SIR,—Dental pain is the commonest cause of facial pain. Perhaps therefore an oral surgical viewpoint on Dr. J. B. Foster's interesting article concerning its neurological aspects would be of value (13 December, p. 667). His understandably brief account of "temporo-mandibular neuralgia" was in my experience misleading.

The oral surgeon encounters pain related to the temporo-mandibular joint frequently. Typically it occurs in young rather than middle-aged women. It is characterized by pain in front of the ear, difficulty in opening the mouth, and often a clicking joint. Mandibular movement certainly exacerbates the pain. Muscle spasm often produces masseteric tenderness.[1, 2] Aetiologically the condition may be associated with over-closure in the edentulous, as Dr. Foster mentions. However, I should like to stress that usually the patients are in their late teens or early twenties and have a fairly full complement of teeth. Overclosure may be found but other forms of occlusal disharmony are more common although sometimes hard to detect by simple observation. Psychogenic factors may be implicated.

Relief of pain may well be obtained purely by reassurance of the patient together with recommendation of a soft diet and avoidance of excessive jaw movement. Should this fail then a bite-raising appliance which minimally separates the teeth almost always eliminates pain. Occlusal rehabilitation may be required and rarely surgical intervention is necessary. The latter may comprise such a simple measure as removal of an infected tooth or occasionally condylar surgery.—I am, etc.,

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REFERENCES

1 Hankey, G. T. *British Dental Journal*, 1954, **97**. 249.
2 Henny, F. A., In Textbook of Oral Surgery, ed. G. O. Kruger, 3rd edn., p.369, Saint Louis, Mosby, 1968.

SIR,—I found the article on facial pain by Dr. J. B. Foster (13 December, p. 667) of great value, and was particularly interested in the section on the treatment of post-herpetic neuralgia. This condition is a well known cause of protracted suffering which responds disappointingly to analgesics, steroids, and vitamin B_{12}. Vibrator therapy is sometimes intolerable and seldom affords rapid relief. As Dr. Foster mentions, recourse sometimes has to be made to powerful, addictive drugs such as heroin so that there is a need for a simple, safe, and effective remedy.

In the last two years I have been impressed by the response of patients with this condition to amitriptyline (Tryptizol). I have now treated six patients, four with simple post-herpetic neuralgia, one with this condition in association with chronic lymphatic leukaemia, and one with painful unilateral neurofibromatosis involving the entire left side of the body. All six complained of persistent pain which had not responded to analgesics or vitamin B_{12}. The patient with neurofibromatosis had suffered for years despite many therapeutic efforts.

All these patients claimed great improvement within a few days of commencing amitriptyline 25 mg. t.d.s. Complete analgesia was not usually obtained, but the residual pain no longer seemed to trouble the patient. One stated that what had been an intolerable burden had become acceptable and present only as a "background nuisance". The severe pain usually returns on withdrawing the drug but remits again with a further course, and complete withdrawal can be attempted again after about three or four months. Most patients require 75 mg. daily in divided dosage but one required 75 mg. t.d.s. and another was well satisfied with 10 mg. t.d.s.

I am not sure of the mechanism of this response; as amitriptyline has no analgesic properties it cannot be one of simple pain relief. It was not an act of analgesic potentiation as no other drugs were used in addition to it. It seems unlikely to be simply the result of its antidepressive effects, because none of these patients were overtly depressed though naturally they were unhappy with their persistent neuralgia. I would tentatively suggest that amitriptyline alters the cortical appreciation of pain, a mechanism which would be consistent with the clinical response observed that the pain was altered in character rather than abolished.

I realize that in dealing with a completely subjective disorder it is difficult to evaluate the apparent response. I do not have access to sufficient numbers of cases to carry out a proper clinical trial with a placebo control but others perhaps could do so.—I am, etc.,

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Management of Deep Vein Thrombosis

SIR,—You published three articles under the general heading of "Deep Vein Thrombosis" (13 December, p. 676). The one entitled "Medical Management" failed to discuss a number of important points. The actions and some of the complications of anticoagulant drugs and fibrinolytic drugs were described, but there was no mention of the drug therapy considered to be the treatment of choice, although it was stated that "continuous intravenous infusion of heparin gives a more stable effect, but causes bleeding more frequently than comparable intermittent doses".

I would have welcomed some information about the length of time a patient with deep venous thrombosis should be treated with an anticoagulant or fibrinolytic drug, as I believe that this varies from centre to centre. It is my practice to give at least one month of anticoagulant therapy, but I have always had a suspicion that this may be too short a course of therapy and I was disappointed that I did not receive guidance from the article.

I believe that it is generally accepted that patients with acute deep vein thrombosis should be initially immobilized, and in some cases the foot of the bed elevated. Should the foot of the bed be elevated in all cases, only when gross oedema is present, or not at all? If immobilization is a rational form of therapy, how long should a patient be immobilized? Should physiotherapy be given during the period of immobilization? These are some of the questions I would have liked to have seen discussed in any article written about the medical management of deep vein thrombosis.

Could I respectfully suggest that the article should have been entitled "Drugs used in the treatment of deep vein thrombosis". A fourth article could then have been included to cover the many other important aspects of the medical management of this very common condition.—I am, etc.,

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The Aspirin Habit

SIR,—A recent newspaper picture showed a long queue outside a chemist's shop. The proprietor had said that most of the people had prescriptions for antibiotics and aspirins. This prompts me to ask the question—what price the aspirin habit?

The habit of prescribing aspirin for febrile illnesses is deeply rooted in the medical profession, but have we asked ourselves whether this is logical and whether it may be harmful? As I see it, the rise in temperature in a febrile illness is a defence mechanism against the bacterium or virus. Might not some of the prolonged illness after influenza be due to the habit of trying to "sweat it out" with antipyretics?

We know that patients expect some sort of prescription. When the mother of a feverish child telephones the surgery she may be satisfied with the message "Give him a couple of Junior Aspirins, put him to bed, and the doctor will call in the morning". But is it not time that we asked ourselves a few searching questions as to the effect of artificially lowering the body temperature in infectious illnesses?—I am, etc.,

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Importing Malaria

SIR,—Each year a few lives are unnecessarily lost because visitors to tropical Africa have omitted, from ignorance of the risk, to take antimalarial prophylactics. One example has recently occurred in this region. A young man left his ship in Dakar, Senegal, and after a stay of 24 hours flew to England. Symptoms began eight days later. His doctor was not called for another week. He was at once admitted to hospital, where, in spite of prompt specific and supportive treatment, he died 48 hours later from the effects of an overwhelming *Plasmodium falciparum* infection.

Such tragedies could be avoided if travellers to and from tropical Africa were clearly warned of the dangers of malaria and informed how to avoid infection. This could easily be done by the exhibition of conspicuous notices on aircraft operating on the danger routes, reinforced by announcements on the public address system. Air traffic to Africa is increasing with the introduction of "package tours", and though some of the passengers are forewarned of the risk of malaria, others to our personal knowledge are not.

Inaction based on the fact that malaria is statistically a trivial cause of mortality in this country is quite unacceptable to those of us who have to deal with the victims and their families.—We are, etc.,

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