

Transcervical resection of endometrium

SIR,—Dr Adam L. Magos and colleagues limited their procedure to women with a uterus no larger than that seen in an eight week pregnancy.¹

Resection of the endometrium need not be limited to such women. We have successfully treated three women with uterine enlargements equivalent to 12-14 week pregnancies who were reluctant to have a hysterectomy.

Case 1—A 47 year old woman presented with a three year history of menorrhagia. Hysteroscopy showed a 5×5×5 cm sessile submucous fibroid and a 3×3 cm intramural fibroid partly projecting into the uterine cavity. Her uterus was enlarged to the size of a 12 week pregnancy. Both fibroids were resected to the level of the surrounding myometrium and then the whole endometrium was resected to include the superficial 2-3 mm of myometrium (20 g of tissue was resected, and the operative blood loss was 215 ml).

Case 2—A 48 year old woman had had a diagnostic curettage, which showed an irregular 10 cm cavity distorted by a posterior intramural fibroid. Hysteroscopy showed a smooth endometrium with no polyps or submucous fibroids, but the posterior wall was severely distorted by the underlying fibroid. This was shaved down to permit access to the whole endometrial cavity (10 g of tissue was resected with an operative blood loss of 42 ml).

Case 3—A 40 year old woman with menorrhagia had a smoothly enlarged uterus the size of that of a 12 week pregnancy. Hysteroscopy showed a large, broad based pedunculated submucous fibroid measuring 10×10×8 cm. The fibroid was resected first as before (64 g of tissue was resected, and the operative blood loss was 400 ml).

All the procedures were performed under discharged laparoscopic control and no complications occurred. The patients were discharged after 48 hours or 72 hours (case 3). Bleeding persisted slightly for three to seven days and was followed by a discharge for seven to 21 days. All three patients were subsequently amenorrhoeic after a three month follow up.

Transcervical resection is suitable when hysterectomy is declined. Although the procedure is more difficult to perform than simple endometrial resection, the presence of fibroids should not exclude it.

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1 Magos AL, Baumann R, Turnbull AC. Transcervical resection of endometrium in women with menorrhagia. *Br Med J* 1989;298:1209-12. (6 May.)

Putting equal opportunities into practice

SIR,—It was regrettable that, in the very same issue of the *BMJ* that the commendable recommendations of the BMA working party on women's careers were reported,¹ the list of BMA sponsored candidates for the General Medical Council was included as an insert.

Among the gallery of photographs of white men there were three overseas trained doctors and a whole one woman candidate. While the Medical Women's Federation and Overseas Doctors Association may well put up their own candidates to pursue these groups' particular interests, that is no excuse for not trying to encourage equal opportunity policies within the BMA.

Fine words about changing the attitudes of the profession at large are not good enough until we see the evidence of the BMA putting its own house in

order. At a time when the medical profession is under such threat it seems imperative that all doctors have the confidence that their representative organisations truly have their interests at heart. This list of BMA sponsored candidates does not, I am afraid, inspire confidence that the BMA will do its utmost to protect women doctors in their careers.

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1 BMA. Supplementary annual report. *Br Med J* 1989;298:1392-6. (20 May.)

Lake Nyos disaster

SIR,—I visited the area described by Dr Peter J. Baxter and colleagues¹ on the second anniversary of the disaster as a doctor in a primary health care team from the Shisong Catholic Mission Hospital. Apart from scars and keloids from burns there was no evidence of long term medical sequelae that could be attributed to the leak of toxic gas.

Social trauma and physical handicap are, however, still evident. After the disaster the nomadic Fulani cattle herders moved up into the highlands, but the native tribesmen returned to the valley. Superstition has prevented their return to the original village, which remains as an overgrown ghost town and a permanent reminder of the tragedy. A new village has sprung up less than 3 km from the old settlement; conditions are slowly improving, but a third of the villagers are still living crowded into the now battered tents provided by the disaster relief agencies. A small health centre has been set up by the Catholic mission, which has trained two local nurse helpers to provide first aid and give out drugs provided by the government. Every three months the area is visited by a doctor from Shisong or Wum. The village school is nearing completion, and more permanent houses are being built, but poor communications make this a slow process.

There has been no deterioration in the food or water supplies either initially as noted by Dr Baxter and colleagues or in the long term, which would have been expected with acidic sulphur or halide gases. The theory of carbon dioxide poisoning remains the most likely cause of the deaths. Popular local theories about the cause of the disaster range from devils and black magic to the dropping of poisonous bombs by a foreigner as part of a test programme.

Unfortunately, geologists fear the likelihood of a future gas leak in this geologically unstable region, and the population, which has dwindled from its 1986 peak, is still at risk from another catastrophe.

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1 Baxter PJ, Kapila M, Mfondu D. Lake Nyos disaster, Cameroon, 1986: the medical effects of large scale emission of carbon dioxide? *Br Med J* 1989;298:1437-40. (27 May.)

SIR,—The pathophysiology of coma induced by carbon dioxide of the type described by Dr Peter J. Baxter and colleagues¹ has in fact been investigated in dogs and seems to be closely related to acidity of the cerebrospinal fluid and not influenced by that of arterial blood.²

This study showed that carbon dioxide had no effect on the minimum alveolar concentration (a measure of the amount of anaesthetic agent required to produce surgical anaesthesia in 50% of subjects) of halothane at arterial carbon dioxide tensions <12.7 kPa, suggesting that below such values carbon dioxide has minimal narcotic effect. Siesjo *et al* suggested that an arterial carbon dioxide tension of 27 kPa producing an intracellular acidity

in brain cells of <6.7 was necessary to induce narcosis.³ As an arterial carbon dioxide tension >13.3 kPa is unlikely to occur when a person is breathing air because the resultant dilution of alveolar oxygen would produce lethal hypoxia⁴ carbon dioxide alone seems unlikely to induce a coma deep enough to account for hypostatic blistering of the skin in those who survived the Lake Nyos disaster. Narcosis produced by higher arterial carbon dioxide tensions have all been recorded in patients breathing supplemental oxygen, and, although narcosis in respiratory failure may occur at lower values, that is probably due to a combination of factors. It is more likely that a mixture of different gases and hypoxia were responsible for the cases of reversible coma observed by Dr Baxter and colleagues. Might the presence of large quantities of carbon dioxide in the lake water be related to its greater solubility rather than the supposition that it was the most abundant gas?

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- 1 Baxter PJ, Kapila M, Mfondu D. Lake Nyos disaster, Cameroon, 1986: the medical effects of large scale emission of carbon dioxide? *Br Med J* 1989;298:1437-41. (27 May.)
- 2 Eisele JH, Eger EI, Muallem M. Narcotic properties of carbon dioxide in the dog. *Anesthesiology* 1967;28:856-65.
- 3 Siesjo BK, Folbergrova J, MacMillan V. The effect of hypercapnia upon intracellular pH in the brain, evaluated by the bicarbonate-carbonic acid method and from the creatine phosphokinase equilibrium. *J Neurochem* 1972;19:2483-95.
- 4 Prys-Roberts C. Hypercapnia. In: Gray TC, Nunn JF, Utting JE, eds. *General anaesthesia*. Vol 1. 4th ed. London: Butterworth, 1980:435-60.

The GMC's disciplinary powers

SIR,—Following the death of our daughter Harriette in May 1985 I complained to the General Medical Council that her treatment had been unacceptable and the practice concerned incompetent. My case was taken up and the two private general practitioners concerned appeared before the council's professional conduct committee in March 1986. They were found not guilty of serious professional misconduct.

I had never complained of such misconduct but about the treatment my daughter had received and the organisation of the Harley Street private practice concerned. Neither of these is subject to the checks and balances exercised in the NHS by family practitioner committees and district health authorities, so the only redress against private doctors is through the courts or the GMC. Having endured the trauma of an inquest, and taking the advice of doctors who had asked to be acquainted with the facts and read the transcript of the inquest, we asked the GMC to help.

The professional conduct committee was told by the doctors' defending counsel that our case should never have been brought before it and that he trusted that such a case would never again be heard, for, he argued, the *Blue Book* of rules was not concerned with errors in diagnosis or treatment.

Great play was then made of the fact that the GMC had failed to find a single general practitioner who would come forward and criticise the two doctors concerned. My wife and I knew then that this was "tails we win, heads you lose." So apparently did our supportive member of parliament, Sir Anthony Grant, who attended the hearing and on learning the verdict condemned it in the House of Commons and has since pledged his cosponsorship for Nigel Spearing's bill to amend the Medical Act.

Until the medical profession is big enough to admit its mistakes it will continue down the road of