A balanced psychosomatic approach would surely have shed more light on this epidemic.—I am, etc.,

G. G. WALLIS

High Royds Hospital,
Ilkley, Yorks

SIR,—The account by Dr. M. J. Dillon and others (23 February, p. 301) of the mysterious illness which affected the staff of the Hospital for Sick Children, Great Ormond Street makes fascinating reading.

Why, I wonder, was none of the patients affected and why was the "epidemic" so selective among the staff? Why, despite every endeavour, did the investigators find virtually no evidence that the illness was in fact attributable to an infective agent?

Dr. Dillon and his colleagues do not say whether poisoning was considered. Is it possible (shades of Cold Comfort Farm!) that the nurses' food was being intermittently laced with cockroach powder—perhaps old stock bought in cheap from the Royal Free?—I am, etc.,

F. STEPHEN PERRY

Albrighton,
near Wolverhampton

Amitriptyline and Imipramine Poisoning in Children

SIR,—We are at a loss to understand Dr. R. N. Wilson's criticism (9 March, p. 455) of our paper (16 February, p. 261). He complains that we do not "make clear, to the lay reader, whether poisoning was due to therapeutic doses or accidental overdose." Our paper was, of course, not written for the lay reader but for our medical colleagues. It is consequently the clear responsibility of the communications media to ensure that their correspondents have sufficient understanding of technical matters not to misrepresent articles which they read in technical journals.

Moreover, it is difficult to understand how anyone, whether medically trained or not, could read the article in its entirety and yet misunderstand it so completely.—We are, etc.,

K. M. GOEL
ROBERT A. SHANKS

Royal Hospital for Sick Children,
Glasgow

SIR,—We were concerned to see the report from Glasgow by Drs. K. M. Goel and R. A. Shanks (16 February, p. 261) on tricyclic antidepressant poisoning in children. From our limited experience of this problem we should like to suggest the use of parenteral diphenylhydantoin in the 24 hours after poisoning. The use of this drug in preventing and controlling convulsions is well known and it has been used to control and prevent cardiac dysrhythmias, both those of ventricular and of superventricular origin.[1 2]

We have used diphenylhydantoin beneficially in two children and two young adults poisoned with amitriptyline. All were drowsy, irritable, and hyperreflexive; three had excessive ventricular extrasystoles and one a sinus tachycardia of 180 per minute. The extrasystoles and tachycardia were abolished after intravenous diphenylhydantoin and there were no subsequent convulsions or dysrhythmias. Continuous cardiac monitoring is essential and diphenylhydantoin should be given intravenously in a dose of 3 mg/kg body weight slowly over three minutes. Further doses can be given intramuscularly over the 24 hours poisoning. We feel that diphenylhydantoin should not be used if there is hypotension or heart-block.—We are, etc.,

D. A. PRICE
R. J. POSTLETHWAITE

Booth Hall Children's Hospital,
Manchester

1 Eddy, J. D., and Singh, S. P., *British Medical Journal*, 1969, 4, 270.
2 *British Medical Journal*, 1969, 3, 403.

Anticoagulants and Treatment for Chilblains

SIR,—Drs. G. E. Heald and L. Poller (9 March, p. 455) have highlighted a problem in the management of patients receiving anticoagulant treatment with coumarin-type drugs. Coumarins interact with many other drugs that may be used concurrently for coexistent disease. One list gives 38 drugs or classes of drug which increase the anticoagulant effect of coumarins and 18 which decrease the effect. Most of these drugs are available only from the doctor, and with knowledge of their influence on coumarin-induced anticoagulation he can, in general or hospital practice, make appropriate adjustments in dosage or choice of alternative drugs. The difficulty arises when a patient fails to report to his doctor his consumption of "over-the-counter" medicines or when the doctor does not know what relevant drugs are contained in the medicine.

Hitherto the onus has been on the doctor to find out what other medicines the patient is taking and order any justifiable modifications or to tell the patient not to take any medicines without first checking with him. This is amplified in instruction booklets supplied by the makers of the major oral anticoagulants to doctors to give to their patients if they wish. However, we, as the makers of Gon, accept the recommendation implied in Drs. Heald and Poller's letter that a warning should appear on the container advising patients on anticoagulants not to take the tablets without first consulting their doctor, and such a warning will be added.

Perhaps the day will come when all drugs sold "over the counter" that may influence anticoagulant effect and coumarin dosage will carry a similar cautionary notice. This may be reasonable for all products containing aspirin or paracetamol and for all multivitamin preparations containing vitamin K, but will every bottle of whisky bear a label describing the enhancing effect on anticoagulants of alcohol?—I am, etc.,

J. MICHAEL SIMISTER
Medical Director,
WB Pharmaceuticals Ltd.

Wembley, Middlesex

Can I Have an Ambulance, Doctor?

SIR,—In the interesting article by Dr. T. C. Beer and others (9 February, p. 226) the patients referred to were privileged to be transferred to and from the physiotherapy centre by ambulance. Each day large numbers of people travel to hospital physiotherapy departments by bus (even when the ambulances are running). This may necessitate two bus journeys followed by a long walk in the hospital grounds. The patients emerge some time later glowing from the exercise, the massage, the various rays—long, short, hot or cold—which have been projected at them from various angles. The glow is soon dispersed while they wait exposed to the elements at the bus stop and exposed to the flu virus on the bus itself. They arrive home perhaps three or four hours after their departure, exhausted from their labours, to find (if female) further exercises awaiting them at home unless the household chores are to be neglected. All this for the doubtful benefit of 20 minutes' physiotherapy.

The authors state that "for some conditions the effectiveness of outpatient physiotherapy is not proved." For "some" perhaps the word "many" should be substituted. A course of physiotherapy lasts about 6-8 weeks and so much improvement can occur in that period of time irrespective of therapy. With certain tiresome patients it is a useful method of keeping them away from the general outpatient department, but surely there are better ways of dealing with this type of patient?

Hospital physiotherapy departments are chronically short of staff. A little more discrimination on the part of referring doctors and consideration of the disadvantage as well as the possible advantages of the treatment would reduce the number of referrals and would leave the physiotherapist more time to deal with conditions which can be improved by their techniques.—I am, etc.,

E. E. RAWLINGS

Manchester

SIR,—Dr. T. C. Beer and his colleagues (9 February, p. 226) have made a useful study of some of the problems associated with ambulance transport and outpatients. Indeed, there are many aspects of the use and abuse of ambulances which should be considered further. Two points, however, arise directly from the article in question.

In the first place the authors were apparently unaware of the study on domiciliary physiotherapy in urban surroundings carried out in Belfast.[1] As a result of this study improvement was obtained in 67% of patients and it was concluded that domiciliary geriatric rehabilitation by a trained physiotherapist could be accomplished successfully in many instances at a much lower cost than in a hospital bed.

In the second place no reference is made in Dr. Beer's survey to the problems of ambulance service as encountered in the geriatric day hospital and, indeed, the important part to be played by such day hospitals in the rehabilitation of disabled elderly patients. As has been demonstrated on many occasions the "side effects" associated with long ambulance journeys can often be minimized in the day hospital setting. Elderly patients have time to recover after the journey and the whole of the orientation and setting of the day hospital minimizes the discomfort and distress so often associated with long and tedious waiting in outpatient departments. This is important and justifies the use of day hospitals with all their ancillary benefits for