

Certainly the general practitioner of the future has a proper part to play in an integrated maternity service, accepting with all other participants, including the consultant, a proper measure of responsibility for the aspect of the service that he is best trained and qualified to undertake. An awareness of individual responsibility and limitation should remove completely any thought of "loss of face." Further education of the patient seems to me to be a necessary part of the responsibility of us all.—I am, etc.,

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SIR,—I am sure that the article by Dr. K. L. Oldershaw and Mr. J. M. Brudenell (13 July, p. 112) describes an exemplary pattern for the future organization of general-practitioner obstetrics. While I do not agree with every detail of their plan, I can support their views about the many advantages of a combined general-practitioner/consultant unit under the same roof. The Horton Maternity Hospital in Banbury has 27 beds under consultant care and 10 beds under general-practitioner care. The unit has been in operation for seven years with very happy results in terms of the amicable relationships between hospital medical staff, general practitioners, and midwives.

7,694 babies have been born with an overall perinatal mortality rate of 26.9 per 1,000. There has been only one maternal death, and that was due to a massive pulmonary embolus. District midwives deliver their own cases in the unit and take them home soon afterwards. All patients pass through the same labour suite and there is close co-operation between the different groups of staff. A 48-hour discharge scheme appears to work satisfactorily.—I am, etc.,

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Phenmetrazine Psychosis

SIR,—Phenmetrazine, an anorectic drug, but also a psychostimulant, may create habituation and sometimes dependence.¹⁻⁴ Consequent to the abuse of phenmetrazine, psychotic states have been described that do not have the classical character of exogenous reactions but stimulate an endogenous psychosis. Recently we had the occasion to follow up such a case.

The patient, a woman aged 36 years, without any particular personality premorbid traits, began to take phenmetrazine six years previously to get thin (she had put on weight after childbirth). Although she lost weight after six months of drug-taking, she continued to take about six to eight 25-mg. tablets a day without being able to explain coherently why she did so (phobic fear of putting on weight appears to have played a part). She maintained that for 18 months she had been followed, photographed by stealth in the street, deceived by her husband, spied upon, and persecuted in her office, so that she changed her job several times and finally gave up her professional activity. At home she behaved suspiciously, withdrew from the others, became rigid and even hostile towards her children. Lately she had reached a considerable state of emaciation. Her dress

emphasized her gauntness and her make-up was gaudy. Finally she broke off all relations with the outside world. She was admitted to hospital against her will and kept on a drug-free diet; after 3-4 days she grew anxious, restless, hallucinated. These phenomena disappeared within a few days (abstinence syndrome), but she continued to be strange, rigid, and delusive, trying to dissimulate her delusion. Treatment with haloperidol and electric shock was followed by complete remission in the course of a month, and this remission was maintained after six months, during which time she did not take up phenmetrazine again.

Like amphetamine psychoses (with whose psychopharmacologic action phenmetrazine has many points in common), phenmetrazine psychoses frequently show the picture of a paranoid syndrome, with or without hallucinations accompanied by anxiety or depression (more seldom elation).⁵⁻¹⁰ In most cases psychosis disappears a few days or weeks after suppression of the drug. Cases with influence delusion, feelings of passivity, or incongruity of affect (as in our case)—that is, with a more clearly defined schizophrenic symptomatology—have seldom been reported.⁸

In view of the use and abuse of phenmetrazine, which appears to have become increasingly widespread, and of its addictive and psychodysleptic potential, measures of control in the use and caution in the prescription of the drug should be obligatory.—We are, etc.,

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REFERENCES

- Radmayr, E. P., *Wien. Klin. Wschr.*, 1959, 71, 374.
- Clein, L., *Brit. med. J.*, 1957, 1, 282.
- Takács, L., *Psychiatr. Neurolog. Med. Psychol.*, 1965, 17, 183.
- Bethell, M. F., *Brit. med. J.*, 1957, 1, 30.
- Glatt, M. M., *Brit. med. J.*, 1957, 1, 460.
- Evans, J., *Lancet*, 1959, 2, 152.
- Schulz, E., *Offenst. Gesundheitsd.*, 1961, 23, 287.
- Quadbeck, G., and Schmitt, W., *Arzneimitt. Forsch.*, 1966, 16, 247.
- Simma, K., *Wien. Klin. Wschr.*, 1960, 72, 177.
- Wittstock, P., *Nervenarzt*, 1967, 38, 39.

ostomy. The use of pancreatic extracts is recommended in replacement therapy in the neonate after surgery.—I am, etc.,

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Pain in the Face

SIR,—In his instructive article on facial pain, Professor Henry Miller (8 June, p. 577) refers to the use of Tegretol (carbamazepine) as an effective agent in the treatment of trigeminal neuralgia, and implies that failure to respond to this particular drug is likely to be the sole reason for referrals to the neurosurgeon. It should not be forgotten, however, that a considerable measure of therapeutic success has previously been achieved using Epanutin (diphenylhydantoin), and that occasional cases of post-hepatic neuralgia also respond, in respect of the paroxysmal pain.¹

Recently I have obtained satisfactory relief of pain in two patients who had been hospitalized with a view to possible Gasserian gangliotomy, with considerable reluctance because of their ages, 75 and 80 years respectively. Each had been treated on occasion with either Epanutin or Tegretol, but continued to have incapacitating trigeminal neuralgia. However, both responded completely to a trial of these drugs in combination (Tegretol 200 mg. plus Epanutin 100 mg., t.i.d.), an experience which suggests that the neurologist may be able to reduce even further the number of cases which he has to hand over to his neurosurgical colleagues.—I am, etc.,

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REFERENCE

- Braham, J., and Saia, A., *Lancet*, 1960, 2, 892.

Oral Contraceptives and Post-partum Symptoms

SIR,—In the article by Drs. A. Nilsson and P.-E. Almgren (25 May, p. 453), the authors suggest that oral contraceptives are directly causative in the increased post-partum incidence of neurasthenic and depressive symptoms of their patients. The authors remark that "It is not possible to establish with certainty why some women were prescribed contraceptive tablets while others did not choose this technique." And later, "It is, however, probable that those who received oral contraceptives were more anxious to use a safe method."

These unknown factors direct attention to the subjects' attitudes toward their new babies. While there was no statistically significant relationship between choice of contraceptive method, post-partum symptoms, and desire for yet another child, there are no data on the patients' feelings about the children they have just borne, and who were presumably in the centre of their mothers' lives at the time of post-partum interview. It does not appear correct to exclude without investigation this potentially relevant psychological variable in the causation of an increase

Pancreatic Extracts in Cystic Fibrosis

SIR,—I would like to join Drs. A. P. Norman and I. S. E. Gibbons's plea for the use of pancreatic extracts in the treatment of childhood cystic fibrosis (8 June, p. 621).

Recently I operated on a case of meconium ileus and found the classical picture of 18 in. (45 cms.) of distended terminal ileum with putty-like meconium and hard pellets. This was evacuated through an enterostomy after irrigation with 1% hydrogen peroxide solution. The proximal colon was also irrigated to the hepatic flexure.

Post-operative progress was stormy, and apart from a little khaki jelly-like mucus there was no true bowel action for five days. Pancreatic extracts were given orally, and within 24 hours a bowel action was obtained which was the normal neonate green colour. Pancreatic extract has been given orally since, and the child has gained weight satisfactorily. His stool has a low fat content, and the bowel actions have decreased in number.

Reviewing his treatment after, I regretted that I had not left a solution of pancreatic extract in his ileum before closing the enter-