

glycaemia, sometimes fatal,² with restricted food intake, age, and hepatic and renal disease alone or in combination being the main predisposing factors.

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¹ Clarke BF, Duncan LJP. *Lancet* 1968;ii:123-6.
² Seltzer HS. *Diabetes* 1972;21:955-66.

ABC of Diabetes: diabetic emergencies

SIR,—While making the useful point that potassium replacement should await the serum potassium result, Dr Peter Watkins (31 July, p 360) should perhaps have made the equally valid suggestion that insulin should not be given before this result is available as the combination of insulin and rehydration may precipitate hypokalaemia in initially normokalaemic patients, especially if potassium replacement is delayed. The counsel of safety is perhaps:

(1) To rehydrate with a potassium-free infusion of saline in the first instance (as he suggests).

(2) Commence insulin only when the potassium result is known, even if the delay is as long as two hours (the urgency for insulin is not great because rehydration per se lowers the blood glucose, by improving delivery of endogenous insulin to the tissues,¹ and ameliorates acidaemia).

(3) Commence potassium replacement with insulin if the patient is normokalaemic and later if the patient is hyperkalaemic.

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¹ Alberti KGM, Natrass M. *Med Clin North Am* 1978;62:799-814.

Prevalence of insulin-treated diabetes mellitus

SIR,—Dr Peter Watkins has discussed the prevalence of diabetes in his series (5 June, p 1690). There are two important reasons why we should be able to identify and count the numbers of (insulin-treated) diabetics in the UK. The first is the need for reliable figures on which specialists and general practitioners in a district health authority can in the future base plans for integrated and comprehensive services for diabetics. Secondly, we require practicable methods, which preserve confidentiality, for identifying individual diabetics who may be suitable for new treatments, screening for complications, or educational programmes.

We have attempted to estimate the number of insulin-treated diabetics in a defined population. The survey began in 1978 when all prescriptions for tablets and insulin issued by general practitioners, for the population of 870 570 served by the Nottinghamshire Family Practitioner Committee, were identified and recorded over a nine-month period. The capture of prescriptions led to the identification of 2630 insulin-treated diabetics, giving an estimated prevalence of 3.02 per 1000. The information from this survey was linked to a 12-month census of insulin-treated patients attending three Nottingham

diabetic clinics and to the records and disease registers of seven general practices. In the general practices insulin-treated diabetics were found using the combined sources of practice registers, records, clinic census data, and prescriptions. Of these, 86% were identified by prescriptions and 73% by the practice registers. Ninety-two per cent of the insulin-treated diabetics, said to be clinic attenders from information in the practice records, were found in the clinic census. Adjusting the estimate of prevalence for this level of under-reporting, yields a figure for insulin-treated diabetics in England and Wales of 3.51 per 1000, or 172 888 in the whole country based on 1982 population projections.¹

Other factors, such as insulins dispensed from hospital or bought over the counter would lead to under-reporting in our study, but the numbers are likely to be small. The prevalence ratio obtained from this study is similar to that of 3.4 estimated by Green *et al* (1981)² in Denmark from prescriptions issued in a population of 450 000.

There are no recently published prevalence estimates for insulin-treated diabetes in the United Kingdom, but we would be interested to hear from any other group with similar data.

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¹ Office of Population Censuses and Surveys. *Population projections 1978-2018*. Series PP2 No 10. London: HMSO, 1981.

² Green A, Haughe M, Holm NV, Rasch LL. *Diabetologia* 1981;20:468-70.

Op-Site and the DHSS

SIR,—I refer to the letter of Dr T S Warrender (31 July, p 378) describing his experience of the use of Op-Site for the management of a patient with malignant involvement of the skin from rectal carcinoma. I write to support his advocacy that this product should be made available on the drug tariff and to confirm the value of this product as a wound dressing for diverse clinical circumstances.

During the last two years I have used adhesive polyurethane membrane, marketed under the trade name of Op-Site, as a wound dressing for such varied conditions as burns, skin donor sites, skin graft recipient sites, wounds healing by secondary intention, clean incised surgical wounds, septic wounds, stasis ulcers, herpes zoster, abrasions, lacerations, and pressure sores, and from this experience I have developed a philosophy of wound care which I refer to as "minimal interference wound management."

On reflection the basic requirement for a wound dressing is that it should "cover and comfort"; that is to say, it should act as a barrier between the environment and the wound to prevent further contamination in either direction, be waterproof, act as a physical barrier against trauma, and relieve pain by covering exposed nerve endings. By so doing a dressing creates a suitable environment for the natural processes of healing to take place, and this is all that can be asked or expected of any dressing, notwithstanding the multiplicity of dressings that have been used in the past and that are

currently available. Op-Site serves these functions more than adequately and is in my experience the nearest approach to the ideal universal dressing that I have encountered.

During the past two years my policy for wound care has been to apply an Op-Site dressing to cover a wound area and generously beyond and to leave the dressing untouched with the accumulation of wound exudate under it until such time as the exudate starts to leak away from underneath the dressing. At that time the Op-Site dressing is removed, the wound is cleaned, and a fresh Op-Site dressing is applied—again to be left in place for several days until once again the accumulation of wound exudate makes replacement of the dressing necessary. During this time the wound is healing by the proliferation of granulation tissue followed by epithelialisation unhindered by the trauma attendant on the frequent changes of more traditional dressings, especially those which may become adherent to the wound granulation tissue. Op-Site, although strongly adherent to the dry skin surrounding a wound area, does not adhere to the moist surface of the wound itself and therefore constitutes a non-stick and an atraumatic dressing.

The advantages of this wound care regimen are several. The relative infrequency of the redressing constitutes an economy in materials and nursing time. This is especially true of patients managed at home, when visits by the community nurse may need to be no more frequent than twice a week. As the polyurethane membrane is waterproof patients can enjoy the benefits of having a daily bath or shower. Wounds are at all times visible through the transparent dressing, and their progress can be monitored without disturbing the dressing and causing the patient discomfort.

The application of this principle of leaving wounds to heal undisturbed under a dressing is analogous to managing septic compound fractures in a plaster cast as advocated forty years ago by Trueta.

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SIR,—May I support Dr T S Warrender (31 July, p 378) in his plea for the inclusion of the Op-Site dressings range in the drug tariff. In addition to the valuable use he quotes in the terminally ill these dressings are useful in other areas of primary care.

Those of us involved in the immediate care of seriously ill road traffic accident victims at the scenes of accidents find these dressings very useful for the fixing of intravenous cannulae and giving-set tubing. As we are often working in cramped and difficult conditions the neat textbook taping of cannulae and bandaging of the arm on to a splint is often impossible, and these dressings provide a rapidly applied means of fixing.

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What shall we do with the drunken citizen?

SIR,—I was encouraged by your leading article "What shall we do with the drunken citizen?" (31 July, p 323). I was encouraged