

pages 86–7), as they appear to have arisen from a number of misunderstandings. His criticism that we had not concerned ourselves with antibiotic therapy which is relevant to our region is presumably due to an obsolete idea regarding the type of bacterial infectious disease currently prevailing in the Far East.

Thus, in the 1990s leprosy is almost as unknown in Hong Kong and its vicinity as it is in the UK. As to the suggestion that we neglected to cover the treatment of tuberculosis, we are truly perplexed. Perhaps the reviewer might care to specify what further information should have been given and/or what additional angles could have been included in our 15 page chapter on tuberculosis.

The vexed question of variations in antibiotic susceptibility, whether between different regions or different hospitals has also been addressed and we endorse the principle that local circumstances should be the basis for devising empirical and non-empirical treatment regimes. The fact is, that with minor exceptions, indications for antibiotics and the types of agents needed in our region are remarkably similar to those in Western nations. Thus, whilst the explicit recommendations we have espoused are certainly consistent with local experience, we contend that their more general applicability is no less valid than guidelines from elsewhere.

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Risks of sedation in endoscopy

Sir—The use of pulse oximetry during any period of sedation, such as that studied by Dr Solomon *et al* (January 1993, pages 16–18), is to be recommended. Arterial oxygen desaturation caused by benzodiazepine induced hypoventilation can be reversed by giving oxygen through a nasal cannula. Unfortunately, the elevated arterial saturation displayed by the pulse oximeter makes it easier to forget the hypercapnoea also associated with hypoventilation. This may increase the incidence of ectopic beats, even without hypoxia, by a direct sympathomimetic effect.

The routine use of pulse oximetry and oxygen supplementation should not lead the endoscopist to use more sedation and give less verbal reassurance.

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Sir—We were surprised to read the conclusions of the paper by Solomons and colleagues (January 1993, pages 16–8), suggesting that cardiac monitoring should be routine practice during diagnostic upper endoscopy. Their study of the frequency of oxygen desaturation and arrhythmias during upper endoscopy

in 114 subjects aged 65 and over, randomised to oxygen (2 l/min via nasal cannulae) or room air alone, did not detect any severe arrhythmias or oxygen desaturation > 7%, although oxygen saturation was slightly lower in the room air group. Consequently, any benefit of cardiac monitoring is not shown by their results and, given an estimated mortality from cardiopulmonary complications of between 0.5 and 3 per 10,000 endoscopies [1], would require a large, multicentre study to answer. Their other suggestion, that continuous oxygen saturation monitoring should be performed in the elderly patient undergoing endoscopy, is already well-recognised and should now be standard practice [2,3].

While there is a general assumption that most patients prefer sedation for upper endoscopy, it is not without risk and adds to inconvenience for both patients and staff. We (unpublished results) and others [4] have found that, when given an informed choice, many patients prefer the brief extra discomfort of throat spray alone to the inconvenience of sedation. Therefore, in addition to supplemental oxygen and pulse oximetry monitoring, the use of throat spray alone in the elderly high-risk patient may lower the risk of hypoxaemia and cardiopulmonary complications even further.

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Treating hyperthyroidism with radioactive iodine

Sir—The recent report by Hedley *et al* (October 1992, pages 348–351) illustrates the wide variation in practice of those treating hyperthyroidism with radioactive iodine but does not consider the training of those administering iodine. Taken up by the thyroid gland, radioiodine emits both beta rays which have a path length of a few millimetres and irradiate tissues locally, and gamma rays which irradiate those with whom the patient is in close contact. After treatment patients are in essence mobile radioactive sources, with the potential capacity to irradiate and contaminate hospital staff and facilities. Urine concentrations are considerable, and ¹³¹I also is excreted in saliva and sweat. This has implications for radiation protection for hospital staff,