

been very great, especially of those who live in ivory towers. However, I appreciate that it is a job that has to be done, and it takes all sorts to make a world.

My admiration of these desk doctors was not increased when I received a letter from a senior medical officer of the Department of Health and Social Security. It read as follows: "Dear Dr. Brown, I enclose further statements [I cannot remember receiving previous ones] of some of your prescribing of methaqualone and diphenhydramine (Mandrax). . . ." The list of patients was taken over the month of August last and amounted to 48. These represented just over 1% of the patients on my list, so that I could hardly be accused of using this drug indiscriminately. Forty-six of the patients had received a month's supply of tablets amounting to 30, and two patients had received 60 tablets to take them over a similar period. None of these patients was under 30 and most of them were in an older age group. I have written to the S.M.O. asking him why he had to go to the bother of reminding me of the patients to whom I prescribe this drug—I keep my own notes—and what was the purpose of writing to me. I am awaiting a reply.

I have been in practice a good many years now, and am thankful to say that I am still interested in my job, and hence still have an interest in my patients. Over the years I have had several patients who have killed themselves with barbiturates and one is quite distressed, and even feels a sense of guilt, when this happens. I now avoid barbiturate hypnotics whenever possible, and I am very pleased to report that I have yet to have a suicide from Mandrax. I am aware that a small minority—I believe mainly among the younger generation—abuse this drug, but I do not think that this is a contra-indication for depriving the greater majority of a very useful drug.

Ivory tower boffins nauseate me, and if they wish to do something constructive in the field of drug abuse there are more useful and practical ways of trying to cope with the problem—for example, the patient who goes around the town getting his (or her) drugs by pretending to be a "temporary resident."—I am, etc.,

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Gastroenteritis of Infancy

SIR,—I was most interested in Dr. A. G. Ironside's lucid article (3 February, p. 284) but did not agree with his recommendation that electrolyte solutions should be used in the oral management of infants with gastroenteritis. In the University Hospital of the West Indies in Jamaica, where gastroenteritis is frequent, oral electrolytes were formerly used—either Darrow's or Hartmann's solution. For the past 10 years oral glucose in water has been used in both in- and outpatients with excellent results, and there has been at no time any indication to change back to the former treatment. Babies will take 5% glucose in water easily while they refuse electrolyte solutions, which taste unpleasant. Hypernatremia is likely to occur when electrolyte solutions are abused at home. The mother is as likely to abuse electrolyte tablets as to give too strong solutions of glucose. Twenty-four hours of

clear fluids is long enough for a patient treated at home, and the introduction then of half-strength milk feeds will soon repair the electrolyte loss. There is evidence that 5% glucose itself promotes the absorption of electrolytes.—I am, etc.,

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Pulmonary Oedema in Pulmonary Thromboembolism

SIR,—I was very interested in the letter of Drs. W. J. Windebank and F. Moran (24 February, p. 485). I am aware of the work of Megibow *et al.*¹ concerning pulmonary oedema complicating experimental pulmonary embolization in dogs.

I found² that when producing embolization in dogs with either glass spheres or lycopodium spores pulmonary oedema was an invariable complication when roughly two-thirds of the lung's arterial supply was occluded, provided that the right ventricular output was maintained. Under these circumstances the pulmonary "wedged" pressure rose above that of the osmotic pressure of plasma proteins leading to capillary transudation. Possibly the same mechanism may occur in man.—I am, etc.,

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- 1 Megibow, R. S., Katz, L. N., and Steinitz, F. S., *Surgery*, 1942, 11, 19.
- 2 Daley, R., *British Medical Journal*, 1957, 2, 173.

Congenital Tuberculosis Successfully Treated

SIR,—Drs. D. C. Gordon-Nesbitt and G. Rajan's letter (27 January, p. 233) prompts me to record a similar episode because so few cases have been reported.

A female infant was born in 1955 to a 17-year-old primi gravida at 34 weeks, the birth weight being 4 lb (1.82 kg). At the age of five weeks she developed an enlarged left preauricular lymph node followed next day by a left aural discharge. Because treatment with intramuscular penicillin was ineffective she was referred to an E.N.T. surgeon, who suggested the possibility of tuberculous mastoiditis. A choroid tubercle was found and the chest x-ray showed changes suggestive of miliary tuberculosis. Antituberculosis treatment (streptomycin, isoniazid, and para-aminosalicylic acid) was started at nine weeks and continued for six months. She recovered well. The Mantoux test was negative at 7, 9, and 12 weeks, but positive at eight months. At the age of 3 years she developed tuberculous cervical lymphadenopathy for which she received antituberculosis treatment for a further year. Tonsillectomy was performed, but no tubercles were found in the removed tonsils. Apart from a chronic ear discharge, she is now well, aged 17 years.

Her mother developed fever a week post-partum, but it was not until the diagnosis had been established in her baby that a chest x-ray showed miliary tuberculosis. She recovered on antituberculosis therapy and has remained well ever since, having had two more children, both healthy. The first baby had been separated from the mother since birth and nursed in isolation in the special care baby unit, thus fulfilling Beitzke's criteria for diagnosis of congenital tuberculosis.¹ Unfortunately the placenta was thrown away.

Thus it is not always true that the mother dies if her baby develops congenital tuberculosis. It should be added that the tubercle bacillus does not cross the placenta, but the latter becomes involved in the miliary

spread of the disease in the mother. A tubercle then ruptures into the fetal circulation or infects the amniotic fluid.²

I am grateful to Dr. Arthur, consultant paediatrician, Derby Group of Hospitals for looking up my old notes of this baby and to Dr. W. Hillary, general practitioner, Derby, for giving me an up-to-date report on the mother and her baby.

—I am, etc.,

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- 1 Beitzke, H., *Ergebnisse der gesamte Tuberkuloseforschung*, 1935, 7, 1.
- 2 Benirschke, K., and Driscoll, S. G., *The Pathology of the Human Placenta*, p. 368. New York, Springer-Verlag, 1967.

Consultants' Superannuation

SIR,—As chairman of the B.M.A. Compensation and Superannuation Committee and as a regional consultant, I deplore the fact that it is necessary for me to seek to use the correspondence columns of the *B.M.J.* to comment on the critical report on the superannuation provisions for hospital doctors, and the part the Association has played in securing improvements, which has recently been circulated widely by the Regional Hospitals' Consultants and Specialists Association in a document entitled "Pension Perspectives—Report on Pensions."

It is surprising to me that this criticism should have been made at a time when wide-ranging improvements in the superannuation of hospital medical staffs are just being implemented after long, involved negotiations between the B.M.A. and the Health Departments. I would not pretend that the position is now entirely satisfactory. Certain of the Association's objectives in the field of superannuation which were drawn up in 1969 with independent expert advice have not yet been achieved, and we have renewed our representations to the Health Departments on these matters. Nevertheless, substantial advances have been obtained, perhaps greater than at any one time in the past, and I would submit that it is not unreasonable to have expected some recognition of this fact in the R.H.C.S.A. document.

I appreciate that superannuation and the funding of pension schemes is a complex subject and, as the one primarily responsible for the negotiations on behalf of the profession with the Health Departments, I would have welcomed an opportunity to comment on the R.H.C.S.A.'s understanding of the situation before the document was published. For its actuarial advice the B.M.A. retains the services of one of the leading firms of consulting actuaries in the country and, having taken their advice, I feel obliged to write to you pointing out that the R.H.C.S.A.'s report contains numerous mis-statements and very optimistic actuarial projections. Accuracy has been sacrificed for emotive appeal.

To give but two of several possible examples, the report lists one of the most serious defects of the N.H.S. Superannuation Scheme as "the confiscation of pension rights for doctors . . . who have voluntarily left the scheme before retirement age, even after a great many years' service." Anyone who has read the B.M.A.'s published statements on the recently negotiated improvements² or the Health Department's official