

and blood return to the heart increased. The graduated compression stocking in the style of pantyhose (tights) provides this. May I commend this use in the elderly patient with postural hypotension?

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Lactic acidosis and beta-adrenergic agents

SIR,—In a recent article (17 May, p 1221) Mr M I Whitehead and others found cardiac failure, metabolic acidosis, and hypokalaemia after infusion of salbutamol. They suggested that the metabolic alterations preceded depressed myocardial function. Increased blood lactate concentration probably caused the metabolic acidosis.

Lactic acidosis has earlier been reported after epinephrine intoxication,¹ but to our knowledge not after the β -adrenergic agents salbutamol or terbutaline. β -Sympathomimetic drugs have been associated with increased plasma concentrations of lactate² and glucose^{2,3} and with hypokalaemia.³

We have seen a patient with lactic acidosis, high glucose values, and hypokalaemia after intoxication with terbutaline. The patient was a 28-year-old woman who had taken an overdose of 225 mg terbutaline together with 1750 mg clomipramine, 150 mg oxazepam, 5 g chloral hydrate, and wine. On arrival she was in a coma and needed artificial respiration. Gastric lavage was performed. There was hypotension with systolic blood pressure 85-105 mm Hg. There were no signs of cardiac failure, shock or oliguria. The electrocardiogram showed sinus tachycardia of 140 beats/min. Metabolic acidosis was present with pH 7.23 and bicarbonate 17 mmol (mEq)/l. Lactate was raised to 12.4 mmol/l (112 mg/100 ml) (normal range 0.66-2.44 mmol/l (5.9-22 mg/100 ml)) two hours after arrival and 6.6 mmol/l (59 mg/100 ml) four hours later. P_{O_2} measured after intubation was normal. The plasma concentration of potassium was 2.4 mmol (mEq)/l, blood glucose 14.4 mmol/l (259 mg/100 ml), and ethanol 40 mmol/l (184 mg/100 ml). She was treated with sodium bicarbonate, low-dose insulin infusion, glucose, and potassium.

Six hours after arrival she was somnolent and extubation was performed.

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¹ Kolendorf K, Møller Broch B. *Acta Med Scand* 1974; **196**:465-6.

² Jenne JW, et al. *J Allergy Clin Immunol* 1977;**60**: 346-56.

³ Leitch AG, et al. *Br Med J* 1976;**i**:356-67.

Comparison of proprietary elemental and whole-protein diets in unconscious patients with head injury

SIR,—The Newcastle authors D C Jones and others (21 June, p 1493) are rightly cautious in drawing firm conclusions from their comparison of five different nasogastric tube feeds in small groups of eight patients after head injury. They themselves point out that the amounts of each feed actually given are not comparable in total energy or nitrogen, in energy to nitrogen ratio, or in the relative proportion of fat and carbohydrate. The assumption is made that the groups containing only eight patients in each are comparable

metabolically because injury scores are similar. This might be true of large groups but is not necessarily so in this study, particularly in the early stage after injury, where the contribution of extravasated blood and dead tissue to nitrogen excretion is both large and difficult to quantify.

This problem might have been overcome if some attempt had been made to validate the comparability of the groups by measuring nitrogen excretion during a "run in" period of a few days before feeding began. It would be quite possible to interpret the results presented as showing that the Trisorbon group had intrinsically the least nitrogen catabolism and the Clinifeed group the largest, irrespective of the feeds given. The same nitrogen input will then produce inevitably a more positive nitrogen balance in those who start with a lower nitrogen excretion. A further assumption is also made that nitrogen losses in the stool were negligible. Is it fair to talk about nitrogen balance unless these are measured and included in the calculation?

I wonder whether the authors meant to state that, "The patients who received Clinifeed had the largest mean nitrogen intake and hence might be expected to have had the smallest nitrogen excretion, since obligatory protein breakdown and gluconeogenesis should have been more nearly balanced by this large intake." The opposite is true. Metabolic status and energy intake being equal, nitrogen excretion rises as the nitrogen input is increased.

The authors' point is well made that the elemental diets were less well tolerated and for this reason better "nitrogen balance" was obtained using the whole-protein feeds. There was no significant difference between the "nitrogen balances" obtained from the two whole-protein feeds, Trisorbon and Clinifeed 400. Both of these have inadequate energy to nitrogen ratios for most patients, and it is surprising that the authors did not adjust this by the addition of Caloreen or some other energy source as is common practice elsewhere.

Any final conclusions as to the relative nutritional merits of the feeds used in this study must await the use of a protocol, which conclusively excludes metabolic differences between study groups and substantial quantitative differences between feeding regimens.

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Thought for the silly season

SIR,—Once more returned from two months of work overseas I face a journal mountain at whose base are the *BMJ*s delayed by the printing problems of the spring. This will just be demolished when the annual vacation spawns another literary burial mound. The heartsinking sight of so much to get through, even if just to make sure that it is not essential reading, is an annual penance faced by most physicians.

Might I suggest, Sir, that your admirable staff close up shop, go off fishing, for two, three, or four weeks each year, retire into cloistered silence? Suppose there were to be no *BMJ* published in August, an idea copied soon by jealous competitors. Imagine returning to the office to sort letters into priorities and consign the advertisements to oblivion. Picture that eager first day, desk already tidy by

evening. The accumulated vigour of the holiday is poured into constructive work rather than dissipated in late night journal orgies.

Not to publish in August would benefit the early vacationer by allowing the journal mountain to be worked into without discouraging additions. The autumn vacationers would have to be content with a tranquil summer. To foresee objections, how much of the information published in a conventional journal is really urgent? Advertisers of jobs vacant can plan around a predictable gap. The seekers of those positions could enjoy their vacation free of the nagging thought that something ideal has just come on to the market and they will find out too late.

Alas, I foresee that my letter, if published, will be dealt with by the tireless journal staff busy, when they should be on vacation, filling August pages. It will be hurried over by word weary autumn eyes and the failure of any support for my idea will only prove that I am right.

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Physicians for Social Responsibility

SIR,—In the United States in March of this year some 700 doctors signed a full-page statement that appeared in the *New York Times*. It was sponsored by 18 eminent members of the profession who head the American organisation known as Physicians for Social Responsibility. The statement, which was also sent to President Carter and Mr Brezhnev, drew attention to the organisation's conviction that there is no realistic prospect for mankind's survival in the event of a nuclear war, in which an overkill of modern nuclear warheads would be employed, and that prevention is our only hope.

Growing numbers of doctors in this country see their responsibility increasingly clearly as extending into this urgent area of preventive medicine. Would those who share our concern and would wish to participate in setting up a Physicians for Social Responsibility group in the UK as part of an international organisation please write to me.

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Is the emergency ambulance service abused?

SIR,—With reference to the recent article "Is the emergency ambulance service abused?" by Mr D L Morris and A B Cross (12 July, p 121) if inappropriate use of the emergency ambulance service is to be curtailed the public must be re-educated as to its proper role and function. To do this, however, more research attention must be paid to why the public perceive many medical conditions or symptoms as emergencies. In 1976 I carried out research on attitudes of the public to health emergencies resulting in 999 calls for ambulance assistance, and although some of the calls were patently frivolous most calls were prompted by genuine anxiety concerning the patient.

From this experience I believe people in general have no idea of what constitutes an injury requiring professional medical treatment and what can be adequately treated by