Simplified Neonatal Scoring System

SIR,—Dr. W. F. K. Morrow and Mr. T. J. M. Myles (28 June, p. 820) reflect the feelings of many engaged in neonatal care. However, I feel they have not carried their simplification quite far enough. At the moment I am undertaking a large series to compare the Apgar score with a score deduced from only the breathing and heart rate. This gives equally good correlation and, giving a score from 0 to 4, is also providing a valuable lead to correct ventilatory treatment.—I am, etc.,

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Medical Records of Neonates

SIR,—I was interested to read the booklet issued by the Department of Health and Social Security on screening for congenital dislocation of the hip in infants.[1]

Like other doctors, it is always a little difficult to know where to record results of an examination for this in the newborn baby, since it is done at an early stage, before we have received an E.C.6. It seems to me that a suitable place on which to record one's findings would be on the back page of the maternity co-operation record card. I have written to the Department of Health and Social Security, but would be interested to know what other members of the profession think about this.—I am, etc.,

E. J. NOBLE.

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REFERENCE

1 *Screening for the Detection of Congenital Dislocation of the Hip in Infants*, Department of Health and Social Security, July 1969.

Vasoactive Compounds in Raynaud's Phenomenon

SIR,—We wish to report four patients with primary Raynaud's phenomenon (three of them very severe) whom we have recently treated in the outpatient clinic of the Orthopaedic Hospital, Copenhagen. We were interested in the role which the associated digital oedema could be playing in the pathogenesis of this condition, and as we were at the time investigating the anti-oedematous properties of a vasoactive compound, hydroxyethylrutosides (Paroven), it seemed reasonable to examine its effect on this condition. We know of no established satisfactory treatment for this disease.

The four patients were all aged between 20 and 30 years and were all longstanding cases of primary Raynaud's phenomenon. Two of the patients—both males—were severe enough cases to require a disablement pension, with periodic gangrene of the fingers and always at least one finger showing an open moist gangrene of the pulp. The third patient—a male—had severe gangrene of the left great toe as well as a less severe gangrene of the pulp of the fourth and fifth toes. The fourth patient—a female—was less severely affected, without gangrene, but with a typical history of periodic lividity of the fingers persisting until swelling and redness of the finger-tips appeared, after which the spasms relaxed.

All four patients were treated with Paroven in the form of 400 mg. capsules × 3 daily. Results were assessed on a purely clinical basis. In all four cases, only a few hours after administration of the first capsule the digits became more red and the pains increased violently. With the second capsule, swelling around the ulceration abated, and after the third capsule fresh bleeding occurred at the site of any open gangrene.

In the first patient the gangrene healed completely in two months. In the second patient it was necessary to remove the tuberosity of the head of the terminal phalanx, which was completely uncovered at the tip of the third right finger. Healing then occurred in the course of one month. In the third patient it was necessary to amputate the gangrenous great toe and part of the first metatarsal, but having commenced treatment with Paroven preoperatively a clear demarcation line resulted, which greatly facilitated the amputation. This also healed, along with the gangrenous fourth and fifth toes, in two months. The fourth patient was rendered asymptomatic by the treatment.

All the patients have now been followed up for two years and have remained free from gangrene. The three patients with finger gangrene now continue their own treatment, and can leave off the drug for periods of up to two months. As symptoms or a pregangrenous condition recur, resumption of treatment at 400 mg. × 3 daily cuts short entirely the condition. The fourth patient is completely symptom-free, with hand-made shoes with plastosote moulding corresponding to the missing toe.

It is interesting to speculate whether the observed effects of this compound on capillary function[1–3] and oedema[4–6] can be related to the findings in this condition. From this small number of cases we are encouraged to investigate further the action of hydroxyethylrutosides in this condition.—We are, etc.,

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5 Van Cauwenberge, H., and Franchimont, P., *Zentralblatt für Phlebologie*, 1968, **7**, 111.
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Awareness during Anaesthesia

SIR,—Drs. D. J. Turner and J. Wilson in their paper entitled "Effect of Diazepam on Awareness during Caesarean Section under Anaesthesia" (21 June, p. 736) state that "diazepam is probably to blame for the increase in unpleasant recall, and therefore is not a suitable premedicant for this type of anaesthesia." I submit, Sir, that it would have been more appropriate if the authors had stated that "this type of anaesthesia is unsuitable, and not even diazepam can patch it up with certainty in all cases." They seem to forget that the primary purpose of general anaesthesia is the prevention of operative pain through the provision of unconsciousness. If it is the intention to practise general analgesia as opposed to anaesthesia, and that is a perfectly legitimate endeavour, we should do just that and inform the patient that consciousness will be maintained during the operation. But to slip from general anaesthesia into general analgesia, or even worse into pain perception and back again in an entirely unplanned manner, surely negates the primary function of the anaesthetist. Looking at the Tables in the article, one must conclude that while diazepam premedication made things worse yet the percentage of unpleasant recall and the incidence of pain perception during operation are equally unacceptable for all three variants of premedication.

Surely modern inhalation anaesthetic drugs in small doses supplemental to nitrous oxide are not so harmful as to eschew their use in favour of such questionable practices as those described in the article under review.—I am, etc.,

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Haemodialysis in Glutethimide Poisoning

SIR,—In spite of the fact that the first case of glutethimide poisoning was reported more than a decade ago,[1] the management of this condition remains a problem and carries a mortality rate of 70% when the ingested dose of glutethimide exceeds 12 g. or when the blood glutethimide level has been 3 mg./100 ml. or more.[2] When haemodialysis is added to the routine treatment of this condition the mortality rate decreases to about 18%.[3] Recently, however, this form of treatment has received unfavourable reports. It is our belief that haemodialysis should be carried out in all cases of glutethimide poisoning, and for this reason we would like to report the following two cases.

The first, a 48-year-old male, ingested an unknown amount of glutethimide tablets. On admission he was deeply unconscious, and was not responding to painful stimuli. B.P. 70/40, pulse 60, tachypnoea with two episodes of apnoea, with blood glutethimide level 4·4 mg. per 100 ml. He was intubated, gastric lavage performed, and an eight-hour haemodialysis started with a twin Kolff kidney, using the Ultra-flow 145 dialyser (Baxter Ltd.). The dialysate fluid was changed every two hours. Approximate amount of glutethimide recovered 5·6 g. Complete recovery occurred 12 hours after the start of haemodialysis, and he was discharged to psychiatric care the following day.

The second, a 57-year-old male, also ingested an unknown amount of glutethimide tablets. On admission he was comatose, responding only slightly to painful stimuli. B.P. 100/75, pulse 80 regular, tachypnoea with several attacks of apnoea, with blood glutethimide level 3·7 mg./100 ml. Despite supportive measures his condition deteriorated and a seven-hour haemodialysis was started using the same technique as in the first case. Approximate amount of glutethimide removed 7 g. Complete recovery occurred 48 hours later, and he was discharged to psychiatric care two days later.

From these two cases it can be seen that haemodialysis efficiently extracts a large quantity of glutethimide from the blood, thus securing a rapid return to consciousness. We did not observe in our two cases signs of cerebral oedema[4] and this might have been due to the fact that haemodialysis was

instituted promptly and that the dialysate fluid was made hyperosmotic with dextrose in order to counteract the dialysis disequilibrium syndrome.[5]

We believe that prompt haemodialysis is the treatment of choice for severe glutethimide intoxication.—We are, etc.,

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Prophylaxis of Recurrent Headache

SIR,—Your leading article on this subject (4 January, p. 5) refers to trials concerning the effectiveness of ergotamine tartrate and of the serotonin antagonist methysergide. No reference was made to another entirely different approach reported by Dr. E. Ask-Upmark.[1] Following a chance observation by one of his patients on the beneficial effects on recurrent migraine of a *Lactobacillus acidophilus* preparation taken for unrelated intestinal disturbances, he tried its administration on a series of 10 other migraine sufferers. Eight of them reported considerable benefit.

The method was used in this clinic[2] on 16 individuals referred because of severe headaches recurring every few days. Nine patients reported either complete relief or marked reduction in frequency of attacks during a treatment period of one to two months. If this method is indeed effective theoretical speculations may tentatively relate it to the observations of Dr. E. Hanington.[3] She found that the administration of tyramine to migraine sufferers who related their attacks to various dietetic factors would provoke a typical bout. This work itself was based on the observation that tyramine is the agent present in cheese which is responsible for the severe headaches experienced by patients who partake of this food and are also receiving monoamine oxidase inhibitor drugs. These latter drugs block the degradation of the ingested tyramine in the intestines.—I am, etc.,

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2 Braham, J., Sarova-Pinchas, I., and Goldhammer, Y., *Harefuah*, 1969, **76**, 201.
3 Hanington, E., *British Medical Journal*, 1967, **2**, 550.

Health Education and Typhoid

SIR,—Mr. E. Q. Archampong must be congratulated on his article on operative treatment of typhoid perforation of the bowel (2 August, p. 273). The incidence and mortality figures that he gave were alarming. It was somewhat comforting to read of the results he obtained by operative treatment—results which were "sufficiently encouraging to suggest that a reappraisal of the general attitude to management of this complication of enteric fever is needed."

It must be pointed out, however, that diseases like typhoid fever are preventable, and in 1969 there should be no reason why adequate steps are not taken in all countries to ensure that no citizen contracts such diseases, let alone dies from any of their complications. What is needed in countries like my own—I am a Ghanaian—is a call for priority to be given to sanitary reforms and the health education of our leaders. Such a call should be added to Mr. Archampong's valuable contribution.—I am, etc.,

Belfast. G. A. ASHITEY.

"Mediflash"

SIR,—An "eight mile traffic queue" between an accoucheur and his patient requiring "an urgent forceps delivery" may give a false impression of British obstetrical practice to some of your readers, especially as the writer (16 August, p. 417) goes on to say "as a busy obstetrician . . . I have often had to use my Mediflash to negotiate holiday traffic jams." The mind boggles at the possible failure of motor-car, Mediflash, police liaison . . . not to mention telephonic communication.

An up-to-date maternity service for a population of 100,000 surely calls for the immediate physical presence of a competent obstetrician 24 hours a day.—I am, etc.,

Greenock, Renfrewshire. WILLIAM I. MARTIN.

Plight of Long-stay Hospitals

SIR,—Dr. Edward Lyons's letter (9 August, p. 361) calls for comment, since it appears to assume that psychiatric and geriatric medicine are set apart in some way from the general work in acute and short-stay hospital units. This is a fundamentally reactionary attitude to these established specialties, for it must now be recognized that the custodial management of the long-stay nursing and mental case is only a minor part of psychiatrists' and geriatricians' considerable clinical responsibilities. But clinicians with such responsibilities know only too well that the funds available for long-stay units have been exasperatingly small since the inception of the National Health Service. One of the reasons for this is the traditional medical concept of "acute" and "chronic" illnesses, though virtually clinically indefinable, being separate entities, and that patients requiring prolonged hospital care are of secondary consideration in matters of hospital expenditure. It is myopic to complain that funds should not now be made available to facilitate the nursing needs and other amenities of patients requiring long-term nursing care, and to ensure a more equitable distribution of a hospital board's limited revenue.

Over the years short-stay hospitals and certain prestigious units have had more than their fair share of available money, and it is high time that the Secretary of State redressed the balance. Clearly the ready availability of long-stay nursing units for major physical and mental disabilities cannot but enhance the effectiveness of investigation and treatment units.

The Clwyd and Deeside Group Medical Advisory Committee, with its "52 members of whom 36 are consultants," should have voiced its dismay at the dearth of suitable custodial nursing units in North Wales long ago. In this neighbouring group I have clinical responsibility for a number of archaic long-stay units, one of which, with 43 beds, admitted its first pauper in 1840. Public opinion must no longer tolerate incongruities like this, and professional opinion should also deplore such continued inequalities within the hospital service. The belated intentions of the Secretary of State are therefore to be commended and welcomed.—I am, etc.,

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North Wales.

Doctor : Patient Ratio in Lancashire

SIR,—The appearance of the *Annual Report of the Department of Health and Social Security* for the year ending 30 September 1968[1] is timely, as it once again shows statistically the unsatisfactory state of general-practitioner manpower in the country, and emphasizes the extraordinary position in the area of the Lancashire County Executive Council.

In the Department's north-western area there were 6,757,093 patients on the lists of 2,604 principals. If the 1,513,415 patients and 598 principals (average per principal of 2,529) in Cheshire are excluded, there are 2,006 principals with 5,244,678 patients (an average of 2,614 patients per principal) in the whole of Lancashire; this average is about 139 patients per principal above the national average.

If Lancashire County Executive Council is considered on its own (separately from the 1,188 principals and their patients in the County Borough and City Executive Council's areas) the Department's tables show that 818 principals had 2,228,842 patients on their lists. This is an average of 2,725 patients for each of the 818 principals—250 above the national average—in a county which has extensive rural areas with considerable seaside and some of the finest countryside in addition to the industrial areas of popular concept. The County Executive Council area contains no town reaching county borough status in size, but of the 818 principals there were no fewer than 314 with 3,000 or more patients on their lists. These lists are well above the national average, and with increasing patient demands for help in various forms—encouraged from all sides, ranging from Government, through various forms of publicity, to our colleagues and ourselves—it is likely to become impossible to give the services without serious danger of complete breakdown.

There surely is a need, becoming more and more urgent, to encourage an increasing