clinically stimulating jobs in the UK. A conversation with Mr Chris Dark, Medical Representative of BUPA (one such private hospital group), revealed his initiation of the enforcement of the Acute Cardiac Life Support and Paediatric Life Support courses for their particular resident medical officers due to a previous disastrous event in one of their hospitals/nursing homes. A very sound reason.

Thousands of South African doctors are being put through courses under false pretenses in order to place them in the lowest-paid medical position in the UK (around £7/hour compared with the norm of £25 - 32 per hour) and to confine them to a contract for 3 - 12 months. Doctors are also generally only allowed to work 2 weeks per month and must live off their earnings to subsidise their accommodation during their 'off weeks'. I speak from personal experience as well as on the basis of countless complaints from doctors caught up in this system in the UK.

Readers should feel free to contact me, should they wish to discuss the above.

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Intravenous infusion — the case for keeping vitamin C in the emergency drug cupboard

To the Editor: In a letter to the *Journal* towards the end of 2001, Dr C E Beyers reported on the rapid response of a patient with amphetamine overdose to an intravenous infusion of vitamin C.[1] This serves as a reminder of the value of a safe, non-toxic acidifying and/or reducing agent for intravenous use in emergency situations. Ascorbic acid is ideal as such an agent and its clinical use outside of treating scurvy (and as a questionable prophylactic for the common cold) is worth re-stating.

My own experience with vitamin C as a life-saving agent began as a fairly new medical registrar at Addington Hospital. I was called in the early hours of the morning to see a young fireman who had been rushed into casualty with respiratory difficulty. The history given was that he had collapsed while extinguishing a fire in the hold of a ship in the harbour. No one could tell us what cargo had been in the hold.

A striking feature, apart from the grave condition of the patient, was a rather odd brownish-grey hue to his skin and mucous membranes in addition to cyanosis. Blood taken from the patient was a chocolate brown colour, suggesting the diagnosis — rapidly confirmed by the laboratory — of methaemoglobinaemia.

The problem, of course, was how to treat this. The *Merck Manual* gave a list of causes as long as an arm but no suggested treatment. *Harrison's Principles of Internal Medicine* recommended emergency treatment with intravenous methylene blue. Ascorbic acid was mentioned as oral treatment in non-emergencies.

With methylene blue not readily available, and a reluctance to dabble in the unfamiliar in a crisis, it was decided to set up an IV infusion of vitamin C.

As with Dr Beyers' case (although the disease process being treated was different) the response to vitamin C was dramatic. By mid-morning we were having great difficulty convincing the patient to stay in the ward a little longer just for observation!

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1 Beyers CE. Rapid recovery from Ecstasy intoxication. *S Afr Med J* 2001; 91: 708-709.

Bone densitometry — role of quantitative CT

To the Editor, Solomon and Jacobs[1] feel that the Clinical Guideline published by the Osteoporosis Working Group in September 2000[2] understates the value of quantitative computed tomography (QCT) and make a plea that 'its complementary role should be acknowledged'. They proceed to compare QCT with dual energy X-ray absorptiometry (DEXA) and conclude that QCT 'has been shown to outperform planar imaging approaches, such as DEXA, in discriminating subjects with and without vertebral fractures'. They finally recommend that 'most modern radiology practices should have the facility on their scanners'.

As the principal author of said clinical guidelines, now over 2 years old, I do acknowledge that some updating is required. However, DEXA still remains the internationally accepted gold standard to measure bone mineral density (BMD), diagnose osteoporosis and monitor response to therapy — a view shared not only by our local Foundation, but also by the European Osteoporosis Foundation,[3] the American National Osteoporosis Foundation[4] and The Royal College of Physicians. Statements that QCT is 'the most sophisticated method of evaluating BD' and therefore fracture risk is simply not substantiated. The most feared complication of osteoporosis is a hip fracture — the best way to assess risk of sustaining a hip fracture, is to measure hip BMD.[5] QCT cannot measure hip BMD! The question of normative data poses another problem for the care