Some patients were given volume loading to improve cardiac output after the application of positive end expiratory pressure. Without measurements of wedge pressure the volume of fluid required is difficult to assess, and clinical indicators of volume state in this type of patient are not accurate. In addition, to maintain optimal oxygen delivery and cardiac output in the face of a high positive end expiratory pressure it may be necessary to utilise vasoactive drugs. These drugs have unpredictable and sometimes deleterious effects on oxygen transport and respiratory function (particularly pulmonary venous admixture). Unless mixed venous oxygen saturation and oxygen consumption are monitored these effects, which may make tissue hypoxia worse, will be missed.

We agree that the study of Drs Singer and Bennett confirms the need for haemodynamic monitoring. Measurements should also be made to ensure that optimal global oxygen transport has been achieved, which, with our present understanding and technical skill, will necessitate pulmonary artery catheterisation.

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Hearing loss in the elderly

SIR,—The prevalence of deafness reported by Dr J K Anand and Ms Ivy Court[1] is similar to that of 42% reported by Townsend and Wedderburn[2] nearly 30 years before in institutionalised patients over 65.

The hearing aid services in many health authorities already have long waiting lists, and so further selection of at risk populations would help to maximise resources. We have recently assessed the hearing of patients aged over 65 who presented to the ophthalmology clinic with senile visual degeneration (for example, cataract or macular degeneration) and found that 12 out of 25 patients had appreciably impaired hearing (that is, over 30 dBA hearing loss in the better hearing ear) on testing by pure tone audiometry.

This group of patients also deserves special priority for audiological rehabilitation because they are already disabled by their visual handicap, which adds to their social isolation. This is particularly relevant in areas where the waiting list for providing a hearing aid is far in excess of the four weeks quoted by Dr Anand and Ms Court,[1] and we recommend further work to identify other specific groups to move audiological rehabilitation to a more proactive service.

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1 Anand JK, Court I. Hearing loss leading to impaired ability to communicate in residents of homes for the elderly. *Br Med J* 1989;**298**:1429-30. (27 May.)
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Neck sprains after car accidents

SIR,—Despite the many statistics he presented, I was surprised that Dr K M Porter did not entertain the possibility that the symptoms of a neck sprain may be related to secondary gain.[1]

While there is no doubt that patients can injure their necks in motor vehicle accidents, the very large variation in the incidence of whiplash injuries in different countries suggests that secondary gain may be an important feature in the development and prolongation of symptoms of this disorder. A study comparing the incidence of neck sprains in Australia and New Zealand found that there were 10 times as many neck sprains in the state of Victoria as there were in New Zealand, two areas with essentially similar populations.[2] The number of motor vehicle accidents and the number of rear end accidents were similar in both population groups. The amount of compensation paid in the state of Victoria was three times higher than that paid in New Zealand because New Zealand has a no fault accident compensation system.

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1 Porter KM. Neck sprains after car accidents. *Br Med J* 1989;**298**: 973-4. (15 April.)
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Non-attendance or non-invitation?

SIR,—The paper by Dr S Frankel and colleagues on non-attendance at outpatient clinics is a valuable work of audit which is relevant to all clinical specialties.[1] They found that 52% of non-attenders—that is, patients on holiday, who had decided that treatment was unnecessary, or who had difficulty getting time off from work—could potentially have contacted the hospital in advance to allow the appointment slot to be reallocated.

My clinical impression is that an appreciable number of both new and follow up patients do try to postpone or cancel appointments if they realise in advance that the time is unsuitable. This is usually done by telephone, but some telephone systems in large hospitals are so inadequate that the patients give up trying in frustration. This frustration can also afflict health professionals, who waste considerable time trying to phone in to colleagues or departments in hospital. I would be interested to learn if the six page questionnaire was able to shed any light on the effects of this type of administrative delay both in general and on the repeat non-attenders.

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1 Frankel S, Farrow A, West W. Non-attendance or non-invitation? A case-control study of failed outpatient appointments. *Br Med J* 1989;**298**:1343-5. (20 May.)

AUTHORS' REPLY,—Dr Davidson points to another important administrative problem that can have the effect of causing patients to appear to be more responsible for non-attendance rates than they may truly be. We did ask about attempts to contact the hospital, and 64% of the 277 non-attenders stated that they had contacted the hospital, of whom 31% stated that they had given one week's notice, 26% that they had given four to six days' notice, and 29% one to three days' notice. At the very least it seems that a proportion of non-attenders had taken reasonable measures to permit their unwanted slot to be used. Of patients who contacted the hospital, 57% reported doing so by telephone and half of those reported considerable difficulty in getting through. It is likely that a proportion of those who did not contact the hospital attempted to telephone but gave up the task. As we said in our paper, it is important to seek practical and soluble explanations for health service problems. A telephone exchange can be modified fairly easily. Such improvements in management or organisation are less likely to be sought where failings in the health service are attributed too readily to uncooperative patients.

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Disimpaction of swallowed bolus

SIR,—We agree with Drs P T Ignotus and A Grundy that carbonated drinks can safely and quickly disimpact a food bolus lodged in the lower oesophagus and were pleased to see their single case report in your widely read journal.[1] Previous accounts of the successful treatment of eight patients[2] and 16 patients[3] have been reported in radiological journals.

The use of the effervescent granules normally used in double contrast studies is a convenient way to administer the fizzy drink and was described by this department in 1986.[4] We have continued to use the technique with success. We have encountered no complications, have avoided endoscopic removal on several occasions, and commend it to others.

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1 Ignotus PT, Grundy A. Disimpaction of swallowed bolus. *Br Med J* 1989;**298**:1359. (20 May.)
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3 Mohammed SH, Hegedos V. Dislodgement of impacted foreign bodies with carbonated beverages. *Clin Radiol* 1986;**37**:589-92.
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Standards of wheelchairs

SIR,—Dr G P Mulley's article is a timely reminder to those of us working in hospitals that the wheelchairs used for transporting patients within hospitals should be of a sufficient standard to meet the requirements of the Health and Safety at Work Act.[1] The problem of inadequate, poorly maintained, and incomplete wheelchairs in hospitals is well known,[2,3] and fewer than a quarter of hospital wheelchairs are safe and in good working order. Since the lifting of crown immunity hospitals need to look carefully at their wheelchairs to ensure that they do not contravene the Health and Safety at Work Act. The DHSS issued a safety bulletin in May 1985[3] and recommended that wheelchairs be inspected regularly and maintained in a safe and clean condition.[4] In most hospitals this is clearly not the case.

Dr Mulley suggests that hospitals should appoint a wheelchair team to ensure that staff are taught more about the problems of wheelchairs and their users and that wheelchairs are regularly inspected, maintained, and cleaned. At Stoke Mandeville Hospital the wheelchair committee has recently published a wheelchair policy that includes policy on portering wheelchairs, ward based wheelchairs, department and clinic wheelchairs, occupational therapy and physiotherapy loan and assessment