Barbiturate Deaths

SIR,—I should like to comment on the letter by Dr. S. Locket (*Journal*, December 12, 1959, p. 1332). There is certainly no control study on the use of bemegride in the treatment of barbiturate poisoning. A control study in this field would be virtually impossible. There are, however, nearly 200 papers dealing with this matter, all of which are favourable. One must therefore give considerable weight to this clinical evidence, otherwise one must say that only Dr. Locket is in step. Dr. Locket then says that he does not know of any work in man which suggests that bemegride by mouth shows any activity whatsoever. It is apparent that Dr. Locket does not read your excellent journal or he would have seen (*Journal*, December 28, 1957, pp. 1509 and 1514) controlled experiments which show that bemegride does prevent signs of barbiturate overdosage when both drugs are given orally.

Since this time we have continued with our experiments in the use of barbiturate-bemegride mixtures for sleep therapy in which doses of up to 4 g. of barbiturate with 10% bemegride are given as often as thrice daily for periods up to three weeks. These patients do not present nursing problems. It would appear that Dr. R. Neville (*Journal*, November 21, 1959, p. 1096) has had similar experience. Dr. Locket is quite unjust in suggesting that Dr. D. T. Heffernan's patient (*Journal*, November 21, 1959, p. 1097) did not take the barbiturate-bemegride mixture. Our results, quoted above, definitely show that as more and more of the mixture is taken the narcotic effect is less and less, and Dr. Heffernan's experience is just what one would expect. Once again out of all the published literature Dr. Locket is the only one to suggest that bemegride may be disadvantageous. Its respiratory stimulation action in barbiturate poisoning has been observed and reported so often that it could not be a figment of the imagination.

To sum up, it has always been the contention of those who use bemegride that it has less benefit for the lessening of coma than for the production of normal respiration and circulation, which results in a patient requiring less nursing care and less worry and expense. The cutting short of the coma depends upon so many other circumstances, and is itself of little importance. The use of artificial respiration and the artificial kidney as advocated by Dr. G. E. Honey and Dr. R. C. Jackson (*Journal*, November 28, 1959, p. 1134) most certainly yielded results, but it does remind one of the old adage of "taking a sledge-hammer to crack a nut." —I am, etc.,

F. H. SHAW.

Department of Pharmacology,
University of Melbourne,
Australia.

Identification of Tablets

SIR,—Dr. J. D. W. Whitney's excellent article (*Journal*, January 2, p. 50) draws attention to what has long been a frightful nuisance to the G.P. It has always seemed quite ridiculous to me that all tablets are not clearly marked by the manufacturer so that they can easily be identified. It is infuriating to be called to the sick-room and there be confronted with the usual pile of mysterious packets of pills. In a chronic illness a large mound of them soon accumulates in the medicine cupboard, and unless they are carefully labelled right from the start—and they seldom are—soon no one, family or doctor, knows which is what; or at best we can only guess.

Dr. Whitney seems to think it is all wrong for the patient to know what the tablets consist of. Why on earth should it be so? Does not this attitude of mystery encourage the mumbo-jumbo atmosphere which surrounded our Victorian predecessors and which we, in this scientific day and age, should be trying to shake off? I always encourage my patients to take an intelligent interest in their treatment, and to have at least a working knowledge of what drugs they are receiving and why. In any case the patient has only to glance at the prescription you hand him to decipher for himself what drugs you are prescribing. In the age when medical treatment consisted of little but reassurance, good nursing, opiates, and elegant placebos such mumbo-jumbo may have been justified, but nowadays it seems as ludicrously old-fashioned as frock-coats, leeches, and blood-letting.

I say let us make it compulsory for all tablets to be clearly stamped with the name. The only surprising thing to me is that doctors and chemists have not long ago put their heads together and solved the problem. Most proprietary names of drugs are mercifully short and could easily be embossed on the face of the tablet. With the longer names they could be stamped round the circumference. The strength (which is almost as important) could be stamped on the reverse side. In the case of some of the longer tongue-twisters of official names an agreed shortened version could easily be arranged for (those over 12 letters, for instance). Dr. Whitney's elaborate system of a code of numbering is far too complicated and in my opinion quite unnecessary. It would cause much inconvenience fiddling about with lists of drugs which would constantly have to be changed and brought up to date as new drugs appeared.

I would also like to see the chemist obliged to put the name on the pillbox; and on the bottle of medicine too, if it comes to that. Polypharmacy is dead. Let us be realistic about modern scientific medicine and say good-bye to mumbo-jumbo!—I am, etc.,

Merioneth. CLAUD C. M. WATSON.

SIR,—I read with interest and some astonishment of Dr. J. D. W. Whitney's suggestions for the identification of tablets (*Journal*, January 2, p. 50). Rather than embark upon a complicated system of marking tablets, why not instruct the chemist, by adding the letters "N.P." (*nomen proprius*) after his prescription, to label the container with the name and strength of the tablets. The patient, of course, will get to learn the name of the tablets.

The days when medicine and tablets were held to hold some magic properties that only the clever doctor knew about should now be past and done with. The majority of patients are now sufficiently well educated, intelligent, and encouraged to understand the nature of their complaints and the way the doctor is endeavouring to help them in their troubles. Just as a doctor would say, "I am going to bandage your ankle, because it is sprained and needs support," or, "I am giving you a special diet to help you reduce your weight, because it is excessive," so he should say, "I am giving you some tablets called digoxin, which will help to regulate your heart beat, and some other tablets called phenobarbitone which will soothe your nerves and help you to sleep."

I believe that this should now constitute the modern approach with the majority of patients, who will leave

the surgery satisfied because they know what they came to find out and are ready to co-operate because they understand what the doctor's medicine will do to help them. There will also disappear that doubt as to the nature of the tablets in the box, because the box will be labelled of its contents.—I am, etc.,

Derby. E. C. DAWSON.

SIR,—Dr. J. D. W. Whitney (*Journal*, January 2, p. 50) has holed in one. Such a step is long overdue. However, the Ministry of Health seem to be dead set against identifiable tablets, on the grounds that patients come back and ask for the same again. This seems to me the *only* real difficulty.—I am, etc.,

Bolton, Lancs. RALPH GOULD.

Treatment of Pilonidal Sinus

SIR,—The recent correspondence on "pilonidal sinus" has not brought out the fact that three quite different conditions are at present confused together under this name. (1) The chronic infection of hair follicles, the treatment of which has been discussed at length. The Army term of "jeep disease," derived from its frequency in those bounced about on hard seats, explains its pathology. (2) The form of spina bifida better described as "spinal dermoid sinus." This is very dangerous, because the skin-lined tube often communicates direct with the dura, with consequent liability to meningitis or myelitis. (3) The very common "coccygeal dimple," in series with those which occur wherever a bony point has been in contact with the uterine wall—e.g., the knuckles or outer condyles of the elbows. The tissues are pressed down on these points and adhere to them, so that when the surroundings rise up with the accumulation of subcutaneous fat they are left as depressions. The more the fat and the sharper the point the deeper and narrower the dimple.

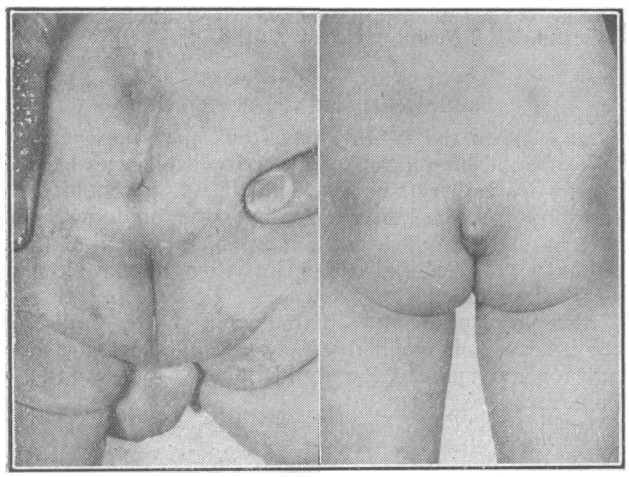

FIG. 1 FIG. 2

FIG. 1.—Dermoid sinus (upper opening) and coccygeal dimple.
FIG. 2.—Deep dimple over posteriorly directed coccyx.

Fig. 1 is a rare case showing a dermoid sinus and a coccygeal dimple present together. The upper opening has the haemangiomatous staining of the skin around it which is often found overlying spinal deformities. Fig. 2 shows an exceptionally deep dimple over a coccyx turned backwards instead of forwards.—I am, etc.,

London, W.1. DENIS BROWNE.

Congenital Dislocation of the Hip

SIR,—Facts and figures should speak for themselves, so perhaps one person's experience of "hip hunting" over a period of ten years may be of interest.

About three out of four babies attend the child-welfare centres in England and Wales.[1] During a period of ten years (April, 1949, to April, 1959) about 4,500 infants under 1 year attending such clinics in a particular area were examined, consecutively and frequently, with the intention of spotting congenital dislocation of the hip before the mother did. Nine cases were found—the average age at diagnosis being 5½ months, but only three of these were diagnosed at the first routine examination. During the same period four children who had been brought to the clinics because the respective parents were worried about their children's inability to crawl or walk, or because of a painless limp, were found to have congenital dislocation of the hip. The average age at diagnosis of these four cases was 14 months. Of the total of 13 cases of congenital dislocation of the hip, 11 had been born in hospitals, one in a nursing-home, and one at home. All 13 cases were referred to the orthopaedic department of one children's hospital for treatment.

During the last ten years I have met three middle-aged mothers who still have to live with their dislocated hips because diagnosis was made too late. Oddly, only one of the three required caesarean section at confinement.—I am, etc.,

Wembley, Middlesex. R. A. STRANG.

REFERENCE

[1] *Britain—An Official Handbook*, 1956, p. 334. H.M.S.O.

Cauda Equina Syndrome

SIR,—We must all be grateful to Mr. R. H. Shephard (*Journal*, December 26, p. 1434) for drawing renewed attention to the little-recognized fact that a central lumbar disk protrusion can erode and finally rupture the posterior longitudinal ligament. In consequence the whole cauda equina suffers compression, the impact being borne proximal to the ganglion in the case of the fourth sacral root. Palsy here may thus prove irremediable, permanent incontinence resulting.

He rightly stresses the dangers of manipulation in these cases. "A complaint of frequency of micturition, paraesthesiae felt in the scrotum, saddle numbness at the buttocks or insensitiveness of the rectum naturally suggests pressure on the fourth sacral root. These symptoms call for immediate laminectomy and provide an absolute contraindication to manipulation."[1] The fact that these cases can usually be picked out in advance is well illustrated by a patient with sciatica seen in one of my clinics last year by Dr. R. Barbor, then one of my assistants. She was offered laminectomy but asked for manipulation. She was warned that this was contraindicated in her case, special dangers being present. Quite unimpressed, she went off to an osteopath, was manipulated, and was admitted the following day with severe bilateral sciatica and a paralysed bladder. At laminectomy the whole disk was found to have travelled backwards, like a penny out of a slot, with the nerve-roots held against the anterior aspect of the laminae.

Situated as he is at a neurosurgical clinic, Mr. Shephard clearly sees cases when the worst has already happened. Increased awareness of this syndrome