the role of the family, neighbours, and the church? The doctor on duty probably had a considerable number of calls to make after he had dealt with this patient.

It is becoming increasingly difficult to provide a high quality service at the same time as a high quantity service. Unless some central action is taken to reduce inappropriate demands for out of hours care, those for whom such care is appropriate, such as Rawlinson's neighbour, may not always receive the service they deserve.

N JOHN SHARVILL
General practitioner

Deal CT14 7AV

- 1 Rawlinson JN. Deputising general practitioners' role in emergencies. *BMJ* 1995;311:394. (5 August.)

Romantic expectations of out of hours care cost GPs dear

EDITOR,—J N Rawlinson's pain, distress, and guilt at having taken part in an unsuccessful attempt to resuscitate a neighbour are evident, and the author is clearly angry at the deputising doctor for having taken so long to arrive and for then holding up the paramedics.¹ But surely we should be looking beneath the surface of this problem at the causes.

The patient's husband said that "[our] own doctor . . . would have stayed with me"; Rawlinson states that their own doctor would have cared for the family. This is a romantic view of general practice: it was their own doctor who had arranged for the deputy to attend, to relieve himself of the burden of working at all hours and being expected to do all things. Rawlinson seems to expect the general practitioner to be not only a skilled resuscitator and leader of the paramedic team but a