antibiotics[6] surely it should be the aim of clinical investigators to determine the smallest amount of antibiotic that is effective therapeutically. It has been stated[6] that if the lowest effective dose of an antibiotic is used the infecting organism is unlikely to become resistant. Since the development of resistance to all the antibiotics is a subject of major clinical importance, and the excessive use of antibiotics appears to predispose to this development, it cannot be too strongly emphasized that practitioners should not use at the present time a dosage in excess of that recommended in the *British Pharmacopoeia* (1953). The publication of papers on ill effects produced by excessive dosage of antibiotics will have one good result if it focuses attention on the importance of correct dosage.

Your annotator also comments that if tetracycline produced fewer side-effects than either aureomycin or terramycin, the importance of this advantage should not be minimized. That terramycin produces fewer side-effects has been shown in at least six published papers in the last few months. In this country Abbott and Parry,[7] using a dosage of 1–2 g. daily of tetracycline, found no side-effects from its use. In a study of tetracycline Wilson[8] stated that "side-effects were uncommon and unimportant." In a comparison of 180 patients treated with the tetracyclines Weaver and McCorry[9] have noted that the incidence of side-effects with tetracycline was half that encountered with the use of oxytetracycline. The paper of Finland has already been referred to in which he noted that side-effects from tetracycline were minimal. The evidence available shows that tetracycline has certain unmistakable advantages over oxytetracycline and chlortetracycline which cannot be arbitrarily dismissed with the statement that the tetracyclines have the same toxicity.—I am, etc.,

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Temporal Lobe Epilepsy and the Psychoses

SIR,—I was interested in the valuable paper on "Psychical Phenomena in Temporal Lobe Epilepsy and the Psychoses" by Drs. Shafica Karagulla and E. Elizabeth Robertson (*Journal*, March 26, p. 748), but I wonder how justified are their comparisons between the two diseases. Surely the analogous symptoms are produced by the fact that they are both the result of a disorganization of the same machine, but this does not imply that the nature of the disorganization is similar. To take a simplified example, a "knock" in an internal combustion engine can be produced by poor fuel, a wrongly timed ignition, or a worn big end. Yet no one suggests that the causation is similar.

Again, what of those psychoses which are produced rapidly in a few hours by great strain? Or in a case which I saw many years ago in which the psychosis disappeared almost instantly? This was that of a woman about 40 years of age who was suffering from a paranoid psychosis and a coincidental mitral stenosis. She was grossly hallucinated and deluded, and spent most of her time parading the ward shouting at those who seemed to be persecuting her. Suddenly in the midst of her shouting she developed an embolus in her left middle cerebral artery. She did not lose consciousness, but at once had a right-sided hemiparesis and complete aphasia. After many weeks her paralysis recovered and her speech came back. She was then able to tell me that the "voices" had ceased at once, at the very moment her limbs became paralysed and she lost her power to talk. Obviously, with the abolition of her power to express herself in words the internal ideational constructive power was abolished. This was the source of the hallucinations, and the "voices" ceased magically. Such an experience does much to uphold J. B. Watson's[1] view that thought is only suppressed speech. It suggests also that schizophrenia is a purely functional illness and that it is not caused by foci of deterioration such as one finds in epilepsy.—I am, etc.,

London, W.1. CLIFFORD ALLEN.

REFERENCE

1 Watson, J. B., *Psychology from the Standpoint of a Behaviourist*, 1929. Lippincott, Philadelphia.

Speaking Up

SIR,—The correspondence on poor standards of speech at medical meetings (*Journal*, April 2, p. 853) gives me the opportunity to comment without, I hope, appearing impertinent to my seniors. I submit that the pathetic and irritating mumbling usually inflicted on the audience at learned medical societies is due to the following factors: (1) nervousness, and the traditional Englishman's reluctance to make himself conspicuous; (2) the fear that emphatic oratory will be ridiculed as conceit or charlatanism; and (3) laziness; many eminent doctors do not seem to realize the importance of clear and emphatic public speaking, and would consider it beneath them to learn how to prepare and deliver an address.

Frequently the speaker resorts to reading (or mumbling) verbatim from a script. But why "read papers"? Matter designed to be assimilated by the eye is seldom ideally composed for absorption by the ear, even if clearly read. Medical papers should be printed in the appropriate journal or "proceedings" shortly before the meeting. The writer could then deliver (not read) a short summary, and the matter could then be discussed (surely the real value of such gatherings) before most of the audience had left to catch trains or sunk into coma.—I am, etc.,

London, W.1. NORMAN A. PUNT.

Night Cramps

SIR,—May I point out that your annotation on night cramps (*Journal*, March 12, p. 653) omitted to mention the value of nicotinic acid or nicotinamide in preventing such cramps? Nicotinic acid was recommended some years ago in answers to "Any Questions?"[1] and I have found it to be efficacious.—I am, etc.,

Chalfont St. Giles. H. H. KING.

REFERENCE

1 *Any Questions?* 1952, second series, p. 17. B.M.A., London.

Hysterical Hyperventilation with Carpopedal Spasm

SIR,—A girl of 8 years was seen recently who had developed a morbid fear of appendicitis. One of her schoolfriends had recently had her appendix removed, and, from personal knowledge of this latter child, I am sure that no morbid details were spared in conversation. The former child was the third in a family of four girls, and, unlike the others, seemed to be withdrawn and perhaps a little emotionally unstable.

The first episode occurred one evening when she cried out with sudden severe abdominal pain. The pain continued for half an hour and was alleged to be in the umbilical region. A full clinical examination failed to provide a diagnosis, and, as the pulse rate and temperature were normal and the pain had mysteriously passed away, the child was reassured and was soon playing quietly. A visit several hours later revealed no further developments. The second episode occurred 24 hours later. This time there were pains in the abdomen, a choking sensation, and painful, paralysed arms and legs, with tingling. The child was sobbing uncontrollably and was hyperventilating for about 20 minutes. The hands were typical "*les mains d'accoucheur*." The child was reassured and a minute or so of breath-