acts of sexual abuse, of which genital mutilation is a gross example. In addition, they state that "genital mutilation does not follow from other forms of child abuse in that it is done with the best intentions for the future welfare of the child." This represents another collusion with the abusive system: there is no benefit to the child. The only people to benefit are the oppressors who wield their power within that particular culture. The authors seem to dismiss the importance of resulting psychological trauma. In my research on post-traumatic stress disorder in women who had undergone obstetric or gynaecological procedures I found that women could be severely traumatised psychologically by painful, mutilating vaginal procedures that were carried out without clear consent in an unsterile environment. Obstetric and gynaecological procedures are an accepted form of medical practice in Britain that women are taught to expect, yet women may still develop post-traumatic stress disorder as a result of their culturally accepted experiences.

Black and Debellas case report refers to "male circumcision" as if it is benign. It is also medically unjustifiable genital mutilation, which is sanctioned by a culture purporting to be civilised.

As well as the three letters here we received five others. Two argue with Janett Menages male circumcision is also genital mutilation of a child without consent; another agrees with Elspeth Webb's anthropological analysis; a fourth contained an account of a 10 year old girl who bled to death after being circumcised in Egypt, where, according to the correspondent, 85% of all women are circumcised; and the fifth was a request for information, which has been passed to the Royal College of Obstetric and Gynaecology. - EDITOR

Dangers of cocaine and adrenaline paste

Exceeding the recommended dose may have serious sequelae

EDITOR.—K E A Nicholson and J E G Rogers report serious complications associated with the use of topical cocaine with adrenaline, but they draw inappropriate conclusions about the evidence they present and fail adequately to emphasise that the recommended doses and concentrations were exceeded. It is perhaps not surprising that serious sequelae may occur under these circumstances.

We are surprised that Nicholson and Rogers fail to conclude from their three cases that it was the combination of cocaine and adrenaline that is responsible for the complications they observed; this is an unreasonable assumption. The randomised trial they quote showed that the addition of 1/1000 adrenaline to a 10% solution of cocaine was generally associated with significantly lower plasma cocaine concentrations than were seen with cocaine alone and that the combination of the two drugs was not associated with a change in cardiovascular variables.

The fact that this combination of the two drugs is potentially hazardous is an important message. The current recommendations in the British National Formulary are accepted by the British Association of Otorhinolaryngologists—Head and Neck Surgeons. There seems to be little evidence that these recommendations are inappropriate.

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Combination is still widely used

EDITOR.—The use of cocaine and adrenaline paste is a controversial issue among otorhinolaryngologists. In 1991 the British Association of Otorhinolaryngologists—Head and Neck Surgeons surveyed all consultant surgeons who were members and found that 63-5% used cocaine without adrenaline, 19% used adrenaline with and without cocaine. Of the 312 who used cocaine, 76 had changed their method of using it since 1986, generally because of concern about safety. Six deaths were recorded in the report. The British National Formulary states that "cocaine is still used in otorhinolaryngology and is applied to the nasal mucosa in concentrations of 4% to 10% (40-100 mg/ml). The maximum total dose recommended for application to the nasal mucosa in fit adults is a total of 1-5 mg/kg, which is equivalent to a total topical dose of approximately 100 mg for an adult male. It should be used only by those skilled in the precautions needed to minimise absorption and the consequent risk of arrhythmias. Although cocaine interacts with other drugs liable to induce arrhythmias, including adrenaline, some otorhinolaryngologists consider that combined use of topical cocaine with topical adrenaline (in the form of a paste or a solution) improves the operative field and may possibly reduce absorption."

My practice is to use cocaine paste, which is given in the anaesthetic room, and then to inject the nasal mucosa with 1/80000 adrenaline in the operating room at the beginning of surgery. There have been no documented problems with this method of sequential administration.

I agree with K E A Nicholson and J E G Rogers that nasal surgery is rarely life saving, and that a heightened awareness of the possible complications and interactions of the drugs being given is to be encouraged.

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Other aspects of anaesthetic technique may have added to danger

EDITOR.—We take issue with K E A Nicholson and J E G Rogers' conclusions regarding use of the combination of cocaine paste with adrenaline for preparing the nose before nasal surgery. We agree that the recommended doses should not be exceeded, but the case for removing adrenaline from the mixture has not been made.

In cases 1 and 2 both children were given premedication of oral atropine, and the endogenous catecholamine concentration would therefore have been high because of anxiety. Anaesthesia was light, and cocaine, which predisposes to arrhythmias when used in combination with adrenaline, was used in both cases.

The papaverine...