UK, for it underlines many of the educational objectives of modern vocational training courses for general practice and may help trainees, particularly as it comes from a consultant physician, to value their role as generalists.

After years of increasing fragmentation the essential unity of medicine is emerging again.

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Anaphylaxis and the community nurse

ANAPHYLACTIC shock may develop within minutes of the parenteral injection of drugs or foreign protein. The patient may develop severe dyspnoea, acute urticaria, and a marked fall in blood pressure, producing severe and sometimes fatal shock. Fortunately it is rare although the exact incidence is difficult to determine. In a recent edition of the *Adverse Drug Reaction Bulletin* (1977) it is stated that 140 cases of anaphylaxis, with 41 fatalities, were reported to the Committee on Safety of Medicines between 1966 and 1975. It is likely that an unknown but probably fairly large number of adverse reactions are not reported to the Committee.

Nevertheless, many general practitioners and nurses will never encounter the condition during their professional career. However, because of its dramatic nature, its high mortality rate, and the possibility of its prevention, anaphylaxis is a condition with which all those who administer drugs should be completely familiar.

The same paper reports the results of a survey into the use of drugs by community nurses in the treatment of anaphylaxis and includes the instructions given to the nurses on its diagnosis and management. This survey has revealed that practice varies considerably throughout the country and in almost a third of the health districts from which information was obtained nurses are not permitted to administer drugs for the treatment of anaphylactic shock on their own initiative. Even in those districts where nurses are allowed to carry drugs for treating anaphylactic shock, a quarter of them receive no special instruction in the diagnosis or management. The Department of Health and Social Security have recently issued a circular on the involvement of nursing staff in vaccination and immunization procedures (DHSS, 1976). A further circular discusses the legal implications and training requirements for extending the clinical role of nurses (DHSS, 1977). Both circulars emphasize that nurses should undertake only work for which they have been adequately trained and that doctors should not delegate work for which nurses have no special qualification.

Health authorities and general practitioners who employ their own nursing staff should ensure that those nurses who work in the community and administer injections are adequately instructed in the diagnosis and management of anaphylaxis. These instructions should include the necessity of questioning a patient about sensitivity to drugs before administering an injection, and should give information about the groups of drugs most likely to cause anaphylaxis. In domiciliary practice these are the penicillins and cephalosporins, streptomycin, vaccines, toxoids and antisera, corticotrophin, and tetracosactrin (*Adverse Drug Reaction Bulletin,* 1977).

Doctors and nurses should remember periodically (perhaps annually) to renew the ampoules of adrenaline which must always be available when injections are being given. It is also essential that supplies of adrenaline are clearly dated.

The suggestion has been made that the range of injections given in a patient's home should be reduced (*Adverse Drug Reaction Bulletin,* 1977) but this could well give rise to difficulties. It seems better to ensure that all doctors and nurses are fully conversant with the prevention, diagnosis, and management of anaphylactic shock. Once adequate instruction has been received, the community nurse should be allowed to give immediate treatment to the rare case of anaphylaxis which she may encounter in the course of her work.

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