giving immediate silence if one is over the subclavian vein.

J CUNDY
G BALDOCK

Lewisham Hospital,
London SE13 6LH

SIR,—Dr M Rosen and others (2 August, p 372) in their article state that when the external jugular vein is used for central venous cannulation the catheter cannot be threaded into an intrathoracic vein in about half the attempts. This success rate may be greatly increased by using the following "guide wire" technique.

A guide wire with a soft preformed curved tip (for example, William Book's type SCM/38/50/3) is inserted into the external jugular vein via a short needle (for example, 17-gauge Venflon), which is then removed. This guide wire is now advanced into the vein while it is gently rotated. In almost all cases the wire will pass into an intrathoracic vein. Once this has occurred then a suitable catheter (for example, the teflon cannula of a Viggo Subclavia needle) can be introduced over the wire into the vein, and the wire withdrawn.

I have found this method very useful when arm veins are unavailable and subclavian or internal jugular cannulation is contraindicated.

J BUTLER

Department of Anaesthesia,
Maelor General Hospital,
Wrexham LL13 7TD

Exceptionally low blood glucose response to dried beans

SIR,—We read with great interest the article (30 August, p 578) by Dr D J A Jenkins and others on the effect of dried legumes on postprandial glycaemia. Jenkins and his associates convincingly showed that among the carbohydrate-rich foods dried legumes were the most effective in lowering postprandial blood glucose. They are to be congratulated for this important finding.

In a similar study, done probably at the same time, we obtained almost identical results with Bengal gram dal (Channa dal), which belongs to the class of dried legumes. We studied four food items each with a carbohydrate load of 50 g on separate occasions in six healthy subjects. The results of our study are summarised in the table. It is clear from the data that Bengal gram dal almost abolished the rise in postprandial glycaemia. In comparison with dextrose, the complex carbohydrates like wheat and rice reduced the postprandial plasma glucose rise significantly at 45 and 60 minutes. On the other hand Bengal gram dal produced a highly significant low plasma glucose response at 15, 30, 45, and 60 minutes.

These findings suggest that we should reappraise the diet of diabetics and take into account particularly the dietary source of carbohydrates, which has hitherto been largely neglected. The study by Dr Jenkins and his colleagues and our study confirm the belief of physicians of ancient India, who used to treat diabetes mellitus with green gram (*Charaka Samhita* and *Sushrata Ayurveda*, published more than 2000 years ago).

J B DILAWARI
P S KAMATH
R P BATTA
S MUKEWAR
K S RAGHAVAN

Department of Gastroenterology,
Postgraduate Institute of
Medical Education and Research,
Chandigarh-160 012, India

Following up patients with rheumatoid arthritis

SIR,—The effective follow-up of sufferers from rheumatoid arthritis (discussed in your leading article of 12 July, p 97), and indeed from most rheumatic diseases, requires that each patient should be seen as frequently and for as long as merited at the material time. Assessment in an often rapidly changing pattern of disease and disability requires skill, which may be readily acquired by any doctor who has an interest in so doing. Basically, the problem stems from the paucity of undergraduate medical training in rheumatology (including good rehabilitation practice) in the majority of medical schools in the UK. The subject may figure in the curriculum of many schools but enthusiastic teachers would be horrified in general to find how little impact has been made on their disciples when they arrive "out in the sticks." Over the years personal discussion with graduates from many schools, has indicated that usually there have been seemingly more pressing options to be taken so close to the pressures of final examinations, in which the chances of meeting questions within this field may be slim. Thus many doctors when faced with a flood of locomotor problems on entering general practice painfully discover their lack of elementary knowledge of how to sort them out, let alone manage them.

A simple example of everyday management problems which occur in this field is provided by the seemingly mundane subject of the non-steroidal anti-inflammatory agents. Fortunately the more agents of this type that become available the greater are the chances that a drug can be found to match each patient's individual need with something which is effective without significant side effects. However, in many cases this can be a time-consuming process and once a particular patient's "best buy" has been observed the dosage schedule has to be individually "titrated." Conveyor-belt techniques do not work here, for more often than not this is an entirely personal process, which may demand weekly attendance for careful discussion about efficacy, side effects, and compliance. Many patients express amazement at the suggestion that they should attend their general practitioner for such a purpose—"They are so busy, doctor, that I would not like to bother them at the surgery." Such problems do not appear to arise in practices which display a genuine interest in their patients' effective management, however time-consuming it may be. In my experience such practices are always willing to take on the regular monitoring of patients on potentially hazardous drugs such as gold and D-penicillamine.

For years, like Dr G A C Binnie (13 September, p 745), I have been greatly concerned that waiting lists for new hospital clinic consultations are undesirably long and wholeheartedly agree with his view that "the clinics are cluttered up with patients being followed up who would be just as well managed by their general practitioners." Regrettably, this entirely logical solution will not be universally achieved until all general practitioners can demonstrate to themselves and their colleagues, and more particularly to their patients, that the standard of after-care afforded to rheumatic disease sufferers in the surgery or health centre is as effective as that provided in the hospital clinic.

For many years now the senior house officers working in this department have been Royal College of General Practitioners vocational trainees. Working with these mostly enthusiastic young men and women has afforded me great pleasure and I have learned from them, as I hope they have learned from me. Frequently the first major impact during their attachment to us has been the realisation of the wide disparity in the quality of community follow-up care. Surely, then, this is the crux of the whole matter and the problem to which the Royal College of General Practitioners and other bodies with an interest in continuing education in patient care, both medical and nursing, should be seeking solutions.

D R L NEWTON

Department of Rheumatology,
Middlesbrough General Hospital,
Cleveland TS5 5AZ

Screening for the small-for-dates fetus

SIR,—Recent correspondence relating to screening for intrauterine growth retardation (17 May, p 1203; 21 June, p 1534; 12 July, p 147; and 6 September, p 679) has revolved around the choice between screening tests. The fundamental characteristics of a test are the sensitivity and specificity. Dr R H Klipstein (6 September, p 679) proposes a model for the familiar situation in which sensitivity is gained at the expense of specificity. It must be pointed out that the problem parallels the exposition of Professor W I Card and Dr P A Merson in the

Mean change in plasma glucose concentration (mmol/l ±SEM) after test meals

Carbohydrate source (50 g)	No of minutes after test meal: 15	30	45	60	90	120
Glucose (N = 6)	+2·14 ±0·2	+3·37 ±0·66	+3·22 ±0·79	2·69 ±0·87	+1·06 ±0·68	−0·41 ±0·49
Bengal gram dal (N = 6)	−0·17 ±0·22***	+0·48 ±0·37***	+0·6 ±0·44**	+0·34 ±0·42**	−0·08 ±0·37	−0·08 ±0·27
Wheat (N = 5)	+0·93 ±0·29	+2·51 ±0·49	+2·15 ±0·48**	1·06 ±0·39**	+0·90 ±0·59	+0·52 ±0·37
Rice (N = 6)	+1·23 ±0·33	+2·82 ±0·49	+1·94 ±0·53*	+0·39 ±0·54***	−0·10 ±0·27	−0·26 ±0·31

Conversion: SI to traditional units—Glucose: 1 mmol/l ≈ 18 mg/100 ml.
*p<0·05. **p<0·01. ***p<0·001.