



Incidence of leprosy, Karimui, New Guinea. Population was surveyed in 1964 then in 1966, then yearly until 1974. 1965-6 is average of two years. From 1975 to 1979, 19 new cases were detected, six in the vaccinated and 13 in the unvaccinated groups; these have been averaged.

leptomatous, multibacillary leprosy (the reservoir of infection), demonstrating the rapid decline of the disease, previously highly endemic in a very isolated area. Virtually complete interruption of transmission has been achieved 12 years after starting chemotherapy, which cannot be due to "socioeconomic standards."

Surprisingly, Lienhardt and Fine do not consider the findings of the three, double blind, random, controlled trials in Uganda,⁶ New Guinea,⁷ and Burma,⁸ which have given contradictory results, in concluding that BCG is effective in preventing leprosy. Moreover the effect of BCG against leptomatous leprosy, the form which spreads the infection, could not be assessed in the Uganda trial because there were no cases in the unvaccinated group. In the Burma trial 40-70% of leprosy was predicted to be leptomatous⁸ but only 19 out of 831 patients, or 2.3% of the unvaccinated group, were found at the final follow up;⁷ the reservoir of infection had virtually been removed by dapson monotherapy,⁹ making assessment of the efficacy of BCG impossible. In Karimui, New Guinea, the effect of BCG against leptomatous leprosy was not statistically significant.¹⁰

The claim that BCG is effective against leprosy in Venezuela is based on the results of a case-control study and not on the randomised, double blind, controlled trial, which compared the effect of BCG alone and BCG with *Mycobacterium leprae* and did not include an unvaccinated group.¹¹ The current trial in Malawi also excludes an unvaccinated group.¹² Finally, in view of the AIDS epidemic, is it safe to carry out routine BCG vaccination?¹³

If leprosy is to be eliminated by 2000 then evaluation needs to be improved. Indeed, it is surprising that a fall in the prevalence of treated cases is being used to monitor the decline of the disease; a fall in incidence should be used. New rates of leptomatous leprosy and leprosy in children should also be recorded. Dapsone monotherapy has been very successful in treating patients and reducing incidence, particularly through the mass treatment campaigns in West Africa; it is unnecessary to give every patient multidrug therapy, which should be reserved for newly diagnosed leptomatous leprosy and for those leptomatous patients who have not responded to dapson. Most patients with non-leptomatous leprosy have self limiting disease, so they should not need multidrug therapy.

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Removal of central venous catheter and venous air embolism

EDITOR,—The report from Mennim and colleagues¹ and the correspondence it has generated^{2,3} serves as a timely reminder of some of the complications that may occur during the introduction and removal of central venous catheters. The "head down" and Trendelenburg positions are ways of increasing central venous pressure and so prevent the aspiration of air into the venous circulation. Another method that has not been mentioned is to ask patients, while supine, to exhale and hold their breath in expiration.⁴ This increases intrathoracic pressure and causes "flow-back" of blood when the syringe is disconnected from the introducing needle. The guide wire is then quickly advanced. If an introducing sheath is placed in the central vein, the pacemaker or pulmonary arterial catheter (for example) may be passed rapidly also during this phase of respiration. For the temporary placement of such catheters, however, the "self seal" type of introducing sheath (with a side arm for flushing) minimises still further the risk of air aspiration. For the occasional patient who is unable to tolerate the head down or Trendelenburg position (because of pulmonary oedema, for example) this is possibly a safer alternative, provided of course that the patient is compliant in performing this sort of manoeuvre. The removal of catheters can also be accompanied by the patient carrying out a similar manoeuvre, the air occlusive dressing being immediately to hand.

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Ecstasy and the dance of death

EDITOR,—John A Henry states that ecstasy's "psychotherapeutic potential began to be explored in fields as divergent as marriage guidance, alco-

holism, and enhancement of perception in elderly people—all without benefit."¹ He also reports the undesirable physical symptoms reported by me in 1986 but mentions none of the benefits.² This is a misrepresentation of the facts.

Eighteen of my 29 subjects reported positive changes in mood after their session; 23 reported improved attitudes, such as toward self and life in general; 28 reported improvement in interpersonal relationships, and three of the five couples reported benefits from a few days up to two years; nine reported improvements in their working life; 14 reported diminished use of abusable substances (alcohol, marijuana, caffeine, tobacco, cocaine, and LSD); 15 reported beneficial changes in their life goals; and all nine subjects with diagnosable psychiatric disorders reported considerable relief from their problems (dysthymia, simple phobia, personality disorders, and depressive disorders). There were also other benefits during the sessions.

A recent article reports the benefits resulting from the use of the drug by 20 psychiatrists.³ Ten reported improved social or interpersonal functioning, nine reported positive changes in values or life priorities, eight reported improved occupational functioning, and five reported a decreased desire to use alcohol, in addition to other benefits.

Henry also states, "While its therapeutic possibilities were being discarded its potential for misuse was being discovered." The therapeutic possibilities are far from being discarded. A group of Swiss psychiatrists have been successfully using the drug as an adjunct to psychotherapy for years, and a psychiatrist at the University of California, Irvine, has applied for permission to study its use in reducing pain and psychological distress in patients with terminal cancer (D Harlow and J Beck, Multidisciplinary Association for Psychedelic Studies international conference of psychedelic psychotherapy, Bern, 1990; C S Grob *et al*, unpublished data).⁴

I agree that ecstasy can be dangerous in high doses, especially when accompanied by dehydration and increased body temperature from dancing for hours, but in a controlled psychiatric setting it can be beneficial to properly screened and prepared patients. Hopefully, governments in addition to Switzerland's will begin to allow controlled studies to prove conclusively that the benefits experienced by my patients are not the exceptions but the rule.

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Understanding schizophrenia

EDITOR,—L S Pilowsky seems to reach a different conclusion from the biological evidence about the nature of schizophrenia¹ than does Julian Leff in a recent commentary in *Nature*.² For Pilowsky it is clear that there are structural and physiological abnormalities present in the brain. By contrast, Leff suggests that schizophrenia remains a puzzle and recognises the plethora of hypotheses about the condition.

Some caution may be required when expressing the results of comparisons of the brains of schizophrenic and normal people. For example, although on average the brains of schizophrenic people may have larger ventricles, a simple statement that "schizophrenics have larger ventricles than controls" will be marked wrong in an MCQ examination of the Royal College of Psychiatrists,³

as the ventricles in the brains of most schizophrenic patients have scores within the normal range.

The difference between the positions of Pilowsky and Leff seems more than semantic. The current dominance of biological psychiatry obstructs the view of the patient as a person. In what sense can Pilowsky's editorial be entitled "Understanding schizophrenia"—knowledge of the brain may give no understanding of the person. Adolf Meyer was fond of seeing his philosophical approach to psychiatry, with its emphasis on the person, as an advance over the mechanistic philosophy of the nineteenth century,¹ but psychiatry seems to have slipped back since his time and his work is now largely neglected. He warned against going beyond statements about the person to wishful "neurologising tautology" about the brain. The link between mind and body is complex and the issue is unlikely simply to go away.

There is a danger that the bald statements of the organic nature of schizophrenia in Pilowsky's editorial will give a false impression. The inevitable uncertainty of the practice of psychiatry should be recognised. The misleading bias of biological psychiatry which may have been encouraged by his editorial needs to be countered.

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1 Pilowsky LS. Understanding schizophrenia. *BMJ* 1992;305:327-8. (8 August.)

2 Leff J. Schizophrenia in the melting pot. *Nature* 1991;353:693-4.

3 Birley JLT. Ventricular size in schizophrenia. *Br J Psychiatry* 1992;161:278.

4 Meyer A. *Collected papers*. Baltimore: Johns Hopkins, 1951, 1952.

Designing clinical information systems

EDITOR,—I am sure that A P Smith's article¹ will provide inspiration to clinicians contemplating the development of a clinical information system. I disagree, however, with his dismissal of information technology advisers: healthy relations with these departments can avoid wasting substantial amounts of time and money. Having spent four years as a management information consultant, I am in a reasonable position to defend the position of the information technology manager, and as a final year medical student I have some insight into the clinician's perspective.

Although nobody would suggest waiting "for the Information Technology Advisory Committee to buy you a white elephant," the importance of having and using a practicable hospital or district systems strategy and an information systems department must not be underestimated. This department can, with input from user departments, put in the necessary time to evaluate and select hardware and software suitable for various clinical and administration needs and pockets, taking into account potential future developments. The department can negotiate discounts with manufacturers and advise users on purchase, installation, and use of their systems, enabling clinicians to get on and use their systems and begin to develop their own applications. More complex problems such as setting up networks can also be tackled centrally, allowing low use peripheral equipment, software, etc, to be acquired and shared between users. Modern database packages are so user friendly that exchange of data, and also of "front end" applications, which can be developed by one user and then copied and modified for another user's needs, is straightforward.

Smith's suggestion that "single user systems could be on every consultant's desk" conjures up images of dozens of individuals struggling up

the learning curve, tackling similar problems in glorious isolation, and ending up with variable degrees of success: this is good news for no one except the hardware and software manufacturers. Certainly, getting to grips with computers is a challenge which can be very enjoyable and absorbing. Clinicians should, however, be using their time as efficiently as possible, and tinkering with microcomputers is not resource effective. Using an information systems department for coordination, advice, and support is the only way to free users' time to use computers constructively, as Smith describes; the assurance of back up may even persuade reluctant clinicians to take the plunge and find out what computers can do for them.

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1 Smith AP. How to design a clinical information system. *BMJ* 1992;305:415-7. (15 August.)

EDITOR,—A P Smith is to be congratulated for an extremely clear description of how he achieved the object of setting up his own computerised audit system following the "small is beautiful" philosophy.¹ What is so sad about the development of such systems is how little support they receive from central administration. Managers seem to be addicted to the philosophy of purchasing large systems and then expecting them to be suitable for all purposes. There is no perception of the type of information that clinicians want, or indeed any real attempt to determine how a particular clinician works. The pressure to conform to an information technology department's specification is becoming enormous, but has to be resisted at all costs.

The computer system developed in the intensive care unit in this hospital followed Smith's precepts closely. We first discussed roughly what we wanted to know. Then we decided on an approximate data set, with the overriding philosophy that the system should not add one single extra piece of work. We built a prototype and ran it, changed some bits, threw away others, and so on, until we got it about right. Then we tested it again. After all this, we ran it for real. It has been providing good information for over a year, does not require a secretary to run, and now administration are asking for information from it despite it being "non-standard."

Where we differed from Smith was to use a commercial software house to build the application in a data management system. This is capable of extremely rapid prototyping, and complex changes can be done very quickly. The cost has been comparable with Smith's system, and the application is fully supported.

One criticism of small systems is that they do not communicate with the bigger patient data networks which are being installed in hospitals. This should not be an excuse for delaying small scale projects, which can be in place very quickly. If the networks are not flexible enough to communicate with almost any other system, they will probably fail in any case.

I would therefore agree with Smith's conclusions. Systems can be comprehensive and easy to use and provide good data if the users, who may have no computer knowledge at all, have been allowed to say what they want and given the opportunity to change their minds as requirements alter. Very little needs to be provided by management in the way of funding to enable small scale development to take place. Enthusiasm results as people get what they need, not what they are given.

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Lottery of appointing junior staff

EDITOR,—John Bennett is right to point out the unsatisfactory nature of our selection and appointment system in postgraduate training.¹ There are, of course, good examples as well as bad, and had he been involved in appointing to a general practice vocational training scheme or to a registrar training scheme in radiology or psychiatry he may not have drawn the conclusion that "it all seems a terrible indictment of our educational system."

To extend and develop good practice we need to persuade our colleagues that it is too important a process to squeeze between a late running outpatient clinic and a 5 pm appointment, and that using agreed selection criteria and structured interviewing are, if anything, less time consuming than making it up as one goes along.

His suggestion of a centralised selection and training authority may be utopian but we can accelerate the process whereby at regional level and specialty by specialty we use coordinated procedures. To facilitate this we need a willingness of more consultants to accept that they may not always be directly involved in interviewing their own trainees. We also require a system of training contracts that are for fixed terms and do not lead to a panic to replace departing doctors immediately to meet service needs.

We have only chaos to lose and a great deal to gain; for example, more security for doctors in training and almost certainly, as Bennett suggests, a saving of resources.

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Royal Medical Benevolent Fund

EDITOR,—Those who, often through no fault of their own, are obliged to live in straitened circumstances often dread the prospect of Christmas. There will be demands on their already slender purses for cards, presents, and a special meal to celebrate the most important family festival of the year.

The Royal Medical Benevolent Fund helps almost 700 medical practitioners and their families who have fallen on hard times, and help is provided in several ways. Each case is carefully and confidentially considered by the case committee, which meets every month. In addition, each beneficiary over 65 receives a birthday card.

But with the approach of Christmas something more must be provided. The Christmas appeal exists to make available the things that make the festive season memorable for those needing help and above all for their children, such as small gifts, cards, and a special Christmas dinner.

We know from the many letters of thanks we receive how much this extra help is appreciated. I hope, therefore, that even in this time of recession this appeal will be supported as generously as in the past. I regard the president's Christmas appeal as probably the most important contribution I can make to give a little extra for those in need at such a special time of the year. I have been greatly heartened by the response in the past years, and I hope it may be maintained.

Contributions marked "Christmas Appeal" may be sent to the secretary, Royal Medical Benevolent Fund, 24 King's Road, Wimbledon, London SW19 8QN, or to the treasurer or medical representative of your local guild of the RMBF.

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