the needles as frequently as they get blunt. As most diabetics in Nigeria do not have fridges, I just tell them to replace the syringe with the attached needle in the packet and put it, as well as their insulin, in a clean container or pot that is properly covered. The pot is then stored in a hole in the ground, dug as deep as one's hand can reach. Since 1974, when I started running the diabetic clinic in this hospital, I have carefully observed the insulin-requiring diabetics without coming across any case of infection with this technique. As the authors noted, the advantages to the patients are considerable. This is even more so in a developing country like Nigeria, where most diabetics are responsible for the cost of their treatment.

J M OLI

University of Nigeria Teaching Hospital,
Enugu

Raised HCG in hyperemesis gravidarum

SIR,—We read with interest the paper by Dr Antti Kauppila and others (23 June, p 1670) on their finding of raised levels of serum human chorionic gonadotrophin (HCG) concentrations in hyperemesis gravidarum.

We have also measured β-subunit HCG by a specific radioimmunoassay in 12 women with hyperemesis gravidarum and 12 control patients matched for gravidity and gestational age. Although the mean value of β-HCG was higher in the hyperemetic patients (36·2 IU/ml as against 24·5 IU/ml for controls), the difference was not significant using the paired Student's *t* test.

We have recently reported[1] altered thyroid function in hyperemesis gravidarum and are preparing for publication our findings of a possible relationship between chemical hyperthyroidism and high levels of β-HCG in some patients with hyperemesis gravidarum.

C THORNTON
E W LILLIE
J R MCSWEENEY
R R O'MOORE

The Rotunda and Sir Patrick Dun's hospitals, Dublin

[1] O'Moore, R R, *et al*, in *Proceedings of 3rd European Congress of Clinical Chemistry*, ed V Marks and D Williams, *Annals of Clinical Biochemistry* (suppl). London, British Medical Association, 1979.

Labetalol in severe tetanus

SIR,—We read with interest the case report by Dr J W Dundee and Dr W F K Morrow (28 April, p 1121) on the use of labetalol in severe tetanus and deem it necessary to make some comments.

While vasomotor instability in severe tetanus may be an uncommon phenomenon in the UK, this is certainly not the case in the respiratory unit at King Edward VIII Hospital. Of the 30 to 40 adult cases of tetanus seen annually at our unit, 15 to 20 cases are severe enough to need controlled ventilation and of these 60% develop vasomotor instability, which usually manifests as tachycardia, labile blood pressure, cold peripheries, and marked sweating. A possible explanation for high incidence of this complication is that many of our patients have had no immunisation whatsoever prior to the onset of the disease.

We have used intermittent injections of labetalol in our tetanus patients with very high blood pressures and found it to be effective in some, though not all, patients.

Regarding management, we were surprised at the use of tubocurarine in their patient, who experienced problems with decurarisation. We stopped using curare some years ago and instead use alcuronium, which in our experience is very effective in controlling spasms and furthermore does not pose the problem of residual curarisation which occurs with prolonged use of tubocurarine. Hence this obviates the need for decurarisation and the problems associated with it.

M A K OMAR
A G WESLEY
M PATHER

King Edward VIII Hospital,
Durban 4001

Why does the Committee on Safety of Medicines do what it does?

SIR,—The DHSS has now banned methapyrilene on the grounds that it can cause liver tumours in rats if given 25 to 30 times the normal human dose throughout the animal's normal life span. We can no doubt get along quite well without one of the many antihistamines just as we can manage without cyclamates, but I feel we are entitled to ask the DHSS or rather its Committee on Safety of Medicines to answer a few questions.

(1) What is the maximum dose that can be used to produce cancer in an animal before the committee will regard such amounts as too ridiculous to have any relevance to humans? Is it 25 to 30 times the human dose daily for life as in methapyrilene or 80 times as in cyclamates, or is there no limit as in the USA?

(2) Why are cyclamates and methapyrilene banned but not saccharin or nitrites, which are under just as much suspicion?

(3) Is it only cancer that the committee is worried about when a drug is given in such huge quantities over a long period? If any substance given in this manner caused disease or death should it not also be banned? This would include most drugs in the pharmacopoeia, even salt.

(4) Has the committee no reasonable standards of its own or are we in future to have the absurd requirements of the American Food and Drugs Act imposed upon us? If so we may well find ourselves like them deprived of useful drugs like chromoglycate for years at a time.

I call upon the Committee on Safety of Medicines to answer these questions. It is not good enough to be given a papa knows best edict. We have a right to ask why he thinks he knows best, before being subjected to American law.

A LEWIS

London W1N 1FJ

Adolescent idiopathic scoliosis

SIR,—The leading article on adolescent idiopathic scoliosis (June 2, p 1446) stressed the importance of early recognition and prompt treatment without explaining why the disease must be treated early. Many medical people still believe that scoliosis is merely a cosmetic problem, but this is not so. Cardiorespiratory insufficiency secondary to thoracic deformity has been recognised for a long time, and recently the socioeconomic and psychological effects of scoliosis have been studied as well.[1–3]

We interviewed and examined 55 adults with untreated scoliosis who were first seen as children in Quebec hospitals 10 to 45 years previously.[4] Two-thirds had back pain, one patient in four was disabled by it, and 20 patients were temporarily or permanently unemployed. Two-thirds of the women and one-third of the men were not married, which is more than twice the national average, most had sedentary hobbies, and two-thirds of all patients were selfconscious of their appearance, some avoiding sunbathing, swimming, and other activities that involved undressing in public.

A separate group of 152 adults with untreated scoliosis consulted us mainly for back pain. Most were improved by non-operative treatment, but 36 required Harrington instrumentation and posterior fusion. The surgical indications were disabling back pain not controlled by conservative measures, progression of the curve, or increasing respiratory distress. The complication rate was higher, and the results of surgery were not as good as they were in a similar group of adolescents, confirming the findings of other authors.[5,6] Besides this, the prolonged convalescence of the adult created socioeconomic problems which did not occur among the adolescents.

We concluded that untreated scoliosis affects the quality of life and is a disabling disease in the adult. Because of the problems associated with surgery in the adult, scoliosis should be treated definitively before the end of the period of growth.

JOHN V FOWLES

PO Box 148,
Kabul, Afghanistan

[1] Collis, D K, and Ponseti, I V, *Journal of Bone and Joint Surgery*, 1969 **51A**, 425.
[2] Nachemson, A, *Acta Orthopedica Scandinavica*, 1968, **39**, 466.
[3] Peyer, J, *Zeitschrift für Orthopedie und ihre grénzgebiete*, 1975, **113**, 577.
[4] Fowles, J V, *et al*, *Clinical Orthopedics and Related Research*, 1978, **134**, 212.
[5] Dawson, E G, Caron, A, and Moe, J H, *Journal of Bone and Joint Surgery*, 1973, **55A**, 437.
[6] Ponder, R C, *et al*, *Journal of Bone and Joint Surgery*, **57A**, 797.

The premature breech

SIR,—It is certainly true that the management of the premature breech presents a major problem to the obstetrician, and your leading article (30 June, p 1747) debates some of the factors which influence the decision to deliver vaginally or abdominally. Neither this article nor the study of Karp and others[1] states which type of caesarean section is being considered, though the reader will assume it to be the lower segment operation.

I would like to point out that the lower segment caesarean section can itself be hazardous to the fetus, and to suggest that the classical caesarean section be considered. When a premature breech is delivered electively by lower segment caesarean section the incision in the often ill-formed lower segment contracts so that the head is in danger of rapid compression and decompression or even entrapment. The situation is little different from the compression and decompression and entrapment by the cervix in a vaginal delivery: only the bony pelvis is bypassed, and this is normally relatively capacious when the fetus is premature. A second problem is that when a premature breech is delivered by emergency lower segment caesarean section for cord prolapse, or fetal distress, after being allowed to labour, the breech is often very low in the pelvis, making disengagement both difficult and dangerous.