many of the doctors in practice today owe their vocation to the example they so unselfishly gave. I wonder if young people nowadays will see medicine in this light?—I am, etc.,

ANTHONY D. CLIFT

Manchester

Drug Dosage Error

SIR,—We request use of your columns to warn of a dangerous drug dosage error in the article on infective endocarditis by one of us (P.B.B.) in the new (14th) edition of the *Textbook of Medicine* (W. B. Saunders Company, publishers). The error is in the sixth paragraph, first column, page 315, where the recommended dose of gentamicin is given as 50 to 100 mg per kilogram body weight. The correct figure should be 1 to 1·5 mg per kilogram of body weight, intramuscularly or intravenously, every eight hours. We would also like to amend the drug dosage of karamycin which appears in the same paragraph as 10 to 20 mg per kilogram body weight to read, mg per kilogram body weight, intramuscularly or intravenously, every eight hours.

The errors were discovered after several thousand copies of the book had been distributed in May and June of this year. All copies released by the publishers in July and afterward will contain a correction. The publishers are sending notices about this to all hospitals and to all booksellers and to purchasers whose names are known, but there is no way to locate everyone who may possess an early copy of the book. We hope that readers of this notice who know anyone in possession of a copy released during the first two months will call the errors to that person's attention.—We are, etc.,

PAUL B. BEESON
WALSH MCDERMOTT

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Washington, U.S.A.

Deaths in the Dental Chair

SIR,—When the more recent history of dentistry comes to be written the malign influence of the fee-for-item-of-service principle coupled with an over-enthusiastic and indiscriminate adoption of intravenous anaesthesia, with the operator often filling both roles, may well be noted, as in some measure the possibilities of greater productivity—no bad thing in itself—could well have influenced its wholesale adoption. The dental supply companies were not slow to note this trend, producing a range of sophisticated equipment facilitating—indeed, largely compelling—a fully supine position of the patient, so essential of course for general anaesthesia, and from this has followed a tendency for students to be taught that all conservative and many other procedures should be undertaken this way. Whether this tendency has merit is open to argument. Some feel that with wholesale adoption of "going-to-sleep" procedures the dentist is reduced to the role of operating technician having no real personal contact with patients. The sequence of mishaps so admirably documented in the *B.M.J.* may well redress the balance in favour of local anaesthesia, with the patient in whatever position he or she and the dentist feel most at ease with each other. Mr. G. G. P. Holden (12 July, p. 100) stresses the value of overall team care should going-to-sleep procedures be adopted, this being confirmed by the statement of Sir Rodney Swiss (24 May, p. 453), though possibly both could have stressed the continuing value of local anaesthetic methods of pain relief as a useful and perhaps safer alternative.—I am, etc.,

ROBERT CUTLER

Surbiton, Surrey

SIR,—Sir Rodney Swiss (24 May, p. 453) and the Chief Dental Officer of the Department of Health, Mr. G. D. Gibb (5 July, p. 51), echoing popular opinion, have made ex-cathedra pronouncements banning the operator-anaesthetist and effectively, therefore, the incremental methohexitone method of anaesthesia. Such pronouncements, though seeming so obviously right, sometimes turn out to have been a mistake. This ban, I believe, is a retrograde step in dentistry. It will cause many people, including those who most need treating, to shun dental treatment.

If Sir Rodney and Mr. Gibb were to make a careful study of all the accumulated evidence on the causes of deaths in the dental chair they might come to agree that the incremental methohexitone method, conducted by a *well-trained* operator-anaesthetist *team*[1] and reserved for dentistry that is easy to perform—simple extractions or conservations taking at the very outside 10 to 15 minutes—is safe and should not be denied to suitable patients who wish to have it.—I am, etc.,

J. G. BOURNE

Salisbury, Wilts

1 Bourne, J. G., *British Medical Journal*, 1967, 3, 616.

Public Abortionists

SIR,—I believe it is generally accepted that the practice of medicine is concerned with the diagnosis, treatment, and prevention of diseases, though I am aware that some members and sections of the profession see themselves as fulfilling a much wider role as experts in all aspects of human behaviour and as social engineers. Abortion may properly be regarded as a medical matter when it is intended to arrest or prevent a pathological process, but when its objective is social convenience or the avoidance of personal or financial embarrassment it is, I submit, non-medical. Therefore if Parliament wishes to allow women to dispose of unwanted fetuses on purely social grounds let it provide appropriate facilities, with suitably trained public abortionists, outside the hospital service and separately funded. It may be that some members of the profession would be willing or consider it their duty to apply for such appointment: if so, so be it.—I am, etc.,

R. D. FRANCE

Cambridge

Miracle Cures in Parkinson's Disease

SIR,—I am sure that the title and last paragraph of your leading article Miracle Cures in Parkinson's Disease (5 July, p. 1) was not meant to imply that levodopa was a miracle or a cure. Certainly levodopa has been a great step forward in relieving the bradykinetic part of the syndrome and to some extent the rigidity, thus making the lot of these patients so much better. However, as every general practitioner and neurologist will know, there remain problems even with the most modern version of the drug, particularly after three or four years of treatment—for example, the oral-buccal dyskinesia which tends to reduce dosage, sometimes to ineffective levels, the "on-and-off" syndrome, and the falls which seem so difficult to prevent as the disease advances. Tremor also remains a difficulty, especially when of the intentional type.

Precise stereotactic treatment did, and still may, abolish tremor and rigidity in 80% of patients.[1] In most it remained abolished after well-planned and executed lesions, but many patients gradually deteriorated because of uncontrolled and progressive bradykinesis. Levodopa has changed that significantly. In 1955, when stereotactic surgery began to prove itself, we did not call the treatment a miracle, but it was tempting at times. We also realized its limitations, dangers of side effects (especially to speech and voice volume in bilateral lesions), and that bradykinesis remained a problem. There remain a number of indications for skilled stereotactic surgery.—I am, etc.,

F. JOHN GILLINGHAM

Royal Infirmary,
Edinburgh

1 Gillingham, F. J., *et al.*, *British Medical Journal*, 1960, 2, 1395.

Sex Aids

SIR,—Nobody today would dispute that sexual intercourse should be satisfying to both parties, and Professor P. Rhodes (12 July, p. 93) is right to say that the doctor's first duty is to give individual advice to those who seek it. That, however, is not our sole duty. As a profession we should be concerned with the biological consequences of sexual behaviour and attitudes to it.

The commercial exploitation of sex pays scant regard to possible psychological trauma to sensitive individuals and none to possible long-term biological consequences. Yet medical science is itself responsible for the fact that it is now possible for the sexual act to be *totally divorced* from its biological purpose. We do not know what the long-term biological consequences of this will be on man as a species.

I suggest that the need for toleration and understanding of individual behaviour should not blind us to the importance of these wider issues. I hope some of your contributors in the current series will have the courage to discuss this aspect.—I am, etc.,

E. O. EVANS

Stratford-upon-Avon

Deafness in Paget's Disease

SIR,—In their interesting report on deafness in Paget's disease, Mr. P. M. G. B. Grimaldi and others (28 June, p. 726) are possibly being less than fair when they question the diagnosis of deafness due to Paget's disease in our paper.[1] This presupposes that deafness cannot occur except when there is gross

structural damage to the temporal bone, and that the underlying mechanism is clearly understood.

The literature on the skull pathology in Paget's deafness is admirable and full of instances of careful, meticulous work.[2-5] Devoted as it is, however, to instances of widespread skull involvement it is forced to speculate on possible mechanisms for the deafness. The issue therefore remains in doubt, which is why we regret our lack of foresight regarding impedance audiometry and the unavailability of temporal bone tomography. From the viewpoint of advancement of knowledge it would seem more valuable to study minimal lesions than to concentrate on the distortive and destructive end-stage result.

Our patient improved with calcitonin therapy and recent audiometric examination shows further improvement in respect of voice perception. At his age (73 years) and with his degree of crippling deafness it is unlikely that this improvement could have been achieved had there not been some, as yet undefined, link between that deafness and Paget's disease of bone.—I am, etc.,

W. H. MOFFATT

Greenisland Hospital,
Newtownabbey,
Northern Ireland

1 Moffatt, W. H., Morrow, J. D., and Simpson, N., *British Medical Journal*, 1974, **4**, 203.
2 Anson, J. B., and Wilson, J. G., *Archives of Otolaryngology*, 1937, **25**, 560.
3 Clemis, J. D., *et al.*, *Annals of Otology, Rhinology and Laryngology*, 1967, **76**. 611.
4 Tamari, M., *Annals of Otology, Rhinology and Laryngology*, 1942, **51**. 170.
5 Henkin, R. I., Lifschitz, M. D., and Larson, A. L., *American Journal of the Medical Sciences*, 1972, **263**, 383.

Society's Responsibility

SIR,—We, the undersigned, also clinicians practising general psychiatry from a peripheral hospital, fully endorse all Dr. B. W. Durrant's observations (21 June, p. 683). It is to be hoped that the social self-deceptions and euphemisms of the 1960s, which were also reflected in some mental health policies, will now yield to a return to the reality being forced upon society by the increasingly colder realism of the present period.—We are, etc.,

H. M. FLANAGAN
J. D. YOUNG
J. R. E. WILSON
E. L. MATEU
S. S. MAAN

St. George's Hospital,
Stafford

Hormonal Pregnancy Tests and Congenital Malformations

SIR,—While I accept the possibility of teratogenic effects as a result of the use of hormones for the diagnosis of pregnancy (leading article, 30 November 1974, p. 485) and the valuable comments by Dr. Isabel Gal (28 June, p. 749), it is surely wrong to emphasize these drugs to the exclusion of many others. The pharmaceutical industry markets a multitude of drugs that should be avoided during pregnancy and especially the first trimester. Yet how many practitioners consider that patients taking these preparations should also be advised against pregnancy? The danger of a pregnancy occurring while currently on drug therapy, which would normally have been avoided if the patient was already known to be pregnant, should not be forgotten. Is there a case for advising patients against a pregnancy during the course of treatment which the manufacturers have stated should be avoided during pregnancy or must this come as a result of litigation for negligence?

It is now standard radiological practice to *x*-ray female patients in the first half of the cycle lest an early pregnancy be inadvertently irradiated. While the concept of refusing dangerous drugs for non-emergency conditions to patients who cannot provide proof of adequate contraception would be unacceptable, the consequences of indiscriminate prescribing without offering contraceptive advice may be equally unacceptable to the patient.—I am, etc.,

ROY P. EDWARDS

Mill Road Maternity Hospital,
Liverpool

Sexual Life after Hysterectomy

SIR,—Mr. A. G. Amias (14 June, p. 608) has usefully stressed some ways of avoiding precipitating sexual difficulties after hysterectomy. "Newspaper medicine" arouses some anxieties, but does try to answer questions that over-hasty consultations leave unanswered.

Hysterectomy is still seen by women as an operation in which "everything is taken away," including the patient's femininity and sexuality. Psychologically it is a mutilation. It will alter the way she sees herself and possibly the way her husband sees her. Pronouncement of the need for hysterectomy induces psychological shock in most women, and this will be succeeded by feelings of deprivation and resentment unless adequate time is given to a full discussion of exactly what the operation is for, why no alternative is feasible, what it will involve in pain, disability, and time, and what her health, appearance, and sexual feelings will be like later. She should be asked her anxieties and given truthful answers. A further discussion after the sense of shock has eased is often helpful.

If her personal history has been unrewarding it should be anticipated that hysterectomy will precipitate breakdown, and careful evaluation of the absolute need for hysterectomy should be made. If there is no alternative on medical grounds, then skilled psychotherapeutic support should be obtained and continued after the operation.

It is my impression that a good deal of distress could be avoided if attention could be given to these points.—I am, etc.,

VALERIE M. THOMPSON

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London N.W.3

Epidemiology of Disappearing Diseases

SIR,—Poliomyelitis provides one example of the modern problem of epidemiological surveillance of a formerly epidemic infection which has almost disappeared as a result of effective control measures. Reduced awareness of this now unfamiliar disease may not only encourage neglect of the immunization that is essential for continued control of poliomyelitis but can also decrease the accuracy and speed of clinical recognition of cases. Notifications could then give a falsely optimistic impression of the degree of control of the disease. Virological data from diagnostic laboratories will not reveal the true situation unless clinical suspicions have caused specimens to be sent to the laboratories.

During the five years 1970-4 11 cases of paralytic poliomyelitis were detected in Scotland. Polioviruses were isolated from three incompletely or unvaccinated adults, two type 1 and one type 2—the last being vaccine-recipient-associated. From the other eight no virus was isolated because faecal specimens were submitted too late or not at all—in one case not until an orthopaedic surgeon was consulted about weak and wasted thumb muscles. Serological tests were too late to detect diagnostic rising antibody titres, but unusually high titres suggested recent poliomyelitis in all. Provisional diagnosis had included multiple sclerosis, neurological complication of rubella vaccination, and various other neurological and psychiatric disorders. The patients diagnosed serologically included four children (three preschool) and four adults. One illness started in Majorca and one shortly after return from Spain, both involving adults—a reminder that immunity to poliomyelitis may be as important as that to typhoid for visitors to our usual warm, sunny vacation resorts.—We are, etc.,

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E. J. BELL
D. REID

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Duodenal Obstruction due to Abdominal Aortic Aneurysm

SIR,—We noted with interest the recent report of a case of duodenal obstruction due to abdominal aortic aneurysm by Mr. H. M. Adair (28 June, p. 727). We should like to report a case of oesophageal obstruction due to a thoracic aortic aneurysm.

An 85-year-old woman presented with a three-week history of dysphagia and recurrent vomiting. On examination she appeared emaciated and grossly dehydrated. A chest *x*-ray film suggested the presence of a dilated and calcified aorta. A barium swallow showed a dilated oesophagus with a smooth termination and complete obstruction at the gastro-oesophageal junction with virtually no barium seen beyond this point. Oesophagoscopy confirmed the narrowing of the oesophagus, but no mucosal lesion was present and the instrument passed easily into the stomach, which was normal. Unfortunately, the patient's condition deteriorated and she died before further investigation and treatment could be undertaken. At necropsy the proximal two-thirds of the oesophagus was dilated and the distal third was compressed by the descending thoracic aorta. No intrinsic oesophageal lesions were present. Both the thoracic and abdominal parts of the aorta were dilated, measuring up to 6 cm in maximum diameter, and histological section confirmed the atheromatous nature of the large aortic aneurysm.

Aneurysmal dilatation of the thoracic aorta is an uncommon cause of dysphagia because the oesophagus is readily displaced to the right.[1] Radiological studies showing displacement of the oesophagus by a dilated aorta