*Case 1.*—A girl aged 20 developed facial twitching and sustained oculogyric crises after perphenazine 5 mg. In view of the known value of chlorpromazine in post-encephalitic oculogyric crises this drug was given empirically. Within minutes of receiving an intramuscular injection of chlorpromazine 25 mg. the oculogyric crisis and the muscle twitching ceased.

*Case 2.*—A woman aged 38 developed her second dystonic reaction to trifluoperazine, approximately 5 mg. in dosage. The first reaction five years previously was diagnosed as hysteria. She showed facial twitching, trismus, and torticollis. The reaction steadily worsened over eight hours, but within 10 minutes of intramuscular injection of chlorpromazine 25 mg. ceased entirely and did not recur.

*Case 3.*—A girl aged 21 developed jerking of the limbs, twitching of the facial muscles, and retrocollic movements of the head. This followed 90 mg. of metoclopramide (Maxolon). Benztropine methanesulphonate 10 mg. was given intramuscularly with no effect over a two-hour period of observation. Chlorpromazine 25 mg. was given by intramuscular injection, and within minutes the reaction virtually ceased. In this case the movements recurred every three hours and over the next 48 hours this quick and predictable response to chlorpromazine was repeatedly confirmed, until the reaction finally ceased.

The apparent paradox of using a phenothiazine to suppress a phenothiazine reaction requires further discussion. The most attractive hypothesis is that of competitive inhibition between the different groups of phenothiazines. The structural similarity of the side chains, particularly those of diclopramide and chlorpromazine, is notable. This suggests the locus of the propensity to produce dystonia may lie in the side chain itself, as the tricyclic nucleus of phenothiazines is quite unlike the single ring of metoclopramide. Whatever the mode of action, this does appear to be a very rapid and reliable way of treating dystonic reactions of non-Parkinsonian type and I hope it may prove of value to others faced with these very distressing reactions.—I am, etc.,

London S.W.4. J. P. PATTEN.

REFERENCE

[1] Ayd, F. J., *J. Amer. med. Ass.*, 1961, **175**, 1054.

## Elastic Band Injuries

SIR,—The interest in this subject has been rewarding.

Dr. F. W. Webb's case (27 January, p. 250) of the elastic band round the child's neck must surely involve some problem of family interrelationship. One wonders if reassessment is needed to prevent any further accidents, particularly in view of the comment that it seemed odd that the mother hadn't noticed.

The picture accompanying Dr. G. Glew's letter (25 November, p. 488) shows an elastic band injury in its early stages. His division of the cases into "deliberate artifacts and accidental production" might hide those cases where the psychology of errors is operative. This would prevent the doctor making the patient aware of the true nature of the disorder, which is important for fundamental cure to take place. Perhaps the spectrum is from the malingerer who can be made to own up, the artifact case who denies knowledge, the patient under tension who forgets with subconscious motivation, and, finally, someone who just loses a rubber band, if this is possible.—I am, etc.,

Beaumont Hospital, Lancaster. R. H. SEVILLE.

## Unusual Case of Anaemia

SIR,—Dr. Sheila T. Callender's recent article on occult bleeding from the gastrointestinal tract (13 January, p. 101) prompts me to report an unusual case of iron-deficiency anaemia seen at Guy's Hospital last year.

The patient, a white English girl aged 23, attended the family planning centre prior to getting married and was observed to be anaemic, her haemoglobin being 5.6 g./100 ml. She was referred to Dr. W. N. Mann, who arranged for her admission under his care. On admission she was symptom-free, the only abnormal physical signs were pallor and gross koilonychia. Her diet had been normal and her menstrual loss not excessive. Relevant investigations were as follows: Haemoglobin 4.6 g./100 ml., haematocrit 19%, M.C.H.C. 24%, W.B.C. 4,500, with a normal differential. The film showed marked microcytosis and hypochromia. Plasma iron 15 $\mu$g./100 ml. Plasma iron-binding capacity 480 $\mu$g./100 ml. Serum vitamin $B_{12}$ 370 $\mu$g./100 ml. Haemoglobin electrophoresis normal. The barium meal was normal. Gastric acidity normal. Examination of the stools for occult blood, ova, and cysts was negative. Bone marrow examination showed normoblastic erythroid hyperplasia and absent marrow iron stores.

The cause of her gross iron deficiency was most obscure. However, after five days in the ward the patient confessed to a strange habit. For five years she had been eating (not sucking) the contents of the ice box of a refrigerator, about 18 ice cubes, during and after each meal, and if she could obtain ice between meals she would eat it at any time it was available. What effect this habit could have upon her iron absorption or gastrointestinal blood loss we were unable to investigate, as the patient left hospital nine days after admission in order to get married. She stopped eating ice, and was given iron supplements, and two months after admission her haemoglobin had risen to 11.8 g./100 ml.

Subsequent questioning of students revealed that occasional ice eating was not at all uncommon, although none of them did it to the same extent as the patient. It seemed that the habit was not unusual and perhaps might be worth inquiring about in cases of obscure iron deficiency.

I am grateful to Dr. W. N. Mann for allowing me to report this case.

—I am, etc.,

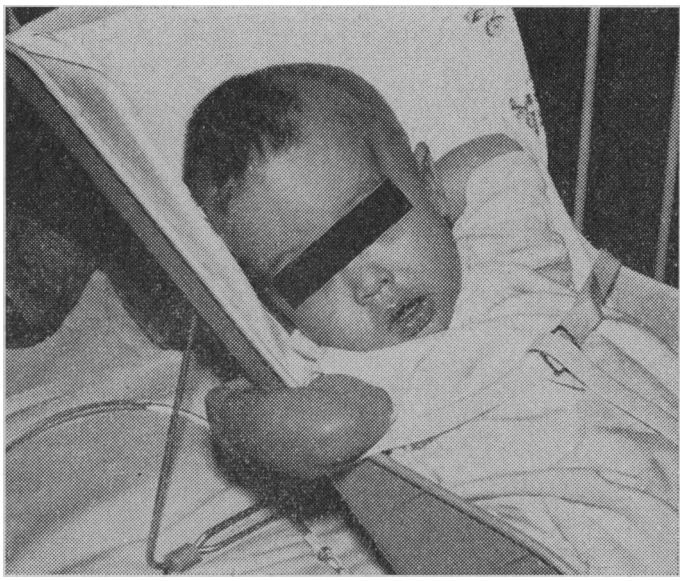
I. G. MCGILL.

Guy's Hospital, London S.E.1.

## Unusual Complication of Oesophageal Reflux

SIR,—Hiatus hernia and oesophageal reflux in the early months of life are frequently treated conservatively and by nursing in an upright position. For some years the joiners' shops in children's hospitals have provided effective though bulky "chalasia" boxes, but during the past few years many people have chosen to use a commercially available plastic carrying chair which is much lighter to handle and more attractive.

A recent experience with a child who had been nursed in one of these chairs has drawn attention to a particular risk as the child gets older and larger. This child was found with a full "Saturday night palsy" with wrist drop and paralysis of the triceps. The photograph shows how the child lay with his flail partially paralysed arm and indicates how easily in a child of this size continuous pressure can be maintained on the radial nerve, either in the musculo-spiral groove, or even higher up in the axilla as in a crutch injury.



Spontaneous recovery occurred within three days after the lesion had been appreciated and the pressure avoided.—I am, etc.,

JAMES LISTER.

Children's Hospital, Sheffield, Yorks.