7.6 cases in the month after immunisation in the United Kingdom, based on the typical reported annual incidence of 1/100 000).[1]

We questioned 103 patients with Guillain-Barré or Miller Fisher syndrome, 98 household controls, and 93 hospital controls in south east England in 1992-4 (before the measles/rubella immunisation programme).[2] Thirteen patients, and nine household and five hospital controls reported being immunised within 12 weeks before onset of neuropathy in the index case. The immunisations were for influenza in 10 patients and eight household and three hospital controls, typhoid/cholera in one patient and one household control, typhoid alone in one patient, tetanus toxoid booster in one patient, diphtheria/tetanus/pertussis in one hospital control, and human immune globulin in one hospital control. The median intervals between immunisation and neuropathy onset in the index case were 44 (range 3-64) days in patients, 44 (7-64) days in household controls, and 36 (14-62) days in hospital controls. The differences in proportions immunised between the patients and either of the control groups are not significant but the confidence intervals for the odds ratios are wide. A matched analysis shows that the odds ratio of cases having been immunised was 4.0 (95% confidence interval 0.4 to 197) in comparison to household controls and 2.2 (0.7 to 8.1) in comparison to hospital controls. A similar study in 1983-4 also failed to show an increase in risk since 6/100 patients and 5/100 hospital controls had been immunised in the previous 12 weeks.[3] The odds ratio for the two series combined was 1.8 (0.7 to 4.4).

Our case-control studies and the literature do not suggest any increased risk of Guillain-Barré syndrome after vaccines currently used in the United Kingdom. However, obtaining the number of individuals required to detect or exclude a small increase in absolute risk would require an active surveillance programme or classification of Guillain-Barré syndrome as a notifiable disease. At present we rely on diligent reporting to the Committee on Safety of Medicines of cases of the syndrome after vaccination.

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Providing intensive care

Cases of trauma can be managed in general intensive therapy units

EDITOR,—D W Ryan points out that increasing resources is one solution to the current crisis in the provision of intensive care services.[1] The editorial fails, however, to address the problem of the inefficient use and staffing of some units.

About 210 cases of major trauma occur in adults each year in Birmingham. About one third of the patients are admitted to the major injuries unit at University Hospital (formerly sited at the Birmingham Accident Hospital). Most of the rest are managed at the two other main district general hospitals. There are 24 general beds in intensive therapy units on the three sites, five of which are allocated to the major injuries unit. The major injuries unit is separately staffed by four consultant anaesthetists and junior anaesthetic staff on rotation and, in addition, has eight consultant and 18 junior orthopaedic staff sharing the on call rota as well as its own complement of nursing staff. The general intensive therapy unit at University Hospital, with six beds, is separately staffed by its own anaesthetists and nursing staff. The two other district general hospitals manage their major trauma workload within existing resources and have no intensive therapy unit beds designated for cases of trauma.

A recent report on the major injuries unit found no significant difference in outcome between patients admitted from the accident and emergency unit and those admitted direct to the major injuries unit.[2] There seems to be no rationale for allocating a fifth of the total complement of intensive therapy unit beds at the three sites to a dedicated trauma intensive therapy unit, particularly when no improvement in outcome can be shown.

While intensive therapy unit services in Birmingham are undoubtedly underresourced, the resources that are currently available are clearly not being used to their maximum efficiency. The amalgamation of the major injuries unit with the existing on site intensive therapy unit would eliminate duplication of staff and services and lead to savings, which could be used to increase the overall number of beds.

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Service can't cope with troughs in demand, let alone peaks

EDITOR,—David Ryan correctly points out that "moving critically ill patients between hospitals has become a far from ideal way of life."[1] Politicians have only recently taken note of this, but in fact this situation has existed for as long as I have been a consultant (11 years) working in an intensive care unit in a large teaching hospital.

Recent deaths of critically ill patients who were being moved between hospitals and the media publicity that followed stimulated the health secretary into a typical knee jerk reaction.[2] The fact that more use will be made of high dependency beds and that a national database of intensive care unit beds will be set up are two such announcements that Stephen Dorrell has made in the House of Commons. Either Mr Dorrell has been misinformed or, as a typical politician, he chooses to ignore the glaring facts that (*a*) the high dependency unit beds that he is talking about do not exist (only 15% of hospitals in Britain have such beds), (*b*) high dependency unit beds are not a substitute for intensive care unit beds, and (*c*) setting up high dependency unit beds will require resources.

The database of intensive care unit beds is flaunted as the "cure all" for the lack of intensive care unit beds in Britain. We have had such a scheme in the north west for the past six years or so (it was previously simply called the bed bureau and is now named the intensive care bed information service). This was set up to save time for clinicians trying to find a bed. It did not (and was not meant to) solve the problems with intensive care unit beds that existed then, as they do now. I recently heard a chief executive of a health authority in the north west say that there were troughs and peaks in demand and that it was not possible to plan for all contingencies. He was absolutely correct. The trouble is that, throughout my working life as a senior registrar and as a consultant, we have barely been able to cope with the troughs.

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Centralised paediatric intensive care beds are blocked

EDITOR,—While I echo D W Ryan's call for more resources for intensive care, I take issue with Ryan's choice of words when referring to paediatric intensive care.[1] The inability of major paediatric centres to accept all referrals for intensive care may undermine but in no way negates the British Paediatric Association's recommendation that sick children be provided with specialist nursing and medical care.[2] The recommendation is sound.

Centralisation of paediatric intensive care is the way forward, as Shann[3] and others have urged. But there are other reasons, apart from a lack of resources, for the shortage of acute paediatric intensive care beds. More children are surviving previously fatal illnesses but remain dependent on a ventilator. At present there is no facility for caring for these long stay patients who no longer need the full resources available in intensive care units. Altogether 42% of our acute paediatric intensive care beds are currently blocked by such patients, and these unavailable beds were an important factor in our having to refuse 276 patients referred to our paediatric intensive care unit last year. These patients are ready for discharge, but the health authorities from which they came are unable to arrange the provision of services for them locally.

This is likely to be an increasing problem and needs to be addressed by those people charged with planning intensive care and high dependency services across Britain.

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Disodium pamidronate has beneficial effect in Paget's disease of bone

EDITOR,—We are surprised that the authors of the review on diagnosing and managing Paget's disease of bone did not comment on the efficacy of a single infusion of disodium pamidronate in active Paget's disease.[1] Several studies have shown the beneficial effect of this treatment, with a substantial number of patients remaining in remission for up to 18 months to two years.[2,3] Our study showed the beneficial effect of even a moderate dose (60 mg) given as a single infusion