Fibre and Irritable Bowels

SIR,—I read with interest your leading article (1 June, p. 457) which referred to recent work on this disorder. I had just completed a survey of most of the medical journals of Africa south of the Sahara from 1960 to 1974 and had found no mention of this disease in Africans. In 1960 I had suggested as a tentative hypothesis that the rarity of non-infective colonic diseases in Africans was due to diets which contained large amounts of fibre-rich starchy carbohydrate. This may be called the "fibre hypothesis," those words being employed at that time. There appeared to be rarity of constipation, irritable bowel disease, diverticular disease, appendicitis, ulcerative colitis, haemorrhoids, polyps, and carcinoma of the large bowel and rectum.[1] The position does not seem to have changed much in the intervening 14 years. My clinical observations, based on some 30 years' medical experience in East Africa, have been considerably amplified by my Uganda colleague, Mr. Denis Burkitt, and the studies of Mr. Neil Painter. There is a possibility that irritable bowel disease often precedes diverticular disease. It is therefore of interest that we are presenting shortly much new information, necropsy, radiological, and clinical, concerning the great rarity of diverticular disease in many countries in Africa and Asia.[2]

At medical boards I had frequently retired European government officials for incurable irritable bowel disease, having satisfied myself that no significant and detectable tropical infection was present. In 1960 I could not remember ever having diagnosed an African as having suffered from irritable bowel disease so I suggested that a placid temperament and high-carbohydrate diets rich in dietary fibre protected them against constipation and irritable bowel disease. Doubtless many risk factors occur and the recorded death rates from diseases which are seldom fatal may be an unreliable source of evidence concerning irritable bowels or diverticular disease. Hospital admissions also for either disease are highly selective[3] and should not be used by themselves to prove or disprove the relationship of dietary fibre to either disorder. It is also suggested that we produce a serious confusion of thought if w refer to the dietary fibre hypothesis as the bran hypothesis[3] for many Africans do not consume cereals or bran but remain almost free of these complaints.—I am, etc.,

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1 Trowell, H. C., *Non-infectious Disease in Africa*, pp. 217-222. London, Arnold, 1960.
2 Trowell, H. C., Painter, N. S., and Burkitt, D. P., *American Journal of Gastroenterology*. In press.
3 Eastwood, M. A., *et al.*, *Lancet*, 1974, **1**, 1029.

Withdrawal of Rifamide

SIR,—A brief note appeared in the *Pharmaceutical Journal* of 5 January 1974 as follows: "Rifocin-M (Lepetit) to be discontinued from U.K. market when present stocks are exhausted." It is commonplace for pharmaceuticals to be replaced by newer agents of greater efficacy and when this occurs there can be little room for complaint. However, in this case there does not appear to be any suitable alternative available in this country.

Rifocin-M (rifamide) is one of the rifamycin group of antibiotics which has a wide range of activity including *Mycobacterium tuberculosis*, staphylococci, and bacteroides,[1] and pharmacological properties which make it valuable in treating infections of the biliary tract.[2] Rifampicin is a different rifamycin which has a similar antibacterial spectrum and is widely used for treatment of tuberculosis, but it is given by mouth, has different pharmacological properties, and cannot replace rifamide. The three clinical uses of rifamide which will be lost if this drug is withdrawn are as follows.

In biliary infections the organisms mainly responsible are Gram-negative bacilli, and though rifamide shows lower activity against Gram-negative than against Gram-positive bacteria, the high levels of several thousand μg/ml attained in bile[3] with this compound make it extremely valuable in biliary infections.[4]

Resistant strains of staphylococci are common in hospital, and strains resistant to cloxacillin or fucidin or lincomycin, kanamycin, and older agents are frequently isolated. The activity of rifamide against staphylococci could prove very useful in controlling severe infections with staphylococci showing multiple antibiotic resistance. Determinations of the minimum inhibitory concentration of rifamide against 232 strains of staphylococci showed that 95% of strains were sensitive to 0·1 μg/ml or less and only 4% were resistant to 5 μg/ml or more. We have not used rifamide for treating staphylococcal infections but it has been held as a reserve compound.

Finally, there are the treatment problems associated with bacteroides infection, which is receiving increasing attention in medical journals. Several studies have shown that bacteroides is reliably sensitive to two antibiotics—rifamide and clindamycin.[5] When there are contraindications to the use of clindamycin or when parenteral therapy is necessary in cases of severe bacteroides infection rifamide might be used to initiate therapy.

There are objections to the use of rifamycins because of their value in tuberculosis, but the number of patients falling into the categories outlined above is small and the amount of rifamycin used in general infections is minute compared with that used in tuberculosis, so that the contribution to the development of resistance by *M. tuberculosis* is negligible.

The withdrawal of this drug creates a gap which cannot readily be filled even though rifamide is mainly held as a reserve antibiotic. Pharmaceutical companies willingly go through detailed studies and prepare lengthy reports in order to have a drug accepted by the Committee on Safety of Medicines. I wonder if some relatively simple procedure could be followed before drugs are removed from the market?—I am, etc.,

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1 Pallanza, R., *et al.*, *Arzneimittelforschung*, 1965, **15**, 800.
2 Stratford, B. C. and Dixson. S. *Medical Journal of Australia*, 1966, **1**, 1.
3 Acocella, G, *et al.*, *Gut*, 1966, **7**, 380.
4 Bevan, P. G., and Williams, J. D., *British Medical Journal*, 1971, **3**, 284.
5 Kislak, J. W., *Journal of Infectious Diseases*, 1972, **125**, 295.
6 Nastro, L. J., and Finegold, S. M., *Journal of Infectious Diseases*, 1972, **126**, 104.

Rapid Weight Loss in Children

SIR,—Rapid weight loss in children presents problems of a type similar to those reported by Dr. J. Runcie and Mr. T. E. Hilditch (18 May, p. 352), but lean body changes in children are highlighted by changes in height velocity. We admitted seven boys and 13 girls aged 1½-16½ years to hospital for treatment of obesity with a 350-kcal diet. Water-soluble vitamins were given and unrestricted water was allowed. Energy expenditure was largely voluntary and was uncontrolled. The weight loss in the group (table I) confirms the change in slope documented by Drs. Runcie and Hilditch. None of the following factors had any effect on the rate of weight loss: age of the child, degree or duration of obesity, or the size or number of adipose cells.

TABLE I—*Mean Weight Loss (± S.D.) Expressed as Percentage of Previous Week's Weight*

Weeks in Hospital	No. of Patients	Mean Weight Loss (± S.D.)
1	20	5·55 ± 1·68
2	19	2·87 ± 1·16
3	19	1·68 ± 1·16
4	19	2·86 ± 1·33
5	15	2·16 ± 0·74
6	14	2·67 ± 1·15
7	12	1·85 ± 1·07
8	11	1·54 ± 1·09
9	4	2·85 ± 0·52
10	4	2·10 ± 0·55
11	4	1·78 ± 0·66
12	3	2·30 ± 1·30

Body composition was measured by skinfold thicknesses[1] in 14 of the inpatient group and in six outpatients who lost comparable amounts of weight over a much longer period on 600-800-kcal diets (table II).

Height was measured in the same children by the same observer before and after weight loss. The change in height was recorded over the periods of treatment and converted into a yearly height velocity.[2] This was compared with the mean expected height velocity calculated from 3-monthly measurements allowing for seasonal variations.[3] The individual variations over a 3-6-month period in normal children are wide and the contribution made by measurement errors over so short a period correspondingly great, but

TABLE II—*Mean Changes (± S.D.) in Body Composition during Weight Loss*

Number of Children	% Body Weight as Fat before Diet	Duration of Weight loss (Years)	% Body Weight as Fat after Diet	% Adipose Mass Lost	% Lean Body Mass Lost
14 inpatients	39·6 ± 4·2	0·21 ± 0·08	28·8 ± 4·3	41·9 ± 11·3	8·3 ± 5·6
6 outpatients	36·1 ± 5·3	0·55 ± 0·13	23·4 ± 3·3	45·8 ± 8·7	2·5 ± 1·9
P	N.S.	<0·001	<0·02	N.S.	<0·05

as only two of the children of the inpatient group grew at even half the expected velocity the growth retardation was considerable and the value for χ^2 was 26·87 (13 D.F., $P<0·02$). In the outpatient group there was no difference between the observed and expected height velocities (χ^2 3·66, 5 D.F., N.S.).—We are, etc.,

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1 Brook, C. G. D., *Archives of Disease in Childhood*, 1971, **46**, 182.
2 Tanner, J. M., Whitehouse, R. H., and Takaishi, M., *Archives of Disease in Childhood*, 1966, **41**, 454, 613
3 Marshall, W. A., *Archives of Disease in Childhood*, 1971, **46**, 414.

Death after E.C.T.

SIR,—The use of muscle relaxants and short-acting anaesthetics has diminished the discomfort of electric convulsion therapy (E.C.T.), while its efficacy, especially in severe and suicidal depression, remains unchallenged. Fatalities are rare, but their incidence is uncertain. The risks are obvious in the elderly with cardiovascular or respiratory impairment, but the case here reported, like that of Malik,[1] was that of a comparatively young, physically healthy woman.

The patient a widow of 55 who had responded well to E.C.T. in puerperal depression some years before, was admitted to Springfield Hospital with psychotic depression and was prescribed further E.C.T. Apart from noticeable agitation while she was waiting, her treatment apparently proceeded normally and respiration was re-established. Some 10 minutes later she became pale and pulseless and stopped breathing, and though prompt resuscitative measures restored the heart beat and, soon after, respiration, she never regained consciousness and died two months later. At necropsy the only pathological findings were areas of cortical softening, consistent with a period of anoxia, and the terminal lung infection.

Review of this case raises the following questions: (1) What are the risks of using cardiotoxic drugs with E.C.T.? The patient had been on amitriptyline 50 mg three times a day for five days. (2) Is the usual preoperative dose of 0·6 mg of atropine adequate? Croper and Hughes[2] suggest that 2-3 mg intravenously is necessary to protect the heart from vagal inhibition. (3) What effect does acute anxiety in a situation of helplessness have upon the heart?[3] Should preoperative anxiolytic drugs be given?—I am, etc.,

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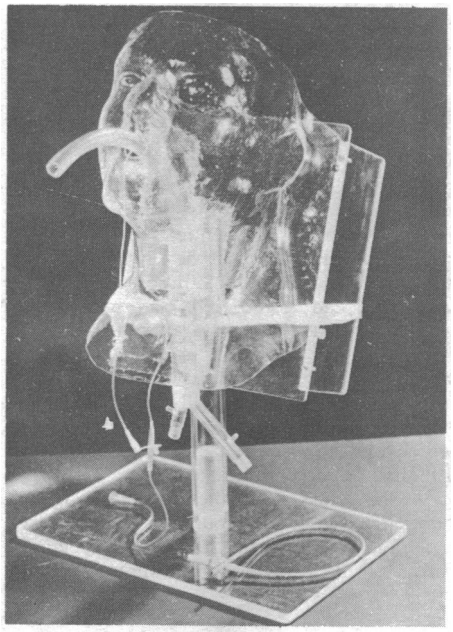
1 Malik M. O. A., *British Journal of Psychiatry*, 1972. **120**, 69.
3 Carruthers, M., and Taggart, P., *British Medical of Psychiatry*, 1964, **110**, 222.
3 Carruthers, M., and Taggart, P., *British Medical Journal*, 1973, **3**, 384.

Teaching Model for Tracheal Suction

SIR,—We read with interest the letter from Dr. T. H. Howells (27 April, p. 226) regarding an endotracheal intubation trainer. We have been interested in this problem in regard to training physiotherapy and nursing staff in the technique of tracheal suction as part of the care of the unconscious patient.

It is our experience when teaching tracheal suction techniques that the following three questions are asked: (1) Can I do the patient any harm? (2) Where does the suction catheter go? (3) How far should the suction catheter be inserted? In order to answer these questions we have constructed a teaching model which also provides an opportunity to practise sterile suction techniques.[1]

The model (see fig.) is life-size and constructed entirely from transparent plastic.



Though the larynx itself has been simplified and is represented by a box, it is anatomically correct in size, as are the attached trachea, carina, and left and right main bronchi with their upper lobe bronchi. A cuffed endotracheal tube or a cuffed tracheostomy tube are easily passed into the trachea. Suction catheters are clearly visible as they pass through the tracheal tubes and their position in the trachea and main bronchi may be easily seen. The head of the model is mounted on a plastic base and may be rotated for viewing at any angle.—We are, etc.,

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1 Hiliar, K. M., and Strunin,, L., *Physiotherapy*, 1973, **59**, 14.

General-practitioner Deputizing Services

SIR,—Dr. B. T. Williams and Professor J. Knowelden (*Supplement*, 16 February, p. 9) wonder "how acceptable the public finds the treatment it receives from deputizing services."

We published a paper some months ago describing how after-hours medical care was organized in a prepaid group practice in New York City with an enrolled population of three quarters of a million.[1] As we then reported, questionnaires were sent to those subscribers who participated in the after-hours programme during a three-month period in 1972 in order to determine the level of consumer satisfaction and thus ascertain those areas where improvement was most needed.

We found that there was an 80% satisfaction rate with the services provided. The 20% dissatisfaction was equally distributed among subscribers no matter what form of treatment they had received—house call, telephone advice, or referral to a night treatment centre. On analysing the data further we concluded that if the patient received the type of treatment which he initially requested then he would be much more likely (80%) to express satisfaction with the service rendered, no matter who the physician providing the service or what the service was. On the other hand, if the type of service rendered did not conform to his initial wish then he would be more likely to be dissatisfied (20%), no matter how appropriate or how capable the service rendered.

The logical conclusion of this analysis (in the situation where medical service is rendered by a substitute physician) was that the enrollee should be given that which he asks for if one wishes to have a satisfied subscriber. The obvious conflict which this produces between prescribing physician and consumer-recipient has yet to be resolved.—We are, etc.,

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1 Miles, A. I., and Goodman, L. J., *Health Services Reports*, 1973, **88**, 868.

Dangerous Drugs: a Warning

SIR,—General practitioners and others should be warned about the possible consequences of the recent introduction of safety precautions at pharmacies with respect to dangerous drugs. I think it is predictable that there will be break-ins into doctors' surgeries for opiates, barbiturates, Mandrax, amphetamines, appetite suppressants, and so on. Doctors should be advised to keep stocks of these at a minimum and to dispose of any unnecessary stock they may be carrying.

As many pharmacies have already installed burglar alarms and safety cupboards it is predictable that these burglaries will soon be beginning.—I am, etc.,

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Death in Hospital

SIR,—We would be interested in the views of other readers about early notification of the death of a patient in hospital.

While we appreciate that all hospital staff are busy, we regard it as essential that a patient's general practitioner should be informed by telephone within 24 hours of a death. This task could be delegated by medical staff provided that the informant is briefed by them. The bereaved relatives often assume that the G.P. has early notification of a death, and embarrassing situations are encountered without this knowledge. Help and explanation are frequently required by the family.

This lack of early communication seems to be shared by a number of district and teaching hospitals. The need for early information