

which incorporate a halogen source and fiberoptic distribution of light generally enable an accurate assessment of the tympanic membrane to be carried out in the surgery.

While the value of pneumatic otoscopy is beyond dispute the mobility of the tympanic membrane can be determined without the traditional Siegle speculum. A valveless rubber bulb simply fitted to the nipple incorporated into most auriscopes with a closed head enables the examiner to alter the air pressure within the external auditory canal while observing whether corresponding movements of the tympanic membrane occur.

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A new method of auditing surgical mortality rates: application to a group of elderly general surgical patients

SIR,—The recent paper by Dr David Gwyn Seymour and Mr Robert Pringle (22 May, p 1539) describes a sensible refinement of activity analysis whereby non-viable issues are not debated at length. The danger does arise, however, that certain categories of illness can conveniently be ascribed to a non-viable category when this may not necessarily be the case. Some would question whether attributing a death to misdiagnosed myocardial infarction at any stage along the referral process to hospital really was correctly categorised as non-viable and certainly the inclusion of postoperative stroke complicating a surgical illness might possibly reflect on occasions suboptimal patient management before and after operation. Certainly let us exclude from analysis those patients for whom surgery has little to offer but let us be certain that this exclusion does not include any potentially viable admissions.

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Objective test for food sensitivity in asthmatic children: increased bronchial reactivity after cola drinks

SIR,—We were interested to read the paper by Dr N Wilson and others (24 April, p 1226) on the effect of cola drinks on airway reactivity in children. The idea that a substance may alter sensitivity to known bronchoconstrictors without actually causing airway narrowing itself is appealing. A similar mechanism may account for the wheezing induced by alcohol in patients who are taking chlorpropamide. Leslie *et al*¹ have noted that some patients with asthma wheeze as part of the chlorpropamide alcohol flush reaction. We have described elsewhere² a more formal, controlled study of the reaction in patients with asthma and in normal subjects. In patients with asthma sherry following placebo resulted in bronchodilatation, especially in those whose airflow obstruction was severe, a response which has been described before.^{3,4} Prior ingestion of chlorpropamide significantly modified this response by causing overt bronchoconstriction in some patients. The mechanism for this bronchoconstrictor response would seem to parallel that in Wilson *et al*'s paper—that is, airway priming by one stimulus, such as cola

or chlorpropamide, with a second stimulus, such as an alcoholic drink, causing airway narrowing. A similar explanation could account for the increased histamine responsiveness in pollen-sensitive asthmatic subjects during the summer months recorded by Altounyan some years ago. The mechanism underlying this interaction of stimuli may involve synergism between mediators as shown for PGF_{2α} and histamine by Walters *et al*⁵ and between PGE₂ and bradykinin by Basran *et al*.⁶ It is likely that there are many interactions of this kind waiting to be defined in the asthmatic population.

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- ¹ Leslie RDG, Bellamy D, Pyke DA. *Br Med J* 1980; **280**:16-8.
- ² Ayres JG, Clark TJH. *Br J Dis Chest* 1982; **76**:79-87.
- ³ Herxheimer H, Stresmann E. *Arch Int Pharmacodyn Ther* 1963; **144**:310-4.
- ⁴ Davis WB, DaSilva AMT, Bloom R, Weir C, Hamosh P. *Amer Rev Respir Dis* 1980; **121**:124 (Abstract).
- ⁵ Walters EH, Parrish RW, Bevan C, Smith AP. *Thorax* 1981; **36**:571-4.
- ⁶ Basran GS, Morley J, Paul W, Turner-Warwick M. *Lancet* 1982; **i**:935-7.

Contact tracing

SIR,—I was very interested to read Professor M W Adler's leading article on contact tracing (now called health advising) (24 April, p 1211) but I must disagree with his view that recruitment of individuals from varied backgrounds would solve the problem of the 14% turnover. My feeling is that a nursing background is essential as part of total patient care. In the clinic where I work, as a sister and health advisor, I find that most patients are reassured in the knowledge that a professionally qualified person is advising and counselling them, not only on their original problem but on many other problems relating to their health or emotional needs. Incidentally, I have been to Harrogate on the training course and, while I found the course very useful in teaching interviewing and counselling skills, it did nothing to diminish my belief that a nursing background is the proper qualification for a contact tracer/health advisor.

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Male midwives

SIR,—The report of two studies into male midwives has recently been published.¹ Minerva (27 February, p 670) would have us believe that the report shows that men midwives are acceptable to mothers, an idea also promulgated by one of the medical weeklies.² Nothing, in fact, could be further from the truth.

The aim of the London study was "to investigate whether male midwifery pupils are markedly worse than their female colleagues . . . it is not necessary to show that they are better than the female pupils, only to show that the midwifery service will not suffer as a result of the scheme." In Scotland, they looked at the "social acceptability of male student midwives." The results must be considered against the background of currently provided and accepted midwifery practice in this country today.

In London, 17% of mothers booking at the Whittington Hospital and 15-45% of those booking at the City of London Maternity Hospital objected to male midwives. For inpatients, the rejection rates were 17% and 20% respectively. In Scotland, only 57% said that the sex of the midwife made no difference to them, while 39% found the idea of a male midwife unacceptable to varying degrees. The report itself concludes that the mothers themselves should have the last word. The results show that at least a fifth of mothers would find a system using male midwives worse than that in operation at present: the service would, therefore, inevitably suffer.

Men wishing to practise midwifery may follow existing training programmes in obstetrics and qualify thereby, albeit after a longer course. Pregnant women have no real choice but to accept the obstetric service at their local hospital and we must not allow any change to take place which might adversely affect their acceptance of it. In this and many other areas, changes in traditional standard practice are foisted upon us as the result of legislation without tangible benefit and often to significant detriment; it is time to call a halt.

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- ¹ *Male midwives: a report of two studies*. London: DHSS, 1982.
- ² *Medical News* 1982; Feb 25:2.

Controlled trial of chlorpromazine as antisecretory agent in patients with cholera hydrated intravenously

SIR,—The reduction of intestinal secretion, diarrhoea, and vomiting of cholera by chlorpromazine (8 May, p 1361) will not surprise those who remember Reilly's demonstration many years ago that chlorpromazine protected experimental animals against typhoid endotoxin,¹ and his subsequent suggestion that it deserved clinical trial alongside antibiotics in the treatment of typhoid.²

Whether this protective action arises through a peripheral effect of chlorpromazine on enzyme systems in the intestine or whether it is secondary to an action in the central nervous system is open to discussion.

Certainly evidence for a primary central action must not be ignored. It is both indirect and direct in nature. As indirect evidence is the fact that the peripheral vasodilatation produced by the drug is greater after intravenous than after intra-arterial injection,³ and the same applies with respect to the vasoconstrictor effect of adrenaline and noradrenaline, which although reduced after intra-arterial is reversed after intravenous injection.⁴ Thus, passage through the central nervous system intensifies the peripheral effects of chlorpromazine.

Direct evidence is even more convincing. After systemic administration chlorpromazine becomes concentrated in the brain and when it is injected directly into the ventricles the effects on behaviour and the electroencephalograph are similar to those seen after systemic administration.⁵

The site of the central effect of chlorpromazine is the brain stem reticular formation, on which it exerts a deafferenting action related to its property of antagonising the excitatory effects of noradrenaline on