Points

If I was forced to cut

Dr JEAN WILSON (Glasgow G41 3SE) writes: Your special correspondent interviewing a general practitioner (1 December, p 1429) says that "now any patient is entitled to a domiciliary visit." This is news to me; any of my consultant friends would take a dim view of being called to see someone who could quite easily get to hospital. Furthermore, "domiciliaries" are most useful in confirming one's opinion that hospital is *not* necessary. . . .

The Revd FRED ADAMS (Northampton NN7 4DA) writes: The consultant "Dr Barrowdean" (20 October, p 985) enumerated what he considered to be superfluous jobs in the hospital service . . . and referred to "young track-suited persons calling themselves remedial gymnasts"—another non-job, he supposed. He could not have been more wrong. Since the last war . . . remedial gymnasts have been . . . rehabilitating accident victims of all types—motor, sports, industrial, etc. They also help those with strokes to recover use or partial use of affected parts, speech included, and to recover their abilities to live as normal lives as possible. For those, like myself, who are in wheelchairs with neurospinal disease long-term treatment is available consisting of exercises to strengthen muscles, practice at standing or walking with special aids or parallel bars, and passive movements—exercises during which the gymnast moves limbs in ways that the patient is unable to do for himself. It is rare when no improvement takes place, but even then two aspects are always present. Firstly, at least the patient retains what movements he is able to make; and, secondly, psychologically every patient knows that *something* is being done. . . . I have been attending for treatment for almost a year and have never ceased to admire the skill, patience, and youthful good-naturedness of our local team of remedial gymnasts.

The politics of contraception

Dr ELIZABETH ELLIOTT (Wisbech, Cambs PE14 7EU) writes: Your reviewer of Carl Djerssi's book *The Politics of Contraception* (24 November, p 1358) gives the impression that women as "consumers" are wrong to question the pill's effects on their health. . . . The "hard sell" approach to contraception has had some obnoxious features and has put in an invidious position those of us trying to give ethical advice on contraception to individual women. For instance, many doctors get only selective information on the pill's side effects. For this we must thank the misleading propaganda of the "population" lobby, for whom apparently anything goes in promoting fertility control and the psychophysical health of the individual woman takes a low priority. . . .

Diabetic impotence

Dr R J JARRETT (Guy's Hospital Medical School, London SE1 9RT) writes: Dr D J Hosking and his colleagues (1 December, p 1394) report 30 diabetics complaining of erectile impotence, of whom only six had grossly reduced tumescence with nocturnal penile erections. They conclude that the prevalence of organic impotence among diabetics has been overestimated. However, their case rests on the assumption that apparently normal basal penile tumescence (they measured at only one point 2·5 cm from the base of the penis) can be equated with an erection adequate to sustain intercourse. My understanding is that, on the basis of the technique employed by Dr Hosking, absent or grossly deficient tumescence is good evidence of organic disease, but that a "normal" recording requires confirmation either by direct observation or by measuring distal penile tumescence before normal erection can be assumed.

Interaction between disopyramide and practolol

Drs D GELIPTER and M HAZELL (Rotherham District General Hospital, Rotherham, S Yorks) write: We were most interested to read the report of an interaction between disopyramide and practolol (17 November, p 1264). . . . A 56-year-old man with a recent history of myocardial infarction was admitted . . . with breathlessness and was found to have a supraventricular tachycardia of 180 beats/min. No response was obtained from carotid sinus massage and intravenous practolol, 20 mg. This was followed 10 minutes later by an intravenous injection of disopyramide. After 70 mg had been given there was a sudden onset of sinus bradycardia of 20 beats/min with no effective cardiac output. . . . This man has had several episodes of supraventricular tachycardia, both before and after this incident; one was also treated with intravenous practolol and disopyramide, but with two hours between their administration. There were no untoward effects then. This would support a possible adverse reaction between the two drugs when given in close proximity.

Theophylline poisoning

Drs G F COLE and D P DAVIES (University Department of Child Health, Leicester) write: The paper on theophylline poisoning (3 November, p 1114) by Dr Helliwell and Mr D Berry suggested that manifestations of toxicity are more severe in patients over 50 years of age. . . . We have seen two preterm babies who when being treated for recurrent neonatal apnoea were accidentally given an overdose of aminophylline administered as a continuous intravenous infusion. In the first infant a plasma theophylline concentration of 48 mg/l was obtained and in the second a level of 79 mg/l. The only sign of toxicity in each baby was a sustained tachycardia. . . . Several studies have shown that plasma clearance of theophylline is age related. The elimination of the drug is markedly decreased in preterm infants[1] but the rapid clearance found in childhood falls towards adult values in the late teens. Some authors believe that old age in itself reduces an individual's capacity to eliminate the drug.[2] The very low plasma theophylline clearance values found in the preterm baby are presumably due to a developmental deficiency in the hepatic enzyme activity responsible for *N*-demethylation of theophylline. It is curious that while the preterm infant, like the older patient, shows a marked decrease in the elimination of theophylline, this most vulnerable of patients appears to remain relatively immune to the toxic effects of the drug.

[1] Aranda JV, Sitar DS, Parsons WD, Loughnan PM, and Neims AM. *N Engl J Med* 1976;**295**:413-416.
[2] Jusko WJ, Koup JR, Vance JW, Schentag JJ, and Kuritzky P. *Ann Intern Med* 1977;**86**:400-404.

Benign recurrent vertigo

Dr A C Young (Salford Royal Hospital) writes: . . . Neurological symptoms are extremely common in the general population but in this country neurologists cannot possibly see all the patients they should see. What Dr Allan Downie (24 November, p 1369) has written about vertigo might also be applied to the ocular palsy and hemianopia referred to ophthalmologists and the tingling, wasted limbs, and gait disorders referred to rheumatologists and orthopaedic surgeons; and so one could go on. The solution lies in skilled general practitioners selecting the appropriate clinic in an age of superspecialisation. It must be very tempting for the general practitioner faced with the vertiginous patient to select the hospital department in which the earliest appointment can be obtained. It is unlikely to be the neurology department—at least in this area.

Bell's palsy and herpes simplex virus

Dr JOHN WILSON (Lockerbie, Dumfriesshire DG11 1PD) writes: Last year (2 September, 1978, p 704) I reported four adult cases of Bell's palsy which were associated with high or rising antibody titres to herpes simplex virus. I suggested a possible causal association but this was questioned in subsequent letters from Drs B E Juel-Jensen and Constance Ross (30 September 1978, p 953). On 11 September this year a man in my practice aged 55 developed left-sided Bell's palsy. His antibody titres to herpes simplex virus, have been followed serially by the same technique as used previously in the same virus laboratory. The reciprocal titres were: 9 September—<16; 21 September—128; 11 November—64. I hope my colleagues will agree that the results in the present case, in the absence of any other clinical signs of herpes simplex infection, do confirm the causal relationship suggested[1] between herpes simplex infection and Bell's palsy.

[1] Adour KK. *New Eng J Med* 1975;**292**:748-50.

Correction

Mycoplasma pneumoniae infection and neurological complications

The letter by Dr G E D Urquhart (8 December, p 1512) contains the following errors in the first paragraph. Line 10—"six" should read "seven"; line 14—"four" should read "seven"; line 16—"two" should read "three." We apologise for these errors. Dr Urquhart wishes to emphasise that there were no cases of serious neurological illness associated with *M pneumoniae* infection.