view of the heterogeneity of criminality).¹ He does not, however, mention food intolerance despite the widespread recognition that hyperactivity in children is often followed by criminality (this is acknowledged in the preceding editorial on preventing crime and violence²). The fact that many hyperactive children can be cured by diet has been established by two controlled trials, so if such treatment also prevented subsequent criminality this would provide more reason for optimism than the ones that Alper lists; more work on this is therefore needed.^{3,4}

The fathers of several of the patients I successfully treated with diet for this condition had criminal records and a similar history in childhood. One patient abandoned his diet in mid-teens and burnt his school down. I visited him in prison, when he said that he would like to try the diet again, but I do not think that this was achieved.

I believe that this food intolerance is allergic and is likely to be familial but of complex inheritance. I have no idea how commonly it causes criminality, but it is important for those in whom it does.

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Sedation in fiberoptic bronchoscopy

EDITOR,—I wish to reply to the letters¹ on the paper on sedation during fiberoptic bronchoscopy of which I was an author.² S P Hanley is correct in stating that nasal anaesthesia with lignocaine is unpleasant: patients often comment that this is the worst part of the procedure. Although some studies have been published in which nasal lignocaine has been given before sedation,³ it was our routine practice to give sedation first.⁴ M R J Parker and colleagues question the amount of topical anaesthesia used during the bronchoscopy. This was not formally measured but did not seem to differ among the three bronchoscopists or among the patients regardless of sedation.

Several letters discuss the recent report on sedation by the Royal College of Surgeons; owing to insufficient space this reference was not included. The report highlights the provision of monitoring equipment and staff trained in life support. This is important for chest physicians, who often perform bronchoscopy in isolation from other medical staff and need to be responsible for both the sedation and the bronchoscopy. Adequate nursing support is essential if sedation is used.

Gareth Thomas and Christine McBeth and Parker and colleague discuss the depth of sedation. This was not formally assessed, but a combination of reassurance and sedation was used to ensure that the patients were relaxed and cooperative—level 2 on the suggested scoring system.⁵ Patients received broadly similar amounts of sedation, and some were more sleepy than others after the procedure; nevertheless, the bronchoscopists had some difficulty in identifying patients who were sedated.

The use of sedation has financial implications and direct risks to patients' welfare,⁶ as Fraser W H Sutherland suggests. Patients who remain sleepy after the bronchoscopy, especially if they live alone, may need to stay in hospital overnight, which increases the costs of the procedure. Alternatively, patients may be allowed home after the sedation has been reversed by specific antagonists,

although differences in the half lives of the sedative and antagonist need to be considered. If sedation is used patients should be given clear instructions not to drive after the bronchoscopy, which potentially increases costs further if transport home needs to be provided.

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Albumin in the nephrotic syndrome

EDITOR,—We challenge Fehmi Akcicek and colleagues' argument against the use of albumin in the nephrotic syndrome on two counts.¹ The first concerns the selection of patients. The urinary protein loss, plasma creatinine concentration, and prior drug treatment are not given in their report, but we assume that the patients had not received either corticosteroids or diuretics. The mean excretion of 2.96 litres of water and 275 mmol of sodium after intravenous frusemide, implying weight loss of about 2 kg in 24 hours, indicates that these patients were not resistant to diuretics. The absence of synergy between albumin and frusemide in such patients is not surprising and confirms that changes in oncotic pressure have no impact on the natriuretic response to loop diuretic.² We agree that albumin infusion is neither useful nor necessary in unselected nephrotic patients. Patients resistant to diuretics do, however, exist; they fail to achieve natriuresis despite strict bed rest, supervised restriction of sodium, and maximal intravenous diuretic treatment. Albumin infusion may be beneficial in these uncommon cases,³ and data from nephrotic patients who are sensitive to diuretics² should not guide management.

The second point concerns the timing of administration of albumin and diuretic. Akcicek and colleagues gave parallel infusions. Optimal efficacy of the combination occurs when loop diuretic is given at the end of a one hour infusion of 40 g salt poor albumin, possibly because the peak diuretic concentration then coincides with maximal expansion of intravascular volume. The table shows the results of this regimen³ in five compliant nephrotic patients, who satisfied our criteria for resistance to diuretics given above and attended our unit during 1994. Only one patient had minimal change disease. Satisfactory and sustained natriuresis was readily achieved; all

of the patients who had a deteriorating serum creatinine concentration improved within one week.

Patients with the nephrotic syndrome are haemodynamically heterogeneous. Measures of plasma volume and oncotic pressure correlate poorly with response to treatment. Albumin infusion is not routinely indicated in the nephrotic syndrome, and, as with all blood products, use should be minimised. In selected cases, however, an appropriately administered combination of hyperoncotic albumin and loop diuretic facilitates removal of extracellular fluid and can ameliorate uraemia induced by diuretic.

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Advance directives

EDITOR,—George S Robertson acknowledges the considerable work of the BMA's medical ethics committee in refining the concept of an advance directive in Britain.¹ Following the recommendation of the House of Lords Select Committee on Medical Ethics that a code of practice for health professionals should be developed, the BMA, the Royal College of Nursing, and the medical royal colleges have worked together to develop such a code; it was published at a special conference on 5 April after the final report of the English Law Commission. Both the Department of Health and the English and Scottish Law Commissions have participated in the drafting of the BMA's code of practice. The medical ethics committee will consider the finalised version of the code and present it to the BMA's council for approval.

The working group and the medical ethics committee do not share Robertson's conclusion that a standard form offers the best way forward. In our view, an advance directive must be tailored to the needs of the individual patient rather than the patient being constrained by the necessary rigidities of a standardised form. It is often assumed that patients wish to make detailed arrangements about all aspects of their care or, alternatively, to express a general wish to avoid overenthusiastic medicine. In our experience, however, patients often wish to use an advance directive to control only a small and apparently minor aspect of their terminal care, leaving all other decisions to the doctor. A patient may, for example, wish to signify only a desire to die at

Details of five patients given loop diuretic at end of one hour infusion of salt poor albumin

Case No	Age (years) and sex	Diagnosis	Urinary protein (g/day)	Serum albumin (g/l)	Dose of intravenous frusemide before infusion (mg/day)	Serum creatinine (μmol/l)		Weight loss (kg)	
						Before infusion	After infusion	In first week	Total*
1	68 F	Diabetic nephropathy	15	18	100	107	112	4	10
2	20 M	Focal sclerosing glomerulosclerosis	21	16	330	235	169	4	7
3	77 F	Membranous glomerulopathy	8	15	200	122	105	4	10
4	54 M	Minimal change disease	14	21	200	263	172	3	8
5	58 F	Focal sclerosing glomerulosclerosis	16	26	250	287	199	6	16

*Determined retrospectively after treatment.