oil). This agent has been implicated in the production of an unusual hyperlipidaemia in patients receiving an intravenous preparation of the antifungal drug miconazole which also contains Cremophor EL.[2]

We have observed a similar pattern on lipoprotein electrophoresis of the plasma of a 33-year-old man with post-traumatic pulmonary insufficiency who had been sedated for seven days with a continuous infusion of Althesin at the rate of 72 ml/day. The pattern is that of disappearance of the α-lipoprotein band and the appearance of a densely staining abnormal band running in the β-lipoprotein region. The total plasma cholesterol concentration was 4·3 mmol/l (166 mg/100 ml) (normal range 3·6-6·2 mmol/l (140-240 mg/100 ml)) and the triglyceride concentration was 2·6 mmol/l (230 mg/100 ml)) (normal range 0·6-1·7 mmol/l (53-150 mg/100 ml)). Bagnarello *et al*[2] pointed out that this unusual lipoprotein pattern is similar to that seen in dogs during continuous infusion of the surface-active agent Triton, which, over a period of a few months, produces severe arteriosclerosis.

We suggest that patients receiving long-term infusions of Althesin or other preparations containing Cremophor EL should have their plasma lipids monitored and that development of the electrophoretic pattern described could be a justification for discontinuing such infusions unless the benefit of the therapy is thought to outweigh the potential risk. We would also suggest that the transitory rise in plasma free fatty acids associated with the induction of anaesthesia with Althesin[3] may be due to its Cremophor EL component.

We thank Mr P M Scott, FRCS, for permission to report this case.

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1 Ramsay, M A E, *et al*, *British Medical Journal*, 1974, **2,** 656.
2 Bagnarello, A D, *et al*, *New England Journal of Medicine*, 1977, **296,** 497.
3 Mehta, S, and Burton, P, *British Journal of Anaesthesia*, 1975, **47,** 863.

Management of children with nephrotic syndrome

SIR,—Your leading article (29 October, p 1103) concerning the treatment of nephrotic syndrome in children requires comment.

A low-sodium diet is traditional and easily prescribed but is unpalatable, tedious for the mother to cook, and unnecessary. A high-protein diet is expensive and illogical: the stimulus to albumin synthesis is hypoalbuminaemia itself and not ingestion of excess protein.

Setting aside these points, the precise indications for steroid therapy are not discussed. The natural history of minimal-change glomerulonephritis is one of relapse and remission. Why should not loop diuretics be used to control oedema until remission occurs? Frusemide and bumetanide are very well tolerated and much less toxic than steroids. Because a condition responds to steroids this does not necessarily imply that steroids are indicated. Is proteinuria per se injurious, provided that oedema is controlled by diuretics? Only a very few nephrotic patients develop hypoalbuminaemic hypovolaemia of clinical importance.

The place of diet, of diuretics, and of corticosteroid therapy in the minimal-change glomerulonephritic nephrotic syndrome are yet to be evaluated by adequate clinical trials.

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Obstetric audit in general practice

SIR,—I was interested to read Dr G N Marsh's audit of a general practitioner maternity unit (15 October, p 1004). The previously unpublished retrospective figures for our GP maternity unit from 1965 to 1976 cover 3410 births, of which 96·2% were normal deliveries, 2·8% deliveries with forceps, 0·6% breech, and 0·1% twins. Post-partum haemorrhage occurred in a further 2·4% and the flying squad was called out for 1·7% of deliveries. The perinatal mortality was 3·8 per 1000 births, although this is falsely low owing to patient selection, etc, and the maternal mortality was nil. These figures merely show that a GP maternity unit is a safe place to have an anticipated normal delivery.

Between 1965 and 1973 54% of patients were breast-feeding on discharge. It was then decided to improve the combined approach of the primary care team and this involved a setting up of a GP unit booking clinic at which patients were separately interviewed by a midwife and a health visitor, and a clerk and practice nurse were involved in routine blood tests, etc. Also the previously separated hospital and district midwives joined together to become truly community midwives. Our patients are therefore cared for in hospital by their midwife who will follow them up at home, they are informally visited by their health visitors who will follow up later, and supervision is by their GP.

Coincident with this change in approach, the incidence of breast-feeding on discharge has risen to 63%. As the advantages of breast-feeding are now so well documented I wonder how many specialist units can claim such a degree of preventive health care for their normally delivered babies on discharge.

B BEDFORD

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Advisory Committee on Borderline Substances

SIR,—It is now several years since the Advisory Committee on Borderline Substances (ACBS) in their wisdom classified the powder formulation (but not the tablets) of Optimax (L-tryptophan compound), a drug used currently in the treatment of depression, as a food, creating a situation on which bureaucracy thrives, confusion abounds, and common sense goes by the board.

To the manufacturer who has the same product classified as a drug and as a food it is, to say the least, irritating. One attracts VAT and the other does not. Both are prescribable in hospitals; only the tablet is prescribable outside in family practice. To the committee it must sometimes seem to be a most regrettable classification, involving them in numerous tribunals and a great deal of paper work, not to mention abuse from general practitioners up and down the country surcharged for prescribing "non-prescribable" medicines. In the case of Optimax powder, after three tribunals and one high court action that involved a great deal of expense and much wasted time, the situation remains unresolved.

Professor Barbara E Clayton in her lucid, informative letter (24 September, p 834) indicates that "the committee is always ready to reconsider any of its decisions in the light of new evidence." What is not spelt out, however, is what constitutes "new evidence." In the early days the clinical efficacy of Optimax was questioned by the committee; accordingly new evidence was generated attesting to the amino-acid's role as a safe, effective antidepressant,[1-3] etc. Regrettably the ACBS would neither change their mind nor advise on the sort of data they were seeking in respect of our petition to change the status of Optimax powder from food to drug—a classic "Catch 22" situation.

Although the ACBS's recommendations are "never . . . more than advisory," the implementation of their simple "guidelines" leaves a trail of confusion and frustration for administrators, clinicians, pharmacists, and, not least of all, the patient. However the ACBS sees itself, it is certainly not fulfilling the role of guide and mentor either to the clinician or to the pharmaceutical industry.

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1 Jensen, K, *et al*, *Lancet*, 1975, **2,** 920.
2 Rao, B, and Broadhurst, A D, *Lancet*, 1977, **1,** 460.
3 Herrington, R N, *et al*, *Psychological Medicine*, 1976, **6,** 673.

Matching resources to needs

SIR,—Our resources are finite and our desires to improve health care are not. After an evening spent considering the RAWP Report[1] and "The Way Forward"[2] I was irresistibly reminded of Macaulay's dictum that nothing is so useless as a general maxim. I must applaud the initiative of the Department of Health and Social Security in attempting to rationalise the planning of the Health Service for the future, but the more I read those documents the more uneasy I became. I appreciate the difficulties of equating the health needs of, say, Yorkshire with those of East Anglia, though it is much easier to contrast Trent with the North-west Thames Region. However, the more closely I study the RAWP formula the more I am impressed by how much we are to depend in the underprivileged areas upon a formula of pseudoscience for our future financial allocations.

"The Way Forward" encourages us to spend more upon community services, and they may be right, though we have no evidence that community health care is either better for the patient or cheaper. It may be both, but we just do not know. I suspect that the DHSS are recommending it because they think it is cheaper. Very large assumptions are being made by such a policy, and to attempt it in the absence of firm information as to its efficacy seems very unwise. Could we not have a trial of it in one region first and see if it is right before plunging the whole Health Service into a course of action which is based upon scant knowledge? We already have the uncomfortable consequences of Sir Keith Joseph's reorganisation to live with—a good

example of a definite and in the event expensive change of policy without finding out properly first whether it worked or not.

Shaw maintained that all progress depends on the unreasonable man. I am going to be unreasonable and say that I think that the objectives of RAWP—namely, a more equitable distribution of health resources nationally —are admirable, but I do not think they go far enough. The underprovision of resources for Trent is obscene when compared with the relative wealth of North-east and North-west Thames. The rest of us lag a long way behind the London area, but in a roughly comparable but less urgently demanding way. In the event it is probably not possible to devise a fairer method than the RAWP formula. The main imbalance lies between London and the rest of us, and it will be a long time before extra finance is likely to be available for the Health Service.

The DHSS therefore, it seems to me, must think a little harder about what to do with Greater London. The imbalance of health care within the London area is in its way just as striking as the contrast of Thames generally with Trent; or perhaps the contrast between Canterbury and inner London. The problem seems to be the gross overprovision of very expensive facilities in the inner London area. The siting of health facilities has just not followed the shift in population. Planning in the Health Service is so slow and capital building so underfinanced that we have been quite unable to provide the flexibility needed to keep pace with modern conditions. We have spent very large sums of money on expensive provision of prestige centres in inner London when the population has gone to live somewhere else.

We must be very careful that by reallocating finance we do not do irreparable harm to our excellent London teaching and postgraduate hospitals. I would be the last to advocate damaging our prestige hospitals. They are far too valuable and have done so much to develop health care nationally and internationally, but *they are in the wrong place*. They should follow the example of St George's Hospital and move to where the population is. I suspect that we could with profit amalgamate the specialist hospitals into two centres—one for London and, say, one for Birmingham or Manchester. We should have the courage to move two or three of the London teaching hospitals to areas where large populations exist and attach them to a university without a medical school—for example, Exeter perhaps, or York. This would entail an enormous upheaval for the staff concerned and they would need to be treated generously and with great sympathy. Nevertheless, other areas would benefit by the bringing of staff of great skill and experience to underprivileged areas where there would be no shortage of work, and the status and excellence of the hospitals would be maintained. They would have a clearly defined sphere of influence to serve, keeping of course their undergraduates by establishing new university medical schools without increasing the overall number of students. The problem of inner London would be at least part way solved by such a move. Perhaps the third teaching hospital could move out to peripheral London to where the people live.

I have no doubt this letter will cause anger and dismay, and sadly nothing will probably be done and I shall have merely merited much abuse. But cannot we have the courage occasionally to open our eyes and *look* at our problems? The plain truth is that we do not distribute our health resources overall either rationally or fairly. A patient has a reasonable right to good health care within reasonable distance of his or her home, whether that patient lives in the north, south, east, or west of England. As caring doctors we should have something constructive to say about that.

A K THOULD

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Truro

[1] Department of Health and Social Security, *Sharing Resources for Health in England. Report of the Resource Allocation Working Party*. London, HMSO, 1976.
[2] Department of Health and Social Security, *Priorities in the Health and Social Services: The Way Forward*. London, HMSO, 1977.

Emergency in emergency departments

SIR,—How widely is it known that the accident and emergency departments of Britain may all shortly have to close?

The result of the revaluing of the junior doctors' pay, involving the payment of varying extra units of medical time for hours of duty rather than amount of work done and responsibility taken, has been to make work in the accident and emergency departments less attractive than ever before. Invariably the appointees to accident and emergency departments are now the least experienced of all senior house officers. Even in rotating posts it is policy that work in the accident and emergency department is the first undertaken. If it is arranged later doctors will default before moving to accident and emergency work. Repeated recent advertisements for posts in accident and emergency work only have elicited no response or have attracted an occasional overseas graduate with no previous experience of work in this country.

It should be accepted by general practitioners and consultants alike that the accident and emergency posts in our major hospitals should be the last posts not to be filled if there is a shortage of doctors. Further, where posts are not needed for training, it could be a career grade for hospital doctors without specialist degrees.

The whole pay structure needs urgent reviewing so that any doctor undertaking resident hospital posts progresses to the accident and emergency department after his other posts because it is the most highly paid in that grade. This rate should be related to hours first on call and possibly graded in proportion to the work load of the accident and emergency department concerned. Only by arranging this can we attract doctors with the necessary width of experience to work in our accident departments.

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Decline of visiting

SIR,—I have long been perturbed about the increasing tendency for visiting to be kept to a minimum and sick people brought to the surgery. However, I have now heard the ultimate.

A patient 10 weeks short of delivery began to lose liquor and blood at 4 am. At 7 am, not having wished to disturb her doctor earlier, she rang through to her GP and the answering phone put her on to a deputy. She carefully explained the situation to the deputy (incidentally, a lady doctor), who told her to "come to the surgery, which starts at 9 am."

A E LODEN

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Points from Letters

Human tick infestation in Britain

Drs I P GORMLEY and J A RAEBURN (Edinburgh) write: Dr J A Slater (29 October, p 1158) expresses an interest in tick infestation in Britain. From personal experience we know that man commonly aquires ticks in the hill-farming areas of the North-west of Scotland which have carried infested sheep and cattle. Holidaymakers and children are most prone to these parasites while walking or sitting in long grass or heather as, unlike those working with stock, their clothing often leaves areas of skin uncovered. . . .

Dr T NORMAN (Blandford, Dorset) writes: . . . Ixodid ("hard") ticks occur commonly in this country where cattle and sheep are grazed, particularly on old, unploughed pastures and downland, and can be a nuisance to the minority of humans whom they like to bite. I find that these tiny ticks (presumably the nymphal stages) take 12-24 hours to become firmly anchored, when they will make their presence known by a red, itchy patch. If found early enough they can be pulled off fairly easily. . . .

Dr ELEANOR P BUTLER (London SE3) writes: Experience with tick infestation in our spaniels has led us to a treatment regimen quite suitable for any human being unfortunate enough to be attacked. The tick can be anaesthetised by placing a Mediswab or pad soaked in ether over it for two minutes. It can then easily be lifted off (head and body together) with forceps. . . .

Dr ELIZABETH J F HARRIES (Wellington, Somerset) writes: . . . The treatment is to squeeze (or singe) the body of the tick—I do it by pressing hard with my fingers protected by a tissue. The embedded head thereafter drops off without further harm. It is a mistake to attempt to pull the ticks out. . . .

Dr T L HENDERSON (Grantown-on-Spey, Morayshire) writes: I was interested to read Dr J A Slater's lively account of his tick bite (29 October, p 1158). May I recommend that when next *Ixodes ricinus* fixes on him to feed he treats his visitor to some topical whisky or methylated ether or even a burn with a lighted cigarette. Removal of the hard tick is then much easier and is more likely to be complete, so that local reaction is much reduced. In over 20 years of practice in Strathspey I have never seen any systemic reaction from, or illness subsequent to, tick bites in human beings, and such bites have been seen in people of all ages from larval, nymphal, and adult ticks. . . .

***This correspondence is now closed.—ED, *BMJ*.