Medicine on Television

SIR,—The present tendencies of television programmes which depict the problems of care for the mentally handicapped are a cause of concern to those who work in the Health Service. Distortion of the full picture by selective editing presents the public with a view of hospital care which may be true in certain places at certain times; it is not, however, representative, and in a recent programme on autism the position of children in hospital was described as "a fate worse than death." In fact, much positive therapy is achieved under difficult conditions and with inadequate staffing. New advances in care and in providing small group living are being made in many places.

The negative image which is given to all hospital care is destructive and is likely to cause a deteriorating service; it lowers the morale of those who work and hinders recruitment of people of the right calibre and motivation. It may also cause despair and hostility in those parents who have at present no alternative but to use our services. I would like to see more public appreciation through the mass media of the optimistic therapeutic approaches which are now being used in this field.—I am, etc.,

M. WAY

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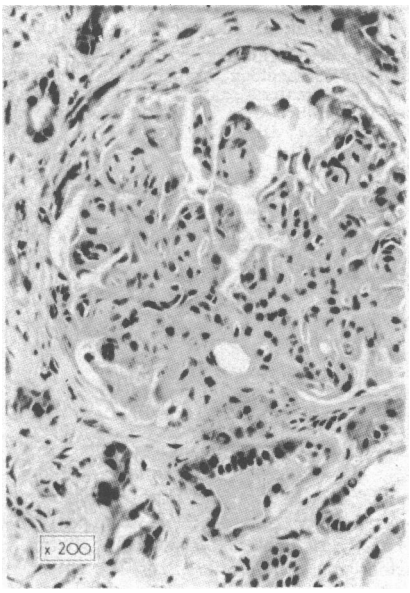
Glomerulonephritis Associated with Coxiella burnetii Endocarditis

SIR,—Like Drs. J. R. E. Dathan and M. F. Heyworth (15 February, p. 376) we have observed the association of valvular heart disease, nephrotic syndrome, haemolytic anaemia, and extremely high antibody titres to *Coxiella burnetii* (complement fixation test, phase I 1/1280, phase II 1/2560).

The patient concerned was a woman born in 1933 who presented two years ago with exhaustion, nose bleeds, anaemia of acquired haemolytic type, and evidence of acute nephritis. She had been known to have valvular heart disease for some years and there were signs of mitral regurgitation. She was treated with digitalis, diuretics, and later prednisone and azathioprine for 14 months. She was then reinvestigated because of persistent oedema and proteinuria averaging 9 g daily. It was felt that immunosuppressive therapy was not helping her and this was discontinued under ACTH cover. At this time a generalized morbilliform rash was noted and a virus infection suspected and it was then that raised Q-fever antibodies were discovered. A renal biopsy on this occasion showed histological features of diffuse mesangial thickening with a moderate increase of cellularity and capsular adhesion (see fig.). Immunofluorescence studies showed heavy deposition of IgG and B^1C complement in relation to the glomerular basement membranes. At no time, however, were L.E. cells discovered and tests for hepatitis B antigen were negative. She has been treated with tetracycline with reduction of urinary protein output from an average of 8 g/day to 4 g/day without alteration of blood urea levels.



It seems, therefore, that Q fever with endocarditis must certainly be regarded as another cause of immune complex nephritis.—We are, etc.,

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Convulsion following Maprotiline Overdose

SIR,—We have recently managed a case of self-poisoning with the new tetracyclic antidepressant maprotiline hydrochloride (Ludomil) which was complicated by a convulsion.

The patient, a 20-year-old housewife, suffered from postnatal depression aggravated by her husband's absence at sea for long periods. She had no past history of epilepsy. After two days of treatment she took 17 25-mg tablets (425 mg) at about 10 a.m. On admission at 7 p.m. she was conscious, there were no neurological signs, and her blood pressure was normal. A grand mal fit lasting about one minute occurred shortly after the patient had been admitted to the ward. No cardiac arrhythmia developed. Plasma calcium, urea, and SGPT were normal. An unremarkable recovery ensued and the patient was discharged two days after admission.

Convulsions are not uncommon in patients taking tricyclic drugs[1] in therapeutic doses and are a recognized feature of the poisoned patient. It appears that maprotiline is much less likely to lead to convulsions.[2] Our experience in this case, however, suggests that it may do so.—We are, etc.,

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H. MAMTORA
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1 Dallos, V., and Heathfield, K., *British Medical Journal*, 1969, **4**, 80.
2 *Depressive Illness*, ed. P. Kieholz. Berne, Huber, 1972.

Anaemia in Pregnancy

SIR,—I read with interest the letter from Mr. T. Lind and his colleagues (15 March, p. 627) in which they put forward the hypothesis that haemodilution occurring in pregnancy may be beneficial in creating a more favourable environment for the developing fetus. They accept that the risk of true anaemia is increased during pregnancy but make no mention of iron balance studies which seem consistently to demonstrate that normal pregnant women go into negative iron balance, regardless of diet if given no iron supplements.[1]

Since anaemia is known to be associated with impaired placental function[2] it seems important to study the effects of haemodilution *uncomplicated by anaemia* on fetal well-being. A small study was undertaken in this department into the relationships between birth weights and haematocrit changes used as an indicator of the degree of haemodilution. One hundred consecutive cases were reviewed. The haematocrit values, calculated by the Coulter counter at the booking visit to the antenatal clinic, were compared with those at 34 weeks of pregnancy. Cases were eliminated in which the time interval between booking and 34 weeks was less than 10 weeks, in which the haemoglobin level was below 11 g/dl, and in which the pregnancy was complicated by other abnormalities such as pre-eclampsia, diabetes, or antepartum haemorrhage, conditions known to be associated with abnormal birth weight. A total of 23 patients were eliminated, leaving 77 for study. All received iron and folic acid supplements during pregnancy. The birth weight was noted and also expressed as a percentage of the 50th centile of the expected weight, standardized for maternal parity, duration of gestation, and the sex of the baby.[3] The mean haematocrit at booking was $37 \pm 2{\cdot}7$ (S.D.)% and at 34 weeks $36{\cdot}2 \pm 3{\cdot}1$%. In 45 cases (58·4%) the haematocrit fell between booking and 34 weeks and in 32 (41·6%) the level rose.

In the group of 45 cases in which the haematocrit fell during pregnancy the mean birth weight was 3217 ± 366 g compared to 3321 ± 625 g in the 32 in which the haematocrit rose. The mean of the birth weights expressed as a percentage of the 50th centile (see above) in the decreased haematocrit group was $95{\cdot}9 \pm 9{\cdot}8$ and in the increased haematocrit group $99{\cdot}5 \pm 16{\cdot}9$. None of these differences is significant.

Admittedly the extent of the haematocrit changes in our study group was limited because they had been on prophylactic iron. However, within these limits there appeared to be no relationship between haematocrit and birth weight.—I am, etc.,

D. J. THOMAS

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1 Wallerstein, R. O., *Clinics in Haematology*, 1973, **2**, 453.
2 Beischer, N. A., *et al.*, *American Journal of Obstetrics and Gynecology*, 1968, **102**, 819.
3 Thomson, A. M., Billewicz, W. Z., and Hytten, F. E., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, **75**, 903.

Misleading Drug Advertising

SIR,—I would like to clarify two points raised by Dr. A. J. Jouhar (5 April, p. 38). It was pointed out at the recent symposium on sotalol to which Dr. Jouhar refers that the membrane-stabilizing action (alias direct depressing effector quinidine-like action) of beta-adrenergic blocking drugs may be of pharmacological interest, but it is of doubtful clinical relevance.[1-4] It is perhaps one of the notable pharmacological red herrings drawn across the therapeutic trail for a long time. The membrane-stabilizing action has no relevance in hypertension,[3 5] the