

significant difference in the occurrence of reactions based on the age of the patient, with an incidence of 2% in patients above the age of 30 as opposed to 27% in younger patients.<sup>9</sup> Diphenhydramine immediately controlled all reactions.

Accumulating evidence from many centres has indicated that metoclopramide in high intravenous doses (1-2 mg/kg every two hours in a 15 minute infusion for three to five doses) is currently the most effective single agent for the control of emesis induced by cisplatin. Acute dystonic reactions with this dose and schedule are uncommon in patients over the age of 30. The incidence of acute dystonic reactions when metoclopramide is given by other routes and schedules is not known. Prophylactic parenteral diphenhydramine (50 mg) should be considered in patients with a history of dystonic reactions and in patients under the age of 30 since it is safe, effective once dystonic reactions occur, and may itself be an antiemetic.<sup>10</sup> Encouraging results with other agents, such as corticosteroids<sup>6</sup> and butyrophenones,<sup>7</sup> in formal studies now reported, may form the basis for improved control of nausea and vomiting combining antiemetic drugs.<sup>11</sup>

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### Postoperative analgesia for circumcision

SIR,—Dr J White and others have reported the effectiveness of bupivacaine penile block in providing analgesia during the first 12 hours after operation in children undergoing circumcision (18 June, p 1934). In adults a major problem is the occurrence of erections after operation, which can put tension on the suture line and cause considerable pain.

Numerous methods of preventing erections

after circumcision have been described such as topical anaesthetic gel<sup>1</sup> or systemic stilboestrol,<sup>2</sup> phenobarbitone,<sup>3</sup> or chlorpromazine.<sup>4</sup> A dorsal nerve penile block will also suppress erections by blocking the sensory afferent pathway of the reflex erection mechanism and has been used successfully in treating malignant priapism when no mechanical obstruction was present.<sup>5</sup>

Our experience with penile blocks in adults undergoing circumcision leads us to recommend that this procedure be performed routinely, using the method described by Bacon,<sup>6</sup> in order to suppress painful erections after operation. Painful erections on subsequent days may then be suppressed either by repeating the penile block or by using one of the other recommended methods.

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### Cuts in the National Health Service

SIR,—With increasing evidence that the Conservative government intends to make the National Health Service more "cost effective" I am continually astonished to read of comments made by leading members of the BMA and Royal College of General Practitioners asking for more money. The BMA Council chairman, Mr Tony Grabham, made such an utterance again at the annual representative meeting in Dundee.

The call for more money may be justified, but apparently on the evidence available the government, and I, are not impressed. I should like to know why more money is required. The main reason seems to be over supply of medical manpower, and this problem can be laid directly at the feet of the doctors themselves. Another oft quoted reason is the apparent underpayment of doctors—Mr Grabham is quoted as saying that "doctors were a source of cheap, but highly skilled labour for the NHS"—but everything in this world is relative and in Britain doctors are relatively highly paid. In most of these utterances there is little reference to patient welfare and to the service best suited to the needs of the community—they are almost wholly concerned with doctors' remuneration.

The aim of doctors and of the government is to find the most efficient, comprehensive, caring NHS suited to patient welfare, and which must be patient, not doctor, orientated. The present doctor orientated NHS is not cost effective and comprehensive; this is most obvious in primary health care, which is undergoing profound changes that the Royal College of General Practitioners and BMA are either unwilling to recognise or purposely ignoring. In primary health care we need a patient orientated system in which suitably trained paramedical personnel would provide the point of first contact and in which the general practitioner would act in his capacity

as a specialist generalist and provide a back up service.

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### GP anaesthetists

SIR,—I should like to comment on Dr C B Everett's and Dr A J Watson's reply (9 July, p 134) to my letter.

In the dictionary sense of the word, their original letter (11 June, p 1901) did indeed "suggest" that the formality of regrading their posts was held up only by the intransigence of some local consultants.

Their second paragraph refers to "agreed criteria" for the hospital practitioner grade. If they reread HC(79)16 they will not find any reference to "agreed criteria" but only to "general guidance" on the criteria for appointment. The circular sensibly acknowledges that the qualifications and experience needed over and above the specified basic requirement have to be decided for each post.

In their fourth paragraph they attribute to me antipathy towards colleagues seeking to implement an agreement which will benefit them. This assertion does me an injustice. I have, on the contrary, successfully assisted three of my general practitioner colleagues in getting regraded as hospital practitioners.

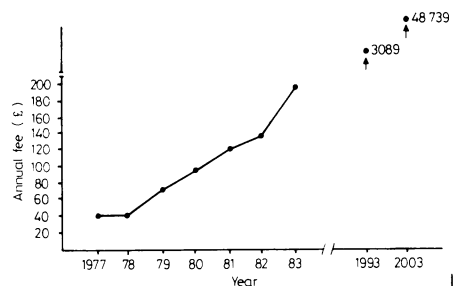
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\* \* \* This correspondence is now closed.—ED,  
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### Medical Defence Union fees

SIR,—For those pondering the recent increase in Medical Defence Union fees, the figure shows the predicted costs 10 and 20 years from now. The data for 1977 to 1983 were correlated by least squares fit to linear and exponential



Predicted costs of Medical Defence Union fees based on annual fees from 1977 to 1983.

expressions ( $y = a + bx$ ;  $y = ae^{bx}$ ). Correlation coefficients for both models were 0.94 and 0.97 respectively. Thus, assuming the exponential equation gives the better fit, it is predicted that in 1993 the annual fee will be £3089 and in 2003 it will reach £48739. Clearly an alternative to professional insurance will be needed long before 1993; perhaps the sooner this change occurs the better?

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