observations. The most remarkable fact of the case comes in the "Final Note," which states, "A few days after discharge the patient died suddenly of acute heart failure."

In recent years there has, quite rightly, been a new awareness amongst the profession of the values of hypnosis in treatment. It is quite obvious that the patient most probably would have died of his status asthmaticus without the use of hypnosis, all other known methods having been tried without avail. Asthma must be considered, however, as a symptom and not a disease. What were the true psycho-dynamics of this patient's asthma? According to Dr. Sinclair-Gieben he was a very well adjusted man. This, with due deference, I question. I am certain that by careful analytical questioning one would find gross emotional upset.

This asthmatic attack was the patient's unconscious means of dying. When the attack was cured he unconsciously realized that this way of escape had been removed, and so three days later he dies of acute heart failure. This case emphasizes that when treating cases of asthma by hypnosis one must endeavour to find the true unconscious meaning of the attacks. In no way am I suggesting that the use of hypnosis in this case led to the patient's death, but I am endeavouring to bring to the notice of all who use hypnosis in the treatment of asthma the tremendous importance of ascertaining a history of its deep-seated dynamics. Unless this precaution is taken other alarming symptoms from time to time will reveal themselves.—I am, etc.,

London W.1. ALAN AKEROYD.

Is Thalidomide to Blame?

SIR,—I feel that four cases which have occurred in my practice recently are worthy of mention, as they may correspond to the experience of other practitioners. They all presented in more or less the same way—each patient complaining of: (1) Marked paraesthesia affecting first the feet and subsequently the hands. (2) Coldness of the extremities and marked pallor of the toes and fingers on exposure to even moderately cold conditions. (3) Occasional slight ataxia. (4) Nocturnal cramp in the leg muscles. Clinical examination in each case has been essentially negative, and during this time I have not noticed similar cases in my practice.

It seemed to me to be significant that each patient had been receiving thalidomide ("distaval") in a dose of 100 mg. at night, the period during which the drug had been given varying from eighteen months to over two years. Thalidomide is generally regarded as being remarkably free of toxic effects, but in this instance the drug was stopped. Three of the patients have now received no thalidomide for two to three months, and there has been a marked improvement in their symptoms, but they are still present. The fourth patient stopped taking the drug two weeks ago, and it is therefore too early to assess the effect of withdrawal.

It would appear that these symptoms could possibly be a toxic effect of thalidomide. I have seen no record of similar effects with this drug, and I feel it would be of interest to learn whether any of your readers have observed these effects after long-term treatment with the drug. I might add that I have found it otherwise to be a most effective hypnotic with no "morning hangover" effect. It has been especially useful in patients with skin pruritus and discomfort.—I am, etc.,

Turriff, Aberdeenshire. A. LESLIE FLORENCE.

Digitalis Poisoning

SIR,—Your contributors (November 12, pp. 1402 and 1409) are to be congratulated on drawing attention to atrial tachycardia with block as a manifestation of digitalis intoxication. Since reading Lown and Levine's description[1] of this five years ago I have noted several examples, one of which has been published elsewhere.[2]

Perhaps the rather confusing terminology prevents wider recognition. "Paroxysmal," although used by Levine, is not a label that can be given as a result of a single cardiographic study, and seems inappropriate when each "paroxysm" is drug-induced. And surely the time has come to stop trying to make a rigid distinction between atrial tachycardia and flutter which Prinzmetal[3] has shown to be essentially the same phenomenon, differing mainly in the rate of discharge of an ectopic focus.

The important point, as Dr. Samuel Oram and his colleagues say (p. 1402), is recognition of the rapid atrial rhythm which is due to digitalis. The curious variability of the auriculo-ventricular block is one of its most suspicious features.—I am, etc.,

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REFERENCES

[1] Lown, B., and Levine, S. A., *Current Concepts in Digitalis Therapy*, 1955. Churchill, London.
[2] Petch, C. P., *Brit. J. clin. Pract.*, 1959, **13**, 266.
[3] Prinzmetal, M., *et al.*, *The Auricular Arrhythmias*, 1952, 3rd edition. Thomas, Springfield, Illinois.

A Case of Atrial Septal Defect

SIR,—I read with great interest the discussion between Professor J. McMichael and Dr. Monica Bishop about the evidence of carditis in a case of atrial septal defect (November 26, p. 1585), as I happen to be working (with Professor R. Scalabrino) on a very similar instance of Lutembacher's syndrome: a 44-year-old woman, with a story of heart disease, cardiogram showing right bundle branch block and right ventricular hypertrophy, who died from cardiac failure and at whose necropsy a 3.5-cm. wide atrial septal defect, mitral stenosis, and tricuspidal lesions were found. Following on serial sections of the His–Tawara bundle, I noticed several round-cell aggregates, fibrosis, and thick-walled, stenotic arteriolae at the upper portion of the ventricular septum. The bifurcation and the right branching of the bundle seemed to be involved and damaged. The base of the tricuspid, the walls of the right atrium, and the region of the sinus node showed groups of lympho-histioid elements. No typical Aschoff bodies, however, have been observed.

I would like to point out that such a carditis in Lutembacher's syndrome could be regarded as not uncommon and, sometimes, as responsible for clinico-pathological changes (conduction troubles) besides the classic valvular ones.—I am, etc.,

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Chemical Diagnosis of Steatorrhoea

SIR,—Although the facts about steatorrhoea determined by Dr. Edward B. Hendry (October 1, p. 975) are mostly unexceptionable, the conclusions are quite misleading. He finds, as do most other investigators, that the 24-hour faecal output of fat is a very reliable method of diagnosing steatorrhoea, whereas values of per cent. of fat in dried stool correlate very