

out despite being used infrequently the cost of the equipment is not an important deterrent. I believe that a machine is more likely to be available and working if it is delivered by the ambulance service, but I do not know, and neither does Dr Rawles. I hope that we shall be able to shed more light on this important topic when the results of our current study are analysed.

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Efficiency of referral for suspected glaucoma

SIR,—As a geriatrician who looks after several elderly people with visual disability I was interested in the paper from the International Glaucoma Association.¹ Though the current system seems to be functioning better than expected, the authors state that improvements could be made with closer cooperation among ophthalmologists, general practitioners, and optometrists. Unfortunately, no mention is made of any future role for other medical specialists: with the high prevalence of glaucoma in elderly people geriatricians seem to have an unrivalled opportunity to detect this insidious disease. The competence of geriatricians in performing eye examination, including tonometry and field screening, has been shown.^{2,3}

In Messrs Maurice W Tuck and Ronald P Crick's study there was a non-attendance rate of 15% among those referred for further assessment.¹ The profile of these non-attenders is not given, but the reasons given for non-attendance lead me to suspect that they were elderly. Poor attendance at eye departments of people suspected of having glaucoma has been one problem of screening in geriatric medical practice.³ Closer cooperation of geriatric medical and ophthalmological departments seems to be necessary. Establishing mini eye clinics at day hospitals or using day hospitals' existing transport facilities to ensure that elderly patients attend their follow up appointments is worth considering.

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- 1 Tuck MW, Crick RP. Efficiency of referral for suspected glaucoma. *BMJ* 1991;302:998-1000. (27 April.)
- 2 Turnbull CJ. Screening for glaucoma in a geriatric unit. *Age Ageing* 1981;10:169-73.
- 3 Bruce DW, Damato BE, Williams BO, et al. Screening for glaucoma in geriatric medical practice using ophthalmoscopy and oculokinetic perimetry. *Journal of Clinical and Experimental Gerontology* 1991;12:13-24.

Hours of work

SIR,—Current attempts to reduce the excessive hours worked by junior doctors will never succeed—as evidenced by the recent unsatisfactory and predictably deferred "agreement" that has been reached¹—the simple reason being that the thrust of our campaign is misplaced. What is needed (and note the example of our Irish colleagues) is a demand that we be paid at least equal rates for overtime hours instead of the archaic one third. Only then will the financial motivations that maintain these excessive hours be removed. Our successors will not thank us for our myopia, even if it is overtime induced.

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- 1 Beecham L. Junior doctors' hours. *BMJ* 1991;302:1542. (22 June.)

SIR,—During the discussions about the hours of work of junior staff the question of whether consultants should work longer hours often arises. From 1 April this year consultants have been required to have a job plan that includes a statement about the average number of hours spent on NHS duties each week. I am a full time consultant physician. The table gives a breakdown, taken from my job plan, of the average number of hours I work each week for the NHS.

Average number of hours worked for NHS by consultant physician according to job plan

Duties	No of hours
Outpatient clinic × 4	14
Ward round × 4	14
Teaching	4½
Management (district management advisory committee)	7½
Medical audit	2
Other committees	2
Administration (summaries, letters, etc)	6
On call work	2
On call for emergencies	22
Total	74

I do four outpatient clinics and four ward rounds each week. The number of ward rounds is high because I have the care of a high number of acute admissions—1150 a year—assisted only by a vocational trainee senior house officer and a pre-registration house physician. I am therefore registrar as well as consultant.

Work dominates my life. I leave the hospital at 7.30-8 pm several nights each week and do work for the district management advisory committee (of which I am chairman) at home at weekends. The other physicians in Eastbourne have similar workloads. Against this background I think it would be unreasonable to ask me to do more.

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Swallowed coins

SIR,—Messrs M D Stringer and S N J Capps highlight the lack of consensus on managing swallowed coins in children.¹ One large series has shown that a lack of oesophageal symptoms means that the coin has passed or will pass through the lower oesophageal sphincter.² We agree with Messrs Stringer and Capps's recommendation of obtaining a chest and neck radiograph irrespective of symptoms as reports of rare but potentially fatal complications, including oesophageal perforation³ and oesophagoaortic fistula,⁴ in asymptomatic patients are sufficient indication for routine radiography. A foreign body that appears to be in the oesophagus in a posteroanterior chest x ray film could be in the trachea or proximal bronchial tree, and a lateral view may be necessary to differentiate this.

Two techniques not mentioned by the authors can be used when coins are seen in the mid and lower oesophagus. Firstly, the child can be given an effervescent drink, which may dislodge the coin (although this should always be discussed with the anaesthetist if an anaesthetic may be required in the event of failure). Secondly, an injection of glucagon, a technique used regularly by radiologists, may cause the lower oesophageal sphincter to relax sufficiently to permit the coin to pass. If the coin still remains in the oesophagus and causes symptoms we recommend prompt removal. Only in an asymptomatic child would we consider waiting 12-24 hours for a repeat radiograph. This is probably safe as reported fatal complications have been in cases of prolonged impaction, but we are unaware of any studies of the progress of coins that are initially lodged in the lower oesophagus.

In their concluding remarks the authors suggest that "many children swallowing other foreign bodies can be managed by a similar policy." No mention is made of the most important exception. All disc cell batteries can produce local caustic and electrolytic effects; mercury cell batteries can also cause toxic effects if disrupted. Any swallowed disc cell battery must be accurately located radiologically. Evidence of disruption of mercury cells (as indicated by a hazy edge or fragmentation) is an absolute indication for prompt removal whatever the location, and blood mercury concentrations should be measured. Any of these batteries lodged in the oesophagus should be removed.⁵

Gastric acid can cause disintegration of disc cells, and thus if a disc cell is seen to be in the stomach a repeat x ray film should be obtained after 24 hours.⁶ If the battery has not passed through the pylorus removal is indicated. The risk of perforation from local electrolytic effects means that the progress of all these batteries should be closely monitored. Failure to progress through the gastrointestinal tract may be a sign of threatened perforation. Haematemesis, melaena, or peritoneal signs are an indication for surgery. Disc cell batteries are a special case; the risks of perforation and toxicity require separate management.

Finally, we recommend that the parents of any child who has ingested a foreign body and is being allowed home should be given written instructions with indications for returning to hospital.

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- 1 Stringer MD, Capps SNJ. Rationalising the management of swallowed coins in children. *BMJ* 1991;302:1321-2. (1 June.)
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SIR,—In their article Messrs M D Stringer and S N J Capps mention the hazards of prolonged gastric retention of swallowed coins.¹ This reminded me of the case presented by Charles Dickens in the "Mudfog Papers."²

Mr Knight Bell (MRCS) exhibited a wax preparation of the interior of a gentleman who in early life had inadvertently swallowed a door-key. It was a curious fact that a medical student of dissipated habits, being present at the post mortem examination, found means to escape unobserved from the room, with that portion of the cast of the stomach upon which an exact model of the instrument was distinctly impressed, with which he hastened to a locksmith of doubtful character, who made a new key from the pattern so shown to him. With this key the medical student entered the house of the deceased gentleman, and committed a burglary to a large amount, for which he was subsequently tried and executed.

To quote Sam Weller,³ "Out with it as the father said to the child wen he swallowed a farden."

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