

Each of these topics is relevant to all occupational groups. Whereas some of these projects might be beyond any single industry to fund, the Foundation can provide a formal mechanism, so that industrial organizations can combine forces and work with each other and with academic departments, to carry out a research project of common interest.

There seem to be grounds for optimism that the British Occupational Health Research Foundation can attract funds, and can aspire to join the Association of Medical Research Charities. This association currently has 41 members, and the criteria for membership are that the principal activity should be medical research and the members should spend more than £250 000 per annum in the UK and use peer review in the allocation of grants and support for research. These principal 41 Medical Research Charities spent £170 million on medical research in 1989/1990. They cover every conceivable specialty that you can imagine, with one exception - Occupational Health.

It is, therefore, high time that our own specialty had its own charitable foundation. The seeds that were sown at the Green College Symposium two summers ago have borne fruit. I am very pleased that The British Occupational Health Research Foundation became a registered charity on 5 June 1991 (Reg. No. 1003105). We have a splendid Board of Trustees, drawn from the top ranks of industry, some of whom will serve on the Management and Scientific Committees with Occupational Health professionals.

On 1 June 1991, Mr David McWilliam took up his appointment as Director-General.

Now all that remains is for us to start raising the funds, so that the work of the Foundation can begin. If well supported, the creation of the Foundation could be as important a milestone in the development of Occupational Health in this country, as the founding of the Society and Faculty of Occupational Medicine, and the creation of this Section 27 years ago.

Sir Christopher Lawrence-Jones  
President (1990/91)  
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#### References

- 1 Harrington JM. Research in occupational medicine - thriving or dying? *J Soc Occup Med* 1990;40:29-33
- 2 News. *Lancet* 1989;ii:232
- 3 The Charity Commissioners - explanatory leaflets. (St Alban's House, 57 Haymarket, London SW1Y 4QX)
- 4 The Association of Medical Research Charities Handbook 1990-1991 (14 Ulster Place, London NW1 5HD)
- 5 Fogarty M, Christie I. *Companies and Communities*. (Policy Studies Institute, 100 Park Village East, London NW1 3SR)
- 6 Ross Treman (Industrial Correspondent). Charity survives the recession. *Times* 18 February 1991

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## Letters to the Editor

Preference is given to letters commenting on contributions recently published in the *JRSM*. They should not exceed 300 words and should be typed double-spaced.

### From smoking behaviour to nicotine addiction: the history of research

Esunge (October 1991 *JRSM*, p 621) discusses the spectacular changes during the last decades in high blood pressure treatment and points out that the main objective of medicine is to keep healthy people healthy, and sick people well. A short review of the history of research on another risk factor - smoking - gives us lots of parallels. There is, however, one big difference; the medical treatment of nicotine addiction is only in its infancy, somewhere in the early fifties in comparison to hypertension treatment. The only efficient pharmacological treatment today is nicotine replacement.

The results in smoking cessation are still bad. Even if nicotine replacement can double the result compared to placebo, the absolute success rates are still very low after 6-12 months. The treatment of recalcitrant smokers in the coming years will most probably still be symptomatic, ie nicotine replacement for shorter or longer time.

'New drugs are however in the horizons, hopefully promising . . .' to increase the success rates in smoking cessation. And hopefully smoking will - in a not too far future - be treated in the same efficient way as hypertension and hyperlipidaemia.

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### Postoperative fluid therapy

I enjoyed the recent article by Kruegener *et al.* (October 1991 *JRSM*, p 611) describing the hazards of dextrose saline when thoughtlessly and automatically prescribed in the postoperative period. A further potential metabolic complication of dextrose saline which also merits attention is hypophosphataemia.

Guillou *et al.*<sup>1</sup> found that both the duration and severity of postoperative hypophosphataemia were greater when dextrose saline was used as maintenance fluid therapy as compared to 0.9% saline. As urinary phosphate excretion was the same in both groups, hypophosphataemia was ascribed to a shift of phosphate from the extracellular to the intracellular space. Glucose promotes cellular uptake of phosphate; insulin promotes uptake of both. This effect is well recognized with hypertonic dextrose solutions and total parenteral nutrition without adequate phosphate supplementation, which are common causes of hypophosphataemia<sup>2</sup>. Other factors which may