missing in the eclamptic condition. In the urine, serum, and saliva of the eclamptic patient thiocyanic acid—a product produced by the detoxication of HCN—is significantly raised. For instance, in the 24-hour urine it amounts to 0.15 to 0.35 g. (normally 0.03 to 0.05 g.), as precise qualitative and quantitative analyses have incontestably proved. For the rough clinical test the deep red colour obtained on the addition of diluted ferric chloride to the urine or saliva, which flow amply from the mouth during a fit, is sufficient.

The conversion of cyanide into thiocyanide—the actual detoxication—can be successfully brought about with the help of thiosulphate and/or cobaltinitrate. The specific action of the HCN is annulled by the nascent sulphur which combines with the cyanide radical when sodium thiosulphate is administered intravenously. Thus the noxious element of eclampsia is neutralized. In the pre-eclamptic, a few intravenous injections of 5 ml. of a 2½% sodium thiosulphate solution suffice. In severe cases, intravenous injection of 2 ml. of a 50% sodium thiosulphate solution in 10 ml. of a 20% dextrose solution are administered one to three times daily. The fits stop gradually or at once. There are no side-effects. In mild cases, one injection every second day is sufficient. Of 34 cases, including some seemingly moribund women, where this method was used, 32 were cured, followed by successful termination of the pregnancy.

The claims made by Grauert are so definite that the method deserves to be subjected to tests in this country.—I am, etc.,

London, W.1. ALBERT W. BAUER.

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[1] *Diet in Gynaecology and Obstetrics*, 1934, Urban and Schwartzenberg, Vienna.
[2] *Münch. med. Wschr.*, 1954, **96**, 719.

## Tetanus Immunization

SIR,—In your annotation "Tetanus Immunization" (*Journal*, January 29, p. 278) you mention the difficult task of weighing the risks of horse serum against those of tetanus. Surely the risk of serum reactions would be greatly diminished by the routine subsequent active immunization of all patients who have received tetanus antitoxin. They would then just be given a booster dose of tetanus toxoid if prophylactic measures were required on a subsequent occasion (reactions following the injection even of tetanus toxoid do, however, rarely occur).

I do not know how many casualty departments pursue such a policy, which presents certain administrative difficulties, but it is a policy which we have in mind for the rather injury-prone population of a colony for mental defectives. It is to be hoped that the triple vaccine (whooping cough, diphtheria, tetanus) will prove its value and become more widely used. In the meantime, following the recommendation of Mr. T. C. J. O'Connell, referred to in your leading article (*Journal*, January 15, p. 154), football players might be added to the list of groups carrying a special risk of tetanus and thus being worthy of active immunization.—I am, etc.,

St. Albans. M. P. NELSON.

## Operator and Anaesthetist

SIR,—I think Dr. E. Schofield (*Journal*, February 5, p. 351) is either very unfortunate or else he grossly overstates his case. He says that competent dental anaesthetists "outside London and one or two other centres . . . do not exist."

I admit that the art and technique of dental anaesthesia in the chair is not an easy one to acquire, but it has a fascination of its own and it has attracted the attention of some of the most active minds among anaesthetists. The literature on the subject is copious and there must be few places in Great Britain where there is not someone who has not given thought, attended demonstrations, and acquired some proficiency in the art of dental anaesthesia.

The remuneration under the N.H.S. is inadequate, but many dental surgeons do their best to mitigate this by grouping their gas cases at a time convenient to the anaesthetist of their choice. By such co-operation I feel sure Dr. Schofield could avoid the added risk and heavy responsibility that he incurs in acting as both anaesthetist and operator in the majority of his cases.—I am, etc.,

Hove, 2. REX BINNING.

SIR,—Dr. Eric Schofield has some very useful points to make in his letter (*Journal*, February 5, p. 351) on the subject of dental anaesthesia. There is, however, one part of his letter which I feel cannot pass without comment.

As a final-year student I feel qualified to write on current instruction in at least one big London teaching hospital. Dr. Schofield will, I am sure, be glad to know that there at any rate all medical students get special instruction in dental anaesthetics during their three-month appointment on anaesthetics in general. The instruction includes lectures and clinical work consisting of the giving of between 15 and 20 dental anaesthetics. Incidentally, they are also instructed in local dental analgesia and the extraction of teeth—including practical experience of both.—I am, etc.,

London, W.14. J. ZORAB.

## A Case of Phaeochromocytoma

SIR,—The pre-operative localization of a phaeochromocytoma is important in determining its surgical approach. In the patient described by Mr. R. A. C. Owen and Dr. G. H. Murray (*Journal*, February 5, p. 331) *x*-ray examination after perirenal air insufflation failed to show a tumour which at operation was found to be 3 in. (7.6 cm.) in diameter. As they imply, perirenal insufflation often fails to achieve its object, and in addition it carries a very definite risk of an air embolism.

Retroperitoneal (presacral) pneumography is a much more satisfactory alternative, its advantage being that both kidneys and suprarenal regions can be visualized with a high degree of certainty, and it is free from the risk of air embolism.[1] The procedure as described by Blackwood[2] was used in a case previously reported by my colleagues and myself.[3] No difficulty was experienced, and the result was entirely satisfactory, since not only was the tumour accurately localized but the contralateral suprarenal was seen to be normal in size and contour. For the pre-operative localization of a phaeochromocytoma retroperitoneal pneumography is, in contrast to perirenal air insufflation, a safe and a more reliable investigation.—I am, etc.,

Nuneaton. A. C. KENDALL.

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[1] Ruiz Rivas, M., *Amer. J. Roentgenol.*, 1950, **64**, 723.
[2] *Brit. J. Surg.*, 1951, **39**, 111.
[3] Israelski, M., *et al.*, *Arch. Dis. Childh.*, 1954, **29**, 18.

## Chloroquine Sulphate in Chronic Discoid Lupus Erythematosus

SIR,—We read with interest the article by Dr. H. J. Lewis (*Journal*, February 5, p. 329) on chloroquine sulphate in the treatment of chronic discoid lupus erythematosus. His results agree with our own published a year ago.[1] Since the publication of these, further trial with chloroquine sulphate has confirmed our opinion that it is the drug of choice in early cases of chronic lupus erythematosus.

We also note with interest his findings regarding the erythrocyte sedimentation rate (E.S.R.) during treatment. One of us[2] used this test in a series of 85 cases of chronic lupus erythematosus and found that as the disease improved the E.S.R. gradually decreased. It was shown that special attention should be paid to cases in which an E.S.R. of 10 mm. or over remained after apparently successful treatment, as these cases were most prone to relapse.—We are, etc.,

G. HARVEY.
T. COCHRANE.

Glasgow, C.4.

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[1] *J. invest. Derm.*, 1954, **22**, 89.
[2] Cochrane, T., *Arch. Derm. Syph.*, 1951, **63**, 323.