

includes better communication between general practitioners and community physicians. It may well be that the best thing is for doctors to communicate only with community physicians, but if the quality of the information provided by general practitioners is to improve they must know what happens to housing "lines" that they write for patients and how assessments are made so that the relevant medical information can be provided.

If doctors had a greater awareness of how the council housing system works more doctors, not just community physicians, might contribute to the debate on housing.

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Recommendations on blood pressure measurement

SIR,—The recommendations on blood pressure measurement prepared by a working party of the British Hypertension Society (6 September, p 611) contain much useful practical information and deserve widespread publicity.

I found one point rather puzzling: in the section entitled "Indication for measurement in both arms" it is recommended that "blood pressure should be measured in both arms in all patients with raised blood pressure at the initial assessment." But what if there is a significant difference in the blood pressure in the two arms and one is unlucky enough to measure the blood pressure only in the arm in which it is falsely low? Clinically important hypertension might be missed. In a case-control study examining the prevalence of various cardiovascular risk factors in patients presenting with cerebrovascular disease, the full results of which will be submitted for publication shortly, seven of 109 patients (6.4%) presenting with cerebral transient ischaemic attacks and 16 of 492 control subjects (3.3%) from the general population were found to have a consistent difference of 20 mm Hg or more in blood pressure between the two arms. Virtually all of these had a palpable difference in the radial pulses. These findings suggest that a more logical recommendation would be that both radial pulses should be palpated and that in every patient (with or without raised blood pressure) the advice given by de Bono should be followed—namely, "when a difference in the pulse in two arms is suspected, the blood pressure should be recorded on both sides."¹

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1 de Bono DP. The cardiovascular system. In: Macleod J, ed. *Clinical examination*. 6th ed. Edinburgh: Churchill Livingstone, 1983.

Severe head injury: the first hour

SIR,—Mr Peter Richards's leading article (13 September, p 643) is a timely update on management of the potentially fatal head injury but serves to illustrate the unsatisfactory provision for such patients in the United Kingdom. With some shining exceptions—for example, Addenbrooke's in Cambridge, Belfast, and a few other centres—the service is to a large extent provided by general or orthopaedic surgeons. Such surgeons are invariably caught up in their own "hidden specialty" whether it be spinal surgery, coloproctology, or arterial surgery and on the whole are not as familiar with developments in the management of head injury as in their own specialty. On the other hand, the neurosurgeon, who is the clinician of choice for

this type of patient, is invariably based in a regional unit often remote from the district hospital accident and emergency department. Furthermore, some regional neurosurgical units do not have the benefit of on site support from their orthopaedic, general surgical, and other district surgical colleagues. The dilemma will probably worsen as specialisation proceeds over the next decade.

A possible solution may be the development of an accident and emergency ward within the district hospital, together with the relocation of the regional neurosurgical unit to the district hospital site. So that patients do not fall between the various stools of specialist surgery there is a need for clinicians who are dedicated to trauma and emergencies in general and head injuries in particular. It may be that the new and growing specialty of accident and emergency surgery would be best suited to provide such clinicians. Finally, with proper development and collaboration between hospital and community rehabilitation units the sorry spectacle of a disabled patient with a head injury from which he might have recovered languishing inappropriately in an acute general surgical or orthopaedic ward would be a thing of the past.

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Obstetric anaesthetic services

SIR,—In his letter concerning obstetric anaesthetic services (30 August, p560) Dr TB Boulton advocates closure of small obstetric units in order to secure better staffed and safer anaesthetic services. Everyone knows the difficulty administrators experience in securing the closure of small, locally popular units, so it may be some time before this happens. Meanwhile, could not consideration be given to the use of simpler (and, equally, safer to the mother) methods instead of more sophisticated techniques requiring endotracheal intubation (responsible for five deaths in the recent triennial report¹)?

Such a suggestion is not as outrageous as some anaesthetists may think. Thirty years ago Parker reported that in Birmingham, from 1942 to 1952, 3048 general anaesthetics were given in patients' homes for forceps delivery with no morbidity or mortality.² The method used was presumably entirely open drop ether or chloroform. Over the same period there were 215 000 deliveries at Birmingham Maternity Hospital. Of these women requiring anaesthesia, eight died from aspiration of regurgitated gastric content. In each case the anaesthetic consisted of nitrous oxide, oxygen, and ether. A reminder of the safety of obstetric anaesthesia by the open drop ether method appears in a report of the use of this method at the Women's Hospital in Katmandu, Nepal, where 90% of all anaesthetics are given by junior obstetric residents.³ Over 12 months 535 caesarean sections were carried out under open drop ether without any morbidity or mortality ascribable to the anaesthetic. These findings support my undocumented observations at Kandang Kerbau Maternity Hospital, Singapore, during the two years immediately preceding and after the second world war. As at Katmandu, practically all anaesthetics were given by newly qualified obstetric residents with open drop ether. The turnover of patients was equal to, or even greater than that in Katmandu. I received no reports of death or other untoward complications, which I would have done as I gave anaesthetics twice a week at the general hospital for the professor of obstetrics and gynaecology at the King Edward College of Medicine. Two patients died while I was on leave, both of whom were induced with thiopentone, whose use was subsequently forbidden.

I am not advocating a return to open drop ether in isolated obstetric units. There is now a wider choice of non-irritant and more pleasant inhalat-

ional agents and Epstein and Macintosh, Oxford inhalers to replace the rag and bottle. Possibly a carefully controlled trial would confirm the safety of this method while at the same time prevent the complete disappearance of the art of inducing anaesthesia by inhalational methods.

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- 1 Cloake E. Report on confidential enquiries into maternal deaths in England and Wales 1979-81. *Health Trends* 1986;18:40-3.
- 2 Parker RB. Risk from aspiration on vomit during obstetric anaesthesia. *Br Med J* 1954;ii:65-9.
- 3 Maltby JR, Dibaba SM, Hira D. Open drop ether anaesthesia for caesarean section: a review of 420 cases in Nepal. *Can Anaesth Soc J* (in press).

Use of captopril in insulin dependent diabetics

SIR,—The results of Dr Eva Hommel and colleagues (23 August, p 467) and Dr Steffan Björck and colleagues (23 August, p 471) seemed encouraging and no side effects of treatment with captopril in their diabetic patients with nephropathy were recorded. Dr Hommel and colleagues concluded that "captopril represents a valuable new drug for treating hypertensive type 1 diabetic patients" and Dr Björck and colleagues that "captopril is an efficient and safe antihypertensive drug."

On the basis of these and other studies the prescribing of captopril to insulin dependent diabetic patients with hypertension will probably increase though we think that a degree of caution in such patients is necessary. Two case reports of profound hypotension occurring in patients taking captopril for hypertension, who developed intercurrent salt and water depletion due to diarrhoea, were published in 1985.^{1,2} Insulin dependent diabetic patients are at risk of episodes of ketoacidosis with attendant severe salt and water depletion, and, in the presence of angiotensin converting enzyme inhibition, profound hypotension could develop rapidly. Although diabetic ketoacidosis did not occur during either of these two studies, the patients had good metabolic control (haemoglobin A_{1c} 8.9% in one study and 10.9% in the other) and the combined observation period of both trials was only 32 patient years.

We would therefore suggest that captopril should be used only with caution in insulin dependent diabetic patients.

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- 1 McMurray J, Mathews DM. Effect of diarrhoea on a patient taking captopril. *Lancet* 1985;ii:581.
- 2 Bennett PR, Cairns SA. Captopril, diarrhoea, and hypotension. *Lancet* 1985;ii:1105.

Salaries of clinical academic staff

SIR,—While clinical academic staff welcome the publicity given to their salary problems by Scrutator (27 September, p 831), the nub of the matter is not the need for the government to bridge the gap between the increase that all university dons will receive and the amount needed to keep clinicians in line with NHS doctors. The salary of dons is irrelevant to the argument. Clinical academic staff have parity with NHS staff and that is the only salary link. The issue is the failure of the government to produce the appropriate funding.

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