hyperplasia of the thymus. I then observed that the rationale of adrenocortical replacement therapy by means of cortisone and the need for damping down the pituitary (and most probably hypothalamic) hyperactivity appeared to be rational. Chlorpromazine would achieve the latter purpose, but, in the light of the well-known hepatic failure already present in thyroid crisis, should be used with extreme caution.—I am, etc.,

London, W.1. T. LEVITT.

REFERENCES

1 Ransom, H. K., and Bayley, R. H., *West. J. Surg.*, 1934, **42**, 464.
2 Foss, H. L., Hunt, H. F., and McMillan, R. M., *J. Amer. med. Ass.*, 1939, **113**, 1090.
3 Levitt, T., *The Thyroid*, 1954, p. 271. E. and S. Livingstone, Edinburgh.

Ban on Heroin

SIR,—The only point on which I agree with Dr. C. W. Walker (*Journal*, January 21, p. 170) is that heroin is a dangerous drug. A revolver is also dangerous, says Dr. Walker. So is a scalpel, say I, but are we to restrict surgeons to the use of blunt instruments because we cannot trust them to be careful? Are doctors to be robbed of what they consider to be a valuable drug because its careless use would be dangerous? Heroin can be prescribed by any qualified practitioner; that they can be thoroughly trusted with such a blessed weapon is proved, whatever Dr. Walker may try to persuade us to the contrary, by the fact that heroin addicts in this country amount only to one in a million of the population.

In pontifical tones he exhorts you, Sir, to "remember that the Government represents the people who are our patients, and that we are the servants of our patients and not their masters." We are only their servants in that our skill is at their disposal. It is the doctors who order the drug, not the patients. The public are in no need of Government protection, and, if Dr. Walker thinks so poorly of his colleagues that they cannot be trusted to control the treatment of their patients, the sooner he ceases to serve on the Standing Medical Advisory Committee the better it will be for the doctor–patient relationship. In order to leave us in no doubt as to how irresponsible he considers doctors to be, he ends his letter thus: "Because of the propaganda and publicity of the last few months, I prophesy that, if the manufacture of heroin is not banned in this country in 1956, within ten years the B.M.A. will lead the whole profession in demanding the ban."

For my part, I hope we shall see an increase in the medical use of heroin. Some doctors may have forgotten its merits, some young ones may never have known them. I have quite enough confidence in my profession to be sure that if we ever have a heroin addiction problem here it will not come about through improper prescribing. But with great confidence I predict that if Dr. Walker has his way and the legal manufacture of heroin is banned, in ten years' time the pedlars will have seen to it that addicts are numbered in thousands instead of dozens. Anyone who troubles to look at what has happened in other countries in the case of heroin, or who follows the pattern of the results of prohibition in general, will see that this would be the almost inevitable result of such a ban.—I am, etc.,

London, N.W.1. R. HALE-WHITE.

Birth Trauma

SIR,—In an otherwise excellent article I feel I must raise a voice of protest against the opening words of Dr. A. P. Norman's "Birth Trauma" (*Journal*, January 7, p. 37), in which he says, "Birth is a traumatic process . . ."

The definition of trauma is "morbid condition of body produced by wound or external violence," and I am sure many women who have brought forth their babies without injury to either their babies or themselves would object strongly to such a term. To apply this adjective without qualification to the natural function of childbirth reveals, in my opinion, a wrong attitude of mind which will eventually lead us to discussing "Defaecation is a traumatic process . . ."—I am, etc.,

Birmingham. H. S. SPILLER.

SIR,—I am surprised to read in Dr. A. P. Norman's article on birth trauma (*Journal*, January 7, p. 37) that in asphyxia neonatorum "so-called respiratory stimulants are of little or no value," and that "no way is known of hastening its [the respiratory centre's] recovery." In fact there is nothing in medicine more dramatic, convincing, and satisfactory than the effect of "cardiazol (leptazol)-ephedrine" in severe asphyxia neonatorum, as I wrote in the *Practitioner*.[1]

Last year I attended a postgraduate session on the subject at which the lecturer spoke just as Dr. Norman writes. When I asked about cardiazol-ephedrine he said lamely, "I did not know you were in the audience, but I wasn't saying much about drug treatment." Afterwards he came up to me and said that when in practice he had actually used it with success, "but of course we don't use it in hospital." Yet nothing is more important than to get a baby breathing quickly and well, which is what cardiazol-ephedrine usually does in less than a minute. Incidentally, the person with whom I sat down to tea said that she also had used it several times with excellent results.

I would like to ask Dr. Norman quite bluntly whether he has ever used cardiazol-ephedrine, and if not why not? Parts of his paper make me wonder whether he has even read or tried to understand Barcroft's famous researches, and if he will read my paper he will see that my work was done in close co-operation with him. The majority of neonatal deaths are associated with asphyxia, and I believe that cardiazol-ephedrine would prevent many, if not most, of these. If obstetricians knew, as my wife and I know, what it is to have a baby stillborn they would not so airily neglect what is the simplest, most physiological, and I believe the safest way of treating asphyxia neonatorum. A practitioner can use it anywhere, and until some better preparation is found everyone who does obstetrics should carry it in his bag.

While writing of obstetricians, may I refer to Dr. R. E. Tottenham's letter on vitamin A and hyperkeratosis (p. 46), and point out that the new *National Formulary* contains capsules vitamin A of the same strength as "ro-a-vit" tablets, together with a reference to their use in hyperkeratotic conditions, especially those conditions of harsh skin which cause so much distress to young females particularly, and which can usually be so easily relieved by this therapy.—I am, etc.,

Winsford, Cheshire. W. N. LEAK.

REFERENCE

1 Leak, W. N., *Practitioner*, 1953, **171**, 653.

Acquired Haemolytic Anaemia

SIR,—I read with interest the account of two patients suffering from acquired haemolytic anaemia described by Dr. W. Weiner *et al.* (*Journal*, January 14, p. 73). Both cases showed an anti-E antibody and their haemolytic crises were satisfactorily controlled with liberal doses of cortisone. I now report a similar patient suffering from acquired haemolytic anaemia who also had a circulating anti-E antibody who did not respond to liberal doses of cortisone but was satisfactorily treated with prednisolone.

A man, aged 39, was seized with acute pain in the left side of the chest 5 days prior to admission to hospital. He rapidly became jaundiced and suffered from pallor, fatigue, dyspnoea on exertion, and giddiness. On examination the skin was jaundiced and there was icterus of the conjunctivae. The spleen was enlarged two fingerbreadths below the costal margin. The rest of the physical examination was negative.

Investigations.—Blood: R.B.C. 2,280,000 per c.mm. Hb 57%. W.B.C. 23,400 per c.mm. (polymorphs 49.5%, eosinophils 0.5%, lymphocytes 18%, monocytes 1.5%, reticulocytes 28%). The red cells showed marked anisocytosis and polychromasia. Some nucleated red cells were also present. R.B.C. fragility: Haemolysis commenced at 0.75% NaCl and was completed at 0.30% NaCl. Mean corpuscular fragility: 0.47% NaCl. Siderocytes, 2.4%; Heinz bodies, nil; Ham's (acid serum) test, negative; Donath–Landsteiner test, negative; direct Coombs test, strongly positive; direct Van den Bergh reaction, negative; blood group, O, Rhesus-positive; chest *x*-ray, negative; blood cultures were sterile.