rate is high, being in the region of 70% to 90%,[1] and it is therefore encouraging to know that three out of the four cases mentioned by Dr. Tasker recovered, in spite of their age (when leucopoiesis in any case is not at its best). Antibiotics were given to them all as prophylactic treatment; the three that recovered also received either cortisone, blood transfusion, or a combination of blood transfusion and folic acid (other lines of treatment suggested in the textbooks are: "pentnucleotide," leucocytic cream, and pyridoxine). As Dr. Tasker only mentions antibiotic treatment in his case, and as Dr. J. Lomas (*Journal*, August 7, 1954, p. 358) treated his patient purely on penicillin for ten days before resorting to cortisone, I wonder if there is any contra-indication to carrying out these "curative" methods, such as blood transfusion, immediately agranulocytosis is diagnosed?

It is wise to heed Dr. Tasker's warning that evidence of sensitivity to chlorpromazine, such as fever, jaundice, and skin eruptions during the early weeks of treatment, should be treated with respect, and should call for regular blood counts, especially in the light of the fatal case of jaundice reported by Dr. R. H. Boardman (*Journal*, September 4, 1954, p. 579), be this toxic or obstructive (see the letter by Drs. J. G. Macarthur and B. Isaacs, *Journal*, September 25, 1954, p. 754). In your leading article on September 4 (p. 581) you advise that if big doses are to be used a liver function test should be performed beforehand and the urine tested for bile while treatment goes on. Pallor of faeces must also be a warning sign. In a further leading article on chlorpromazine (*Journal*, February 5, p. 338) you conclude that as the effects of this drug are prolonged and for the most part irreversible, together with evidence of toxic action on the liver, great caution must be exercised in its use. In Dr. Tasker's article we have yet another reason for caution.

I doubt the advisability of using it for treating children suffering from intractable vomiting following whooping-cough (Dr. Howard Reeve, *Journal*, April 23, p. 1034), especially when ketosis and dehydration were probably accompanied by some impairment of liver function. With so many new drugs of considerable potency and toxicity available, it will be wise, especially for the general practitioner, to exercise great care and discrimination in using them, and, until we have better knowledge of their more remote effects, to confine their use to a carefully selected series in which constant supervision is possible.—I am, etc.,

Penygroes, N. Wales. JOHN H. OWEN.

REFERENCE

1 Wilkinson, J., in *British Encyclopaedia of Medical Practice*, vol. 1, p. 261. London.

SIR,—I was interested to read the account of chlorpromazine jaundice by Dr. A. G. W. Whitfield (*Journal*, March 26, p. 784). I have recently had a similar case.

A housewife aged 74 was admitted to hospital on February 16, 1954, with mental confusion and loss of memory. In October, 1954, she became restless and agitated. Chlorpromazine (200 mg. daily) was started on November 25, the dosage being increased to 300 mg. daily on December 2. Since admission she had vomited small quantities of food from time to time, but on December 6 copious vomiting began and the chlorpromazine was discontinued. On December 9 jaundice was first noticed. The jaundice steadily increased. It was accompanied by pale stools and bile in the urine. Her general condition deteriorated progressively and she died on January 25, 1955.

In brief, the post-mortem findings were as follows: external examination: thin, deeply jaundiced, with slight oedema of the ankles; respiratory system: lungs congested with oedematous lower lobes; cardiovascular system: normal, apart from a flabby myocardium and some old thickening of the mitral valve; abdomen: liver atrophic (880 g.) and firm, surface bile-stained with a fine nutmeg surface; gall-bladder shrunken; biliary tracts all free of obstruction; other viscera not significantly abnormal; central nervous system: C.S.F. jaundiced, brain rather atrophic with area of softening 2 cm. in diameter in the right temporal lobe.

Histologically, the liver showed severe centrilobular degeneration of the parenchymal cells with well-marked fatty change and deposition of bile. The appearance suggested a toxic change superimposed on mild chronic congestion. In sections of the myocardium there was some hypertrophy of the muscle fibres and a little interstitial fibrosis.

In common with other cases reported the clinical picture was one of obstructive jaundice, and the pattern of the liver function tests carried out supported this conclusion. The post-mortem findings suggested that the liver had already suffered mild damage as a result of anoxaemia due to heart failure. In life heart failure had not been apparent clinically, but her extremely restless condition made proper examination difficult. The total dosage of chlorpromazine (2.6 g.) was small, but the initial dosage (200 mg. daily) probably rather high. This is the first case of jaundice in over 100 cases treated with chlorpromazine by the present writer. Although a valuable drug in the treatment of certain psychiatric disorders, it should not be used unless definitely indicated and is probably dangerous in the presence of any liver damage already present.

I would like to thank Dr. J. O. P. Edgcumbe for the pathological reports.—I am, etc.,

Exeter. B. V. EARLE.

Cyst Formation Following Hernia Repair

SIR,—I was interested in the article by Mr. A. G. Rutter (*Journal*, April 16, p. 951) on the formation of a cyst following dermal implant repair of a hernia. Actually, in our experience at the Birmingham General Hospital this is more common than his article would suggest. We have now seen half a dozen of these, one of them five inches in length. Another contained large amounts of golden hair. Another complication we have observed is complete disappearance of the grafts. We have now completely abandoned the operation owing to these complications, and also to the fact that sepsis is not an infrequent occurrence. All these complications are, of course, not surprising in view of the completely unphysiological nature of the operation.—I am, etc.,

Birmingham, 4. G. T. WATTS.

Chicken-pox Quarantine

SIR,—Dr. Neil McDougall's letter (*Journal*, April 23, p. 1030) is interesting. In 1922 a patient aged 55 paid several visits to his brother, who had herpes zoster in a severe form. My patient developed herpes. His daughter, living with her parents and near full term in her third pregnancy, developed chicken-pox. Three days after the appearance of the rash she gave birth to a healthy boy, who developed the rash of chicken-pox at the age of 14 days. Mother and son did very well.

In the case of a mother suffering from small-pox at her confinement, the infant usually has the disease at the same stage as the mother.—I am, etc.,

London, S.W.12. S. G. ASKEY.

SIR,—I was surprised to read the suggestion in Dr. G. E. Breen's letter (*Journal*, April 23, p. 1030) that an attack of chicken-pox might be beneficial in protecting the patient from a subsequent attack of herpes ophthalmicus with concomitant iritis. Surely this view is contrary to observed fact. Thus, McNair Scott,[1] in a full discussion of the association of chicken-pox with herpes zoster, states that "it is very common for a person with herpes zoster to have a previous history of chicken-pox; about 70% of cases were found to have such a history in a recent survey of epidemic diseases in schools." In fact the author suggests the hypothesis that herpes zoster is a response of an immune person to an overwhelming dose of varicella-zoster virus. Likewise, Ker[2] states that "it is undoubtedly the fact that many adult patients suffering from herpes zoster are able to give a definite history of chicken-pox in childhood." It would seem more germane to the argument concerning the quarantine of chicken-pox to point out that exposure to chicken-pox can in an adult result in herpes ophthalmicus with risk of damage to the eye.

I would support Dr. Breen's statement that severe complications of chicken-pox do, exceptionally, occur. Besides