Human Tetanus Antitoxin

SIR,—I write in full support of your plea for universal active immunization with tetanus toxoid (16 December, p. 635). However, I cannot agree with your view that, until adequate supplies of human tetanus antitoxin are available for use in non-immune or doubtfully immune patients, "1,500 units of tetanus antitoxin (preceded in the usual way by a small trial dose) should be given" when wounds have not been seen until six hours or more after injury, in addition to a thorough surgical toilet. Many workers[1 2] have now discontinued using prophylactic equine-derived tetanus antitoxin in all tetanus-prone patients, including those who have never been given tetanus toxoid, and recommend that the management of such patients should comprise adequate excision of wounds, antibiotics for five to seven days, and active immunization with adsorbed tetanus toxoid. It has further been stated that thorough wound toilet makes the use of either tetanus antitoxin made with horse-serum or prophylactic antibiotics unnecessary.[3]

Your leading article has rightly laid particular emphasis on the fact that in addition to failing sometimes to prevent tetanus both equine-derived antitoxin and antibiotics may cause hypersensitivity reactions. However, in support of this statement you only cite the finding of Mrs. C. A. Cox and her colleagues[2] that in Britain about 12% of patients develop a significant reaction to antitoxin, whereas in the United States, where over two million doses of antitoxin were being given each year, it has been estimated that from 15% to 30% of persons develop hypersensitivity reactions,[4] and Mr. H. K. Bourns[3] states that there is some reaction in at least 35% of cases. Further, you make no mention of the danger of serum shock, which is occasionally fatal, after a prophylactic injection of equine-derived tetanus antitoxin, or of the serious neurological complications which occur. An extensive review of the published reports by Bardenwerper[4] has revealed 130 cases of serum neuritis, with permanent neurological sequelae present in 20% of cases, and death may occur as a result of encephalomyelitis and respiratory paralysis.

In support of a previous plea you made for universal active immunization with tetanus toxoid,[5] I presented full clinical details of two further cases of serum neuritis following a prophylactic injection of tetanus antitoxin made with horse-serum; in one patient permanent neurological complications resulted from a single test dose of only 175 units.[6 7] Trinca's[8] recommendation that "bovine antisera should be used for patients showing sensitivity to horse-serum" can therefore no longer be considered valid.

But, because a prophylactic injection of tetanus antitoxin made with horse-serum is still being advocated and practised, I make no excuse for reiterating my view that adequate supplies of human tetanus antitoxin must be made available for general use in place of equine-derived tetanus antitoxin.[6 7 9] Human tetanus antitoxin, which is non-antigenic in man, does not produce hypersensitivity reactions; and though it is scarce, since it must be obtained from volunteers, surely in these days when so many people, including members of the armed Forces, are being actively immunized, there should be no shortage of persons willing to donate blood,[10] as has already been demonstrated in Leeds, where human tetanus antitoxin has now been in use for some years.[11]

I thus find myself unable to accept the recommendation of the Advisory Group on Protection Against Tetanus[12] that "in those cases in which tetanus antitoxin is indicated a horse-serum preparation will almost always be appropriate," and I therefore feel that the case against the use of equine-derived tetanus antitoxin requires restating.[9 13] On the basis of evidence submitted, and in the knowledge that even a test dose of tetanus antitoxin made with horse-serum may result in serious neurological complications with permanent sequelae, is it not high time that equine-derived tetanus antitoxin should be banished from hospital casualty departments and doctors' surgeries?—I am, etc.,

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SIR,—Your leading article on tetanus prophylaxis (16 December, 1967, p. 635) and Mr. M. Ellis's letter (30 December, 1967, p. 806) bring to light once more the special dangers attending the treatment of wounded patients. Two points, however, must be made even more clear.

(*a*) That a fully immunized person (that is with three doses of toxoid, properly spaced) is adequately protected for five years or even more,[1] and therefore does *not* need to have any A.T.S. injections unless in very exceptional circumstances of long delay in treatment and a very severe wound difficult to clean surgically[2]; and

(*b*) That, as most of the difficulties encountered at the emergency arise from the lack of adequate knowledge about whether the patient is or is not adequately immunized, it should be made *mandatory* that all motorists (to begin with) should have their driving licences officially stamped with a record of tetanus immunization: initial course, and boosters.

A suggestion to this effect was submitted by me over three years ago[3] and again over two years ago,[4] but I have had no response whatever. The suggestion, if put into practice, would cover a very large proportion of the population at special risk of sustaining injuries and would highlight the importance of tetanus immunization. The risks attending A.T.S. injection are not sufficiently realized and there is often misunderstanding on the relative merits of toxoid and A.T.S.

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Polstead Heath,
Nr. Colchester, Essex.

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Improving the Psychiatric Services

SIR,—Dr. J. H. Raphael (30 December 1967, p. 806) states: "As for day hospitals, I am completely sold on their virtues and efficacy." One wonders on what basis he makes this assertion. Statistics on day-hospital achievements are hard to come by. Farndale's standard book[1] was notably short on results, and there is only a single entry under this heading in the index of the 1967 volume of the *British Journal of Psychiatry*[2] and none at all in the 1966 volume.

Our experience in Blackpool may therefore be relevant. A one-year follow-up on 115 day-hospital patients showed that only 24 were free of some social handicap remaining from their illness. This is hardly sufficient to make one feel "completely sold." Of course it depends what significance one attributes to the phrase "improving the psychiatric services." Who, for instance, is to be the judge of the improvement?

The 63 general practitioners who were the family doctors of these 115 patients were asked to compare the day hospital with other types of service available in the area (in-patient unit, mental hospital, outpatient clinic, private patient treatment, etc.). They rated it fifth out of eight. This group of observers were not impressed either.

This is not to say that the day hospital has no virtues. It may well have. It may, for instance, do much of what the inpatient unit does, and do it more cheaply. But this is a fairly modest kind of "improvement."—I am, etc.,

R. S. FERGUSON.

University of Salford,
Salford, Lancashire.

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2 Haider, I., *Brit. J. Psychiat.*, 1967, **113**, 173.

Psychotropic Drugs

SIR,—I am concerned about the increasing ubiquity of the concept and diagnosis of "depression" in psychiatry. As Dr. I. Atkin remarks (16 December, p. 680), "conditions which are now classified as 'masked depression' were given all sorts of other labels" in the past. Is this change progressive, or may it not be like a return to the diagnosis of "fever" before differentiations were achieved? Monistic tendencies in psychiatry are fairly prevalent—for example, the monistic theory of psychoanalytical psychiatry.

Perhaps the literature accompanying and arising from the promotion of the antidepressives has caused the extended labelling of all sorts of psychiatric illness as "masked" or "atypical" depression. This literature promotes the idea that depression is everywhere, lurking behind all kinds of clinical pictures. It is of course convenient for us to have a standard approach to treatment for a standard diagnosis in a large and often vexatious section of clinical practice. "Treat for depression" can be time-saving, but the considerable psychiatric relapse rate is time-consuming, and may partly arise from the blanket diagnosis of "depression" tending to smother other important considerations which refuse to stay smothered. Is "depression" in danger of losing precise meaning and reference? Perhaps a diagnosis of "depression" and consequent use of a drug to cure

"depression" is as precise as the diagnosis and therapy of "anaemia" without further analysis.[1]

I recently listened to a lecture for general practitioners on depression by a consultant psychiatrist, in which nearly every psychiatric complaint or condition other than schizophrenia, mania, and sociopathy was accused of being "depression." Does anyone else share my misgivings about the near-total victory of "depression" over psychiatry?—I am, etc.,

Gnosall, Stafford. H. M. FLANAGAN.

REFERENCE

[1] Cawley, R. H., quoted by W. H. Trethowan in "Mental Myths and Mechanisms," Inaugural Lecture, University of Birmingham, 1963.

Requests for Abortion

SIR,—I agree with Mr. Wilfrid G. Mills (30 December, p. 802) that an increase in requests for termination of pregnancy has already occurred. This has not only increased the work load of gynaecologists but also of general practitioners who sift and prepare the medical and social backgrounds before patients are referred to the consultants. Many of these cases do not reach the outpatient clinics. However, there should be no criticism of the Act on this account. If a law is socially just then a place must be found for it on the statute-book. One might as well say that a crime cannot be punishable by imprisonment because there are not enough prisons to contain the offenders.

The answer may well be to press for additional outpatient sessions and the consequent appointment of more gynaecological consultants. The public will also have to be educated to the fact that this is not an Act for abortion on demand.—I am, etc.,

Stourport-on-Severn, Worcs. W. T. MACKIE.

Congenital Dislocation of the Hip

SIR,—I have read with interest the recent correspondence (9 December, p. 618, and 23 December, p. 745) on early diagnosis of the unstable hip in infancy. I hasten to congratulate Dr. H. V. L. Finlay and others on the excellence of their article (18 November, p. 377). While wholeheartedly agreeing with the principles laid down in their paper and while paying tribute to the sterling work of Van Rosen, Barlow, and others, may I be permitted to record a note of caution?

It is now accepted that if the unstable or dislocated hip is detected within the first few days of birth subsequent luxation is largely preventable. That the corollary to this implied in recent publications and Ministry[1] statements holds—that is, that all babies with unstable hips can be easily spotted by routine testing by competent staff—is, in my experience, open to question. Numerous colleagues in paediatric and orthopaedic practice in this country still suspect that, despite most careful examination of the newborn by medical personnel in well-run maternity units, there are still intrinsic difficulties involved in total prophylaxis of congenital dislocation of the hip. In other words, notwithstanding the apparent simplicity of the Barlow manœuvres, some cases still escape diagnosis and present months hence with established dislocation. (Corroborative data are available if needed.)

This is a disturbing state of affairs, but nevertheless needs emphasis at this time. It follows that although every effort must be made towards "total diagnosis" some regimen is needed to detect the admittedly few cases that escape the sieve. Indeed, such a scheme of further examination by public health personnel at the second or third month may well be the answer.—I am, etc.,

ROBERT OWEN.

Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry, Salop.

REFERENCE

[1] *Screening for Congenital Dislocation of the Hip*, prepared by the Standing Medical Advisory Committee for the Central Health Services Council and the Ministry of Health, 1966. Ministry of Health.

British Association of Manipulative Medicine

SIR,—I should be grateful for space in your correspondence columns to correct an erroneous impression which I gave general practitioners in the London area when announcing a few weeks ago the opening of the British Association of Manipulative Medicine Evening Clinic at the Italian Hospital, Queen Square, London W.1. I gave the telephone number correctly as 01-834 6524 ext. 804, but by stating that this was the telephone number of the B.M.A.'s Emergency Treatment Service I seem to have given the impression that the British Medical Association sponsors this new outpatient clinic for patients of limited means suffering from minor locomotor disabilities and painful spinal origin.

Such is not the case, and I have been asked to make it clear to all concerned that the B.M.A. is not associated with the B.A.M.M.'s venture.

I apologize to all those who may have been misled inadvertently by the announcement.—I am, etc.,

JOHN EBBETTS,
Hon. Secretary,
British Association of Manipulative Medicine.

London W.1.

Bethanidine in Hypertension

SIR,—We were interested in the report of Dr. J. Bath and his colleagues from Edinburgh (2 December, p. 519) on their experience with bethanidine in the treatment of hypertension.

We have treated 65 patients with bethanidine for periods ranging from three months to a year and have found that larger doses were required for adequate control than were found necessary in the Edinburgh series (Table I).

Our experience also differs in that tolerance was not a negligible factor and many patients taking bethanidine required frequent increases in dosage. As the average dose after initial stabilization was 44 mg., the figures in Table I emphasize this point.

TABLE I

Duration of Treatment	Sheffield Series. Average Dose of Bethanidine	Edinburgh Series. Average Dose of Bethanidine
3 months ..	61·5 mg.	32·5 mg.
6 „ ..	59·5 „	37·0 „
9 „ ..	87·0 „	—
12 „ ..	71·5 „	45·0 „

Blood-pressure control in our series was closely similar to that in the Edinburgh series (Table II).

Further, after eight years' experience in the use of guanethidine we cannot agree that bethanidine has replaced guanethidine as the drug of choice.

In our hands blood-pressure control with guanethidine has been as good as with bethanidine (Table III) and is rapidly achieved

TABLE II.—*Blood Pressure Control on Bethanidine*

Good control	51%	33 cases
Moderate „	32%	21 „
Poor „	17%	11 „
	100%	65 „

TABLE III.—*Blood-pressure Control With Guanethidine*[2]

Good control	63%	140 cases
Moderate „	20%	45 „
Poor „	17%	29 „
	100%	224 „

using the test dose technique recommended by Leishman and Sandler.[1] Tolerance has not been a greater problem with this drug.—We are, etc.,

A. W. D. LEISHMAN.
J. L. THIRKETTLE.
B. R. ALLEN.

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REFERENCES

[1] Leishman, A. W. D., and Sandler, G., *Lancet*, 1965, 1, 668.
[2] —— —— *Angiology*, 1967, in press.

Cause of Death

SIR,—Dr. S. Bradshaw suggests (30 December, p. 806) that you should publish the cause of death in your obituary notices. We read this letter the day after noting with dismay the American trend in a list of notable deaths in 1967 in a "quality" Sunday newspaper. In one of these it read "by decapitation, in a car crash," as if "in a car crash" is not enough for our modern curiosity.

The facts of (medical) public interest are the ending of a professional life and the review of that life. Its mode of ending is not relevant, and should properly be allowed to remain private to the family and close friends. If the family wish the cause to be published (as may be the case in the death of a young person in an accident) this can be done.—We are, etc.,

V. H. A. BLACK.
MARIE T. KENNEDY.
W. O. MCCORMICK.

Department of Mental Health, Queen's University, Belfast.

SIR,—The bastions of good taste in British journalism are falling fast. The omission of the cause of death in your obituary notices is one of the few still remaining. Dealing as we do in disease and death surely makes it all the easier for us to suppress our mild morbid curiosity about the aetiology of the ultimate cardiac arrest in our colleagues. If we require a more eloquent reminder of our own mortality than the weekly pages of obituary notices we can always seek out the lurid details in the popular press.