We firmly believe that adoption of an "injury control" rather than "accident prevention" or, indeed, "crash" perspectives will allow a more appropriate focus by health authorities and health and safety strategists on the distribution of injuries and their socioenvironmental aspects.

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Sister hospitals in Bosnia

EDITOR,—Hugh Dudley is more than right in his straightforward statements that "putting a team in place is far more effective than evacuating people . . . the very presence of a team has great meaning for the community" and "surgical teams will never change the course of history but will . . . be remembered in the marketplace."[1]

More than remembered—in our case, such help may mean life for hundreds of people and, indirectly, a psychological impact that would facilitate the flow of humanitarian convoys to all endangered peoples in Bosnia and Herzegovina.

Nova Bila Hospital, located near Novi Travnik, middle Bosnia, is the only hospital in an enclave with a surrounded Croatian population of 70 000. Since the hospital was established in the spring of 1993 its staff have performed 330 operations with general anaesthesia and 1500 with local anaesthesia; 59 have been on wounded children. Some 7000 sick civilians were treated in the hospital, with 50 babies born every month, 70-80 patients being checked daily, and about 60 visiting the pharmacy looking for medicines.

The hospital has serious problems with staff, supplies, equipment, and communication. Raging war and total lack of mutual confidence of warring sides cut the hospital completely off from the world, from all those who could help. It urgently needs a paediatrician, gynaecologist, neurologist, psychiatrist, internist, anaesthesiologists, and all other specialists. Haemodialysis machines, electrocardiographs, and equipment for developing *x* ray films are among the most needed devices. All drugs are in short supply.

We have already sent a similar appeal for help to our colleagues in Croatia. I believe, however, that because of the delicacy of our setting, foreign doctors and help would be more efficacious and have wider impact. The presence of foreign doctors would assure all sides of their impartiality and this, in turn, would ease the flow of supplies, diminish the direct danger to the hospital, and facilitate the evacuation of heavily wounded patients. Thus, purely medical aid and presence may have far reaching consequences that might prove Hugh Dudley wrong in at least one of his statements: surgical help may, at least a little, also change the course of history.

Knowing the situation in Nova Bila, the doctors of Mostar Hospital proclaimed Nova Bila Hospital as a sister hospital. The idea of establishing the sister hospital relation stems from a recent initiative of the International Physicians for the Prevention of Nuclear War (IPPNW) to formalise the concept of IPPNW peace hospitals as places for "inner and outer peace."[2] The idea includes the concept of proclaiming hospitals endangered by war as sister hospitals of those willing to help.[3] In as much as Mostar Hospital employs physicians from all major nationalities of Bosnia and Herzegovina (Moslems, Croats, Serbs, and Jews) and impartially treats patients of all nationalities, occupations, and sides, we have submitted our application for an IPPNW peace hospital. Unfortunately, the war proved faster than the acceptance procedure and we decided to work along the lines of a peace hospital even before the formal decision of the IPPNW. Both hospitals would appreciate help from our foreign colleagues to find our sisters in more peaceful and less troubled parts of the world.

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Value of confidential inquiries

EDITOR,—In saying that the confidential inquiries into maternal death are of doubtful value Jane Wells and Jean Chapple ignore their educational impact.[1] Those of us who worked in obstetrics in the three decades after 1950 always eagerly awaited the confidential inquiries. They certainly increased our knowledge of where the thrust of education for undergraduates and postgraduates should be. Teachers' attitudes to the problems to be solved changed: emphasis was placed on the organisation of the midwifery services; the importance of management in "toxaemias," haemorrhages, abortions, and sepsis; and the dangers of anaesthesia and pulmonary embolism. Thus the inquiries formed a basis for more relevant teaching at all levels. Opinion on what was important to look out for, in all phases of childbearing, was undoubtedly altered. It may not be possible to measure in statistical terms the effects of these changes, but they did occur.

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1 Wells J, Chapple J. Value of confidential inquiries. *BMJ* 1993;307:1426-7. (27 November.)

Unemployment and psychiatric admissions

EDITOR,—Robert M Kammerling and Susan O'Connor's study of the relation between socioeconomic status and psychiatric admission rates is useful.[1] Their finding that the unemployment rate outperformed the Jarman score as an indicator of admission rates agrees with findings in Sheffield.[2]

Their conclusion that the allocation of resources to fundholders in general practice should take account of deprivation as reflected by unemployment rates requires comment. They acknowledge that differences in clinical management can affect use of acute beds—perhaps particularly reflected in variations in length of stay and ratios of readmissions to admissions. In districts there is a weak negative association between the proportion of psychiatric nurses working in the community and admission rates.[3] Activity of mental health services is represented by more than inpatient admissions, and currently the general practice fundholding scheme includes only community mental health services. In a study of referral patterns over one year in south east Sheffield we found wide variations in general practitioners' referral rates for inpatient admission, for consultant domiciliary visits, for outpatient assessment, and to community psychiatric nurses and no clear correlation with deprivation, which almost certainly mainly reflected the practice of individual general practitioners. These findings suggest that caution is required in allocating resources on the basis of activity alone, but there is little evidence to suggest that unemployment rates should be taken as a proxy of need for community mental health services as opposed to need for inpatient admission.

The introduction of fundholding may shift the basis of community mental health services from secondary to primary care. More work is needed to establish a rational basis for allocating resources for mental health care. Kammerling and O'Connor's paper perhaps indicates that research should attempt to establish correlations for community mental health activity rather than relying on a remarkably high and consistent association between unemployment and admission rates to dominate thinking about funding.

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Height and weight of rural and urban children

EDITOR,—Richard Reading and colleagues report that low birth weight and children's heights differ considerably between urban and rural areas in Northumberland, even after social deprivation was taken into account.[1] For both indicators rural areas produce better outcomes.

It is surprising that nutrition is not mentioned in the study, let alone considered as a possible cause of these important differences, given the worldwide evidence of the links between poor nutrition, low birth weight, and reduced growth. Among the many studies by Margaret and Arthur Wynn of dietary influences on health, growth, and handicap, one in particular points to major differences between rural and urban areas in the percentage of home grown goods.[2] The nutritional quality of freshly grown produce is generally recognised to be superior to that of food harvested before it is fully ripe, transported long distances, packed, and left on shop counters for sale many days later.

Other studies of women's nutritional intake, by the same authors, include an examination of the links between hypertension, low birth weight, and deficiencies of magnesium and other nutrients[3]; they have also studied the impact of maternal nutrition around the time of conception, again linking this to birth outcomes.[4] These studies themselves cite a considerable volume of other research evidence linking nutrition and low birth weight in Western countries. The idea that malnutrition is not a serious problem in the United Kingdom (an idea held at one time by the former Department of Health and Social Security) is no longer tenable.

It is interesting to note that magnesium is one of the key nutrients in serious deficiency as a result of food processing.[3] Again one comes back to the strong implication that the individual nutrient quality of rural diets, with their high proportion of home grown produce, is likely to be superior to

that of urban diets, at each level of affluence or deprivation.

Regretfully, most research in this field continues to search for the holy grail rather than examine the more pedestrian reality of how the health of each of us is directly influenced by our daily food intake. Other factors, such as social cohesion and housing, also contribute, though probably to a much lower degree.

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Hyponatraemia after ingestion of "ectasy"

EDITOR,—In the week that D L Maxwell and colleagues' report on hyponatraemia and stupor after ingestion of 3,4-methylenedioxymethamphetamine ("ecstasy") was published I saw a similar case.

A 23 year old woman had taken half a tablet of 3,4-methylenedioxymethamphetamine at 11 pm, as she had done on previous occasions. She had drunk half a bottle of wine several hours earlier in the evening. Eight hours after taking the drug she vomited and then slept. Eighteen hours later she was found crying and behaving abnormally and did not recognise her friends. She was taken to the local casualty department 24 hours after ingesting the drug. She was noted to be behaving strangely; she was drowsy but when roused seemed to stare without recognising anyone. She was mute and incontinent of urine. She moved all her limbs and reacted to pain but not command. Her pupils were dilated and equal and reacted to light. There were no other physical signs or fever. Investigations showed a serum sodium concentration of 123 mmol/l (normal range 133-146 mmol/l), but other biochemical and haematological tests yielded normal results. She was observed overnight, and the next morning she had recovered fully but remembered nothing of the night before. Her serum sodium concentration was 133 mmol/l.

This adverse reaction to 3,4-methylenedioxymethamphetamine seems to be fairly new. One possible cause is contamination of the tablets with other substances, though not necessarily psychoactive drugs. This might explain the variable effects in the same person.

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1 Maxwell DL, Polkey MI, Henry JA. Hyponatraemia and catatonic stupor after taking "ecstasy." *BMJ* 1993;307:1399. (27 November.)

Laparoscopic nephrectomy

EDITOR,—In their article on laparoscopic nephrectomy Kurt Kerbl and colleagues rightly comment that for malignant renal disease this operation is presently controversial, one reason being the fear of the release of the malignant tissue into the abdominal cavity during "morcellation and retrieval of the diseased kidney."[1] We feel, however, that they incorrectly conclude that with their technique of entrapment with a sac before retrieval "seeding is no longer an issue."

There is now ample and increasing evidence that, for a variety of reasons as yet incompletely understood, "port site" recurrences of deposits can occur in a number of operations where malignant tissues are manipulated laparoscopically, including the colon and gall bladder,[2-4] whether or not there is any specimen to be removed and almost certainly despite "entrapment," which of course occurs late on in a laparoscopic procedure, in Kerbl *et al*'s case up to six hours after the start of the operation. Also, the possibility of seeding at other unusual and unexpected sites during laparoscopic surgery has recently been raised.[5]

For these reasons we consider that seeding during laparoscopic surgery for malignant disease remains very much an issue and are pleased to note that the Society for Minimally Invasive General Surgery is currently considering this problem.

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Lead shot passed per urethram

Four unlikely explanations...

EDITOR,—David Vicary's short item addresses an interesting question.[1] Assuming that the patient definitely passed the lead shot per urethram and had definitely never been shot, four unlikely possibilities might explain the passage of lead shot per urethram: the presence of an occult enterovesical fistula; a ureteroenteric fistula secondary to ureterolithiasis; the gradual migration of previously ingested lead shot from the intestinal lumen to the urinary system (for example, after transient inflammation of a colonic diverticulum) without a fistula; and passage of shot from the umbilicus into the bladder through a patent urachus. The third possibility is unlikely as lead is encapsulated after impregnation into tissue.[2] The fourth possibility is unlikely as a patent urachus would cause symptoms, and the possibility of such a port of entry is only theoretical.

Finally, the calibre of a weapon cannot be determined by looking at the shot: most game in Britain is shot with size 6 (2·6 mm) or size 7 (2·4 mm) lead shot, which can be fired by any calibre shotgun. The term rifle should be reserved for a weapon that fires a single missile.

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... and an appendix full of lead

EDITOR,—David Vicary reports that a man with renal colic who had been in the habit of eating game birds passed in his urine what seemed to be the shot with which they had been shot.[1] This reminds me of a case which a surgeon in Auckland told me about when I was a medical student in 1938. A man who was a keen duck shooter and ate the ducks he shot consulted the surgeon about haematuria. *x* Ray films showed some lead shot in the region of his appendix, which was lying on his ureter. The appendix was found to contain shot and was removed; the haematuria ceased. If there had been a fistula from his appendix to the ureter or bladder would he have passed the shot per urethram?

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1 Vicary D. Photo finish. *BMJ* 1993;307:1634. (18-25 December.)

Ischaemic preconditioning

EDITOR,—In their editorial on ischaemic preconditioning Michael Marber and colleagues emphasise the value of early reperfusion in suspected acute myocardial infarction.[1] They go on to suggest that a "preconditioning stimulus" could somehow be used to delay the onset of myocardial necrosis and thereby increase the time available for therapeutic thrombolysis in suspected acute myocardial infarction.

It is difficult to imagine how such a stimulus, however it was given, could greatly influence the ischaemic process. To reach jeopardised myocardium the preconditioning stimulus would have to be given before the onset of symptoms since the vessel related to the infarct is occluded in over 80% of instances.[2] Even if a preconditioning agent could be given prophylactically to patients at risk the additional "breathing space" afforded would be only of the order of 90 minutes.[3] If spontaneous or therapeutic thrombolysis was not achieved within that time the necrotic process would resume. As angiographic studies suggest that early spontaneous recanalisation occurs in only a minority of cases the onus would then be on giving thrombolytic treatment early. Most patients presenting with a suspected myocardial infarction, however, have experienced symptoms for well in excess of the 90 minute breathing space afforded by any prophylactic preconditioning.[4]

Thus on current evidence a hypothetical preconditioning agent seems to be of limited value in the management of acute myocardial infarction.

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Screening for HIV in pregnancy

EDITOR,—We agree with the policy of voluntary named testing being offered universally in antenatal clinics, as in the Swedish national screening programme for HIV infection in pregnant women,[1] and would like to report on our experiences in the Riverside Health District in central London.

A system of voluntary named HIV testing has been in operation in the hospital based antenatal services since 1987. We studied this service in 1991, when the uptake rate of the test was 17% (134/788), asking 318 women whether the test should be offered to all women in the clinic[2]: 296 (93%) of the women felt that it should be, but only