It would appear that four bodies are concerned, the driver, the public, the insurance companies, and the doctors. The first three might be taken together, for I understand that the insurance companies are no more concerned with the elderly driver as an insurance risk than with anyone else; in fact if the amount of premium required is a criterion he is considered to be less of a risk than the young driver. Again I would ask who has put up the quarry?

As far as the doctors are agreed (and it is about the only matter on which they are agreed) the blind should not be permitted to drive; the State debars epileptics, but here the doctors are at variance.

Who is to be considered unfit to drive: the patient with too high or too low a blood pressure, the hyperglycaemic or the hypoglycaemic, the psychopath, the ill-tempered, the inattentive, or the adventurous? There is little difficulty in understanding why the doctors have not come to any conclusion.

I would suggest that unfitness to drive lies not so much in senility or physical deformity as in the realm of Freud, Jung, and Adler.—I am, etc.,

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## Atrial Function

SIR,—Dr. W. J. Gillespie and others (14 January, p. 75) conclude that "atrial systole has a powerful augmentative effect on stroke output in the normal heart, while its effect is less valuable when the myocardium is diseased." This is of great interest in relation to the clinical examination of the heart in health and disease. In health the effects of the left atrial contraction are neither audible nor palpable. In such diseases as hypertension, chronic ischaemic heart disease, aortic stenosis, muscular obstruction to the outflow from the left ventricle, and acute cardiac infarction the force of the left atrial contraction amounts to an "explosion." The shock-wave commonly is visible and palpable, and the noise is recognized as the "presystolic," "atrial," or "fourth sound" gallop.

These clinical findings suggest that the atrial contraction is more powerful when the myocardium is diseased, and I should be most grateful if Dr. Gillespie and his colleagues would explain the paradox.—I am, etc.,

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## Obstetrics in Africa

SIR,—I would like to thank Mr. Graham Cole for a thoughtful contribution (28 January, p. 238) on the subject of obstetrics in Africa. I must, however, disagree with his assessment of the operation of symphysiotomy.

He states that in Africa he met mothers "fleeing the nearby hospitals where this was practised. They spoke of the pain immediately afterwards and of the unpleasant sensation on walking for some time afterwards."

In my experience in Nigeria postoperative pain is of little consequence and is certainly less than after caesarean section. Neither did I find complaints about the sensation on walking. Indeed, they could all walk normally without discomfort when discharged home, which was nearly always on the tenth day. Such "fleeing" as takes place is likely to be away from any hospital where the woman thinks she may get a caesarean section. Generally speaking it is unwise even to suggest the need for an elective section in the antenatal period, as this is likely to result in an attempt to deliver at home.

Mr. Cole quotes another doctor as saying that patients who have had a symphysiotomy refuse to return for a "repeat." A repeat symphysiotomy? Surely not, for the operation usually results in a permanent enlargement of the pelvis so that subsequent deliveries are normal. On the contrary, it is those women who have had a section for disproportion who are most likely to refuse to return and who are therefore in great danger in a subsequent labour. Other things being equal, the symphysiotomy patient is in much less danger if she refuses to return to hospital for her next delivery.

Mr. Cole also advocates the use of induction of labour as the best means of avoiding section for disproportion. He makes out a strong case, though there is much which could be said for a limitation of the procedure. However, it does not matter how many inductions are done, the practitioner in many parts of Africa will still be frequently confronted with the patient in obstructed labour with a live baby and in whom forceps or vacuum extraction has failed. In such a situation there is an obligation to consider symphysiotomy as a possible alternative to section.

There has now been ample evidence to show that symphysiotomy can be a useful procedure in the circumstances which pertain in many parts of Africa. My own somewhat meagre experience has been described elsewhere.[1] Dr. D. A. M. Gebbie has recently (17 December 1966, p. 1490) given his opinion based on experience in Uganda that "symphysiotomy has a definite place in obstetric practice in Africa."

Most impressive of all, however, is the experience of those working in the obstetric departments of the University of Natal. Referring to 1,389 cases Crichton and Clarke[2] state, "In short, our technique of symphysiotomy appears to be a safe operation with few sequelae, *providing that no contraindications exist and that the operation is carefully performed.*" I have added the italics because it is the neglect of his advice which is sometimes the cause of poor results and consequent unpopularity of the operation.—I am, etc.,

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REFERENCES

1 Cox, M. L., *J. Obstet. Gynaec. Brit. Cwlth*, 1966, **73**, 237.
2 Crichton, D., and Clarke, G. C. M., *S. Afr. J. Obstet. Gynaec.*, 1966, **4**, 76.

## Population Explosion

SIR,—The gas chambers for the sick, aged, disabled, and mentally handicapped which Dr. D. C. Clark (21 January, p. 174) cited as the logical outcome of planning about population explosion seems to me so far-fetched that I can only think he produced it as a red herring to draw attention away from the responsibility doctors should shoulder in combating the results, in developing countries, of the advances in medical science—for example, increasing numbers outstripping food supplies. No problem can be solved by ignoring it or by postulating gas chambers or moral degeneracy from birth control.

The old sex war appears to be raging just now in the field of legalized abortion, State aid for contraception and disputations about the contraceptive pill; all means seem to be fair in love and war.

Women want to control their fertility. Men appear to have an inherent dislike of women being able to do so. I think women will win in the end, but meanwhile millions of children are being born in developing countries with every prospect of starving to death before they reach maturity.

I find this prospect much more real and horrifying than Dr. Clark's gas chambers.—I am, etc.,

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## Imipramine and Benzhexol

SIR,—The acute toxic psychosis that may follow the administration of benzhexol hydrochloride (Artane) has recently been described and reviewed by Dr. D. A. Stephens.[1] Dr. I. Haider has described similar states following imipramine (Tofranil).[2] As they point out, the clinical pictures produced bear a close resemblance to belladonna poisoning as described in the standard texts.

As I have inadvertently precipitated similar states of excitement, confusion, and hallucinations in three elderly patients who were taking imipramine or desipramine (Pertofran) by prescribing benzhexol 2 mg. t.i.d. in addition, I feel that there may be particular dangers in the combined administration of tricyclic antidepressants with antiparkinsonian drugs.—I am, etc.,

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1 Stephens, D. A., *Brit. J. Psychiat.*, 1967, **113**, 213.
2 Haider, I., *Clin. Trials J.*, 1966, **3**, 479.

## Poisoning with Mandrax

SIR,—Overdosage with methaqualone has been reported to increase markedly the vascular permeability leading to effusions in serous cavities, frank haemorrhage into the skin, intestinal lumen, etc. A dose of 4–6 g. may cause circulatory collapse.[1] Twenty-eight cases of Mandrax poisoning have been reported in this country recently, but only one has shown evidence of bleeding tendency (Lawson and Brown, 10 December 1966, p. 1455). We report a case which presented with this feature of generalized haemorrhagic tendency, combined with prolonged unconsciousness and agitated hypertonic movements. This raised the question of possible haemorrhage into the cerebral cortex.

The patient, a girl aged 19, was admitted having taken 20 5-g. tablets of Mandrax about 12 hours prior to admission. She was deeply unconscious and her reflexes were sluggish, with bilateral extensor plantar responses. Pupils were equal and reactive. She had bizarre, agitated, epileptiform movements of both upper and lower limbs. The muscle tone was increased at this time. Owing to this, analeptic drugs were not given. Respiration was normal. Her colour was good, blood pressure 130/80 mm. Hg, and pulse was 110–120 per minute. Her temperature was 95° F., which spontaneously rose to normal in four hours. Closed urinary drainage was established, and with great difficulty (because of rest-