colleges, Ludhiana, takes in an equal number of men and women medical students, and for its 50 places this year had 2,400 applications, a steadily rising number over the past six years.—I am, etc.,

E. GERARD HOUSDEN.

London S.W.19.

Abbreviations

SIR,—I should like to support most strongly the plea by Dr. J. A. Frai (21 December, p. 776) that some attempt be made to standardize abbreviations.

Many abbreviations in current use mean different things to different people—for example, T.C.A. on outpatient notes may mean “to come again”; or, to dermatologists, trichloroacetic acid.—I am, etc.,

E. M. DONALDSON.

Newcastle, Staffs.

Folic Acid and the Nervous System

SIR,—Your leading article on folic acid and the nervous system (21 December, p. 722) repeats the statement that folic acid can precipitate epileptic fits. Dr. I. Chanarin and his colleagues¹ reported one patient who began to have frequent epileptic fits after treatment with folic acid. In a condition so variable as epilepsy this and subsequent evidence² seems insufficient to prove this point. In Reynolds's series the folic acid was stopped after periods varying from 10 days to 22 months. After giving any drug to patients with epilepsy, including barbiturates and phenytoin, there may be an exacerbation of the fits, and the drug may have to be stopped. Little may be known of the causes of this, but they are likely to be complex, and only sometimes the results of toxic side-effects. Certainly it cannot be claimed that barbiturates tend to make epilepsy worse. It would seem much more important to direct attention to the possible risks of folic acid deficiency among patients taking anti-epileptic drugs, and if this is present to rectify it. Although the role of folic acid in the treatment of epilepsy may be unproved it certainly can be given without making the fits worse.³—I am, etc.,

NEIL GORDON.

Royal Manchester Children's
Hospital,
Pendlebury, Manchester.

REFERENCES

- 1 Chanarin, I., Laidlaw, J., Loughridge, L. W., and Mollin, D. L., *Brit. med. J.*, 1960, 1, 1099.
- 2 Reynolds, E. H., *Lancet*, 1967, 1, 1086.
- 3 Gordon, N., *Devel. Med. Child. Neurol.*, 1968, 10, 497.

Revising Psychiatry

SIR,—There can be very few textbooks which achieve perfection in their first edition. Reviewers therefore have a responsibility to point out faults not only to your readers but also to authors, who, if they are sensible, heed these strictures. Neither are all reviews perfect, and, while one should overlook minor errors, it is equally the responsibility of authors to your readers and reviewers alike to answer unfair or misleading comment.

Dr. E. A. Bennet (28 December, p. 817), after a short preamble on the intention of our recent book *Basic Psychiatry*, uses most of his space on the following points.

(1) The lack of an index. To illustrate this deficiency (if I may use this word) he quotes, “The student, puzzled by psychiatric jargon, turns expectantly to this volume to find the meaning of, say, porphyria.” One would have thought that with the recent publicity given by the *British Medical Journal* to porphyria, the royal malady, students and your reviewer would not regard the word as belonging to “psychiatric jargon.” Neither is it a purple passage but the name of a well-known organic disease. It is indeed listed under the section on organic psychiatry at the end of the seventh line (total 8+) between pages 79 and 116. It should not therefore be necessary to scrutinize the first 30 pages of the section. One would start to look for it between pages 105 and 110. As each term in the table of contents refers to a question in the text, the key word of which is in bold type, the question on “porphyria” is readily found on page 108. In a leisurely search I reached it in under 10 seconds.

There are terms and surnames mentioned in the text which are not in the table of contents, but this surely is not a serious criticism; it would be if it was the other way round. The book is meant primarily for people who wish help in passing examinations and a basic, articulate framework for psychiatry. It is not intended to be a psychiatric dictionary.

(2) Dr. Bennet disapproves of the term “mental deficiency” on the grounds that the Mental Health Act (1959) uses the term “mental subnormality.” In our section on legal psychiatry, as he points out, we do use the term “mental subnormality,” but we prefer to confine it to this aspect, for it has not yet achieved general clinical acceptance. In several countries the term “mental retardation” is favoured, yet the specialist journals on the subject still use the term “mental deficiency.” Furthermore, there are many who are mentally defective who are not dealt with under the Act, and it looks as if this number will increase now that education departments will be mainly responsible. Dr. Bennet should know that I am not so conformist as to abandon a well-recognized clinical term because of a recent change in the law. He may disagree, but he has not proved me wrong.

(3) His parting shot, that disorders of pregnancy are not discussed, is only partly true, for under Section 8, p. 133, there are two questions and answers on this subject. The psychoses of pregnancy are not dealt with as such for they approximate to other functional psychoses.

As stated in the preface, *Basic Psychiatry* is intended for the student who needs help in formulating answers to questions in psychiatry and for those who need quick and helpful revision for examinations. I am pleased to note that on these points Dr. Bennet and I are in agreement.

I regret that as my co-author, Dr. E. B. Gordon, is on holiday, I sign this letter.—I am, etc.,

MYRE SIM.

Queen Elizabeth Hospital,
Birmingham.

Use of Word “Blind”

SIR,—I notice in your report (*Supplement*, 30 November, p. 46) of the proceedings of the Ophthalmic Group Committee held on 15 November that a proposal was discussed to substitute for the one word “blind” the two words “visually disabled” in connexion with blind certification, while partially sighted

persons are to be designated “partially visually disabled.” What a mouthful!

What possible advantage can there be in this profuse verbosity?—I am, etc.,

F. J. CURTIS.

Reigate, Surrey.

Cathartic Action

SIR,—The leading article on cathartic action (21 December, p. 723) states the reasons for taking laxatives are hard to determine. I suggest in the elderly the reason is to overcome dyschezia. Bulky food is uncomfortable, and the alternatives to aperients are suppositories or enemata. Why have the chemists ceased to manufacture 1 gr. (65 mg.) cascara sagrada tablets?—I am, etc.,

DUNCAN WOOD.

Hallatrow,
Nr. Bristol.

Wearing Tights

SIR,—I was interested to read my colleague and neighbour Dr. L. Tann's observation regarding the increasing incidence of pruritus vulvae in his practice (21 December, p. 776). I think this must be a common experience of general practitioners at the present time, and further inquiry might reveal that many of his patients are not only wearing tights but also regularly ingesting oral contraceptive drugs.

The increased incidence of vaginal candidiasis in patients on contraceptive steroids is already a well-established example of iatrogenic disease, and in my own practice, out of 121 patients currently using oral contraceptives 13 (11%) had complained of pruritus. In 9 of these vaginal swabs were positive for yeasts (usually *Candida albicans*), although the full clinical picture of vaginal candidiasis was not always apparent.—I am, etc.,

M. J. V. BULL.

East Oxford Health Centre,
Oxford.

Christmas Cracker or Duogastrone Symptoms

SIR,—While I was reading the history of a newly admitted patient on the final ward round before Christmas a loud crack, like a pistol shot, rang out from the other end of the ward disturbing the proceedings. We found no commotion and no weapon, not even a prematurely pulled Christmas cracker. Instead, there was a timid woman of 40, Mrs. A, who called out apologetically that it was her and her capsules. She told us that her general practitioner had prescribed Duogastrone (a special preparation of carbenoxolone sodium), which according to her doctor would dissolve beyond the stomach and heal her duodenal ulcer. She then explained in detail that since taking her capsules a loud shot would occur in her bowels from three to seven hours after swallowing them. She and her husband had many sleepless nights awaiting the “shot” at 2 a.m. after the evening meal at 7 p.m. Two weeks before Christmas the television repair man had called in the afternoon to adjust the set while

Mrs. A sat watching on the settee. Just as he was tuning the set she "exploded." The man dropped his tools and pulled the wires from the socket but could not find any electrical fault. He then turned to Mrs. A and suggested that the metal springs of the settee had broken. Mrs. A, too shy to explain her abdominal secret, let him examine the settee.

The medical and nursing staff and last but not least the patient herself can vouch for the truth of this story, which was not the result of surrender to Christmas spirits. It is felt that this new and somewhat dramatic Duogastrone side-effect should be known to others. We shall indeed be interested to hear if other patients have experienced intra-abdominal shots after taking Duogastrone.—We are, etc.,

C. C. EVANS.
J. B. RIDYARD.

The Royal Southern Hospital,
Liverpool 8.

Drinking Drivers

SIR,—The breathalyser experts seem to have assumed that the path from mouth to stomach is a one-way street. As a result of this, the breathalyser efficiency is about 120%.

The police surgeon and the analyst are thus doing unnecessary work, and this could be reduced with due respect to the Road Safety Act. I stress again that a properly conducted mouth-wash is indicated between the first and second breath tests.—I am, etc.,

JAMES HERD HENDERSON,
Police Surgeon,
Renfrew and Bute Constabulary.

Greenock,
Renfrewshire.

Home Preservation of Food

SIR,—Your leading article (5 October, p. 6) entitled "Home Preservation of Food" is a timely reminder of the dangers of home preservation methods which allow "survival of clostridial spores in a food medium conducive to growth and the production of toxin. . . ." However, spore-forming organisms which may survive boiling for several hours are readily destroyed by temperatures in the region of 240° F. (115.5° C.), and I should like to emphasize that reliable methods are available for the home preservation of vegetables (and fruit).

Ministry Bulletin No. 21, first published in 1929 and revised as necessary from time to time,¹ is a practical handbook which is used widely by home economists, women's institutes, rural domestic economy instructors, teachers, students, and housewives; the methods which it recommends have been proved sound and safe in practice. These include carefully worded detailed instructions for preserving vegetables, using a pressure cooker with an accurate pressure control for 10 lb./sq. in. (0.7 kg./sq. cm.) for the sterilization of the cans and bottles. As far as vegetables are concerned, the British housewife has not been discouraged from preserving, but only from using the wrong methods.

It is also well to remember that while bacteria are inactive at deep-freezing temperatures (0° F. (−18° C.) and below), they

are not destroyed by the process. Thus it is important to ensure that the rate of freezing and the final temperature are always clearly defined, and to stress that frozen foods should be properly handled during preparation in the home.—I am, etc.,

T. J. B. DAWES,
Chief Press Officer,
Ministry of Agriculture, Fisheries and Food.
London S.W.1.

REFERENCE

- ¹ Ministry of Agriculture, Fisheries and Food: Bulletin No. 21, *Domestic Preservation of Fruit and Vegetables*, 1966. H.M.S.O., London.

Bilateral Tension Pneumothorax in Newborn

SIR,—We would like to draw your attention to an unusual and interesting problem which arose when a baby, immediately after birth, developed a bilateral spontaneous tension pneumothorax. The mother had a normal antenatal period, and this was her second child.

This baby boy at birth, following a normal delivery, took two breaths and cried briefly. At this stage he was a normal colour. He then stopped breathing, and rapidly became blue-black in colour. A surgical emphysema rapidly developed, which obliterated his neck, so that he appeared to be like a Michelin tire advertisement. The emphysema spread down over the thorax and the abdominal wall. Over parts of the emphysematous areas the skin became a bright pink in colour, contrasting with the blue-black appearance of the rest of his body. Spontaneous respiration ceased, apart from slight gasping movements, and the heart became inaudible.

An endotracheal tube was passed and mouth-to-mouth breathing commenced. An incision was made into the neck in the midline, releasing some air, but without resulting in any improvement in the baby's condition. An incision was then rapidly made with a pair of scissors into the right thorax, releasing air under tension, and the incision was held open with a haemostat. Following this the baby's colour rapidly improved, the heart became audible and the peripheral pulses were palpable. Artificial respiration continued via the endotracheal tube. A portable chest x-ray confirmed a left pneumothorax.

The baby was taken to the operating theatre. At this stage the baby's colour and general condition were satisfactory. Movement of the right lung could be seen clearly through the right thoracotomy. The left side of the chest was then opened, revealing also a tension pneumothorax. Both thoracotomies were then closed around indwelling intercostal catheters attached to underwater drainage bottles. Following this the baby appeared to be perfectly normal, and his subsequent progress did not give rise to any anxiety. A chest x-ray showed fully expanded lungs.

The right intercostal tube was removed at 24 hours, and the left tube at 48 hours. A further chest x-ray showed that both lungs remained fully expanded. The baby was completely normal on discharge at 10 days old and when seen again after six weeks.

Spontaneous pneumothorax is not uncommon in the newborn period. In 1930, when Davis and Stevens¹ reported on the value of routine radiographic examinations in newborn infants, they found six examples in 702 examinations. The report of Lubchenco² emphasizes the occurrence of pneumothorax in premature infants. Seventeen of the 27 infants she reported were less than 2.5 kg.

birth weight. Solis-Cohen and Bruck³ found eleven pneumothoraces in chest x-rays in 500 newborn infants.

Therefore pneumothorax should be borne in mind as a diagnosis in every case of respiratory difficulty in the newborn infant, and the early recognition of a pneumothorax will be enhanced if a chest x-ray is taken as a routine in all infants with respiratory distress. In our case a clinical diagnosis was made easier by the occurrence of a surgical emphysema. If it had not been for this it is possible that a diagnosis would not have been made in time to save the baby's life. It is interesting to speculate that in the absence of emphysema a necropsy would not reveal the true cause of death.

The orthodox treatment of pneumothorax is to insert a catheter into the pleural cavity by a trocar. It is unlikely, however, in the average maternity unit that the correct instruments, etc., would be available immediately. Inserting a needle into the pleural cavity would be of temporary value in relieving tension, but in our case the gross surgical emphysema made recognition of the normal anatomy almost impossible. However, it is likely that a knife or a pair of scissors would be at hand.

A small anterior thoracotomy is very easy and quick to perform, and it is our suggestion that this is a safe and quick procedure to perform in an emergency.—We are, etc.,

I. V. LISHMAN.
F. MANSFIELD.

Bunbury,
Western Australia.

REFERENCES

- ¹ Davis, C. H., and Stevens, G. W., *Amer. J. Obstet. Gynec.*, 1930, 20, 73.
² Lubchenco, L. O., *Pediatrics*, 1959, 24, 996.
³ Solis-Cohen, L., and Bruck, S., *Radiology*, 1934, 23, 173.

Fluphenazine Enanthate and Schizophrenia

SIR,—The interesting letter of Drs. M. Valentine and H. Trueman (2 November, p. 328) on fluphenazine enanthate prompts me to report my experience with the 100 schizophrenics I have put on the drug so far (20 months). Initially I used doses of 0.5 ml. (12.5 mg.) weekly, and later, because of the incidence of side-effects, at much less frequent intervals—for example, 1 ml. (25 mg.) every three or four weeks. I found that the paranoid schizophrenics responded better than the others, while schizophrenics with affective features, catatonia, or subnormal I.Q. were little, if any, improved.

Nine of the 100 patients are still in hospital being stabilized on the treatment. The remaining 91 have been discharged on a maintenance dose. In 18 (20%) it was subsequently discontinued for the following reasons: extrapyramidal side-effects, 9 patients; psychotic relapse, 4; lack of co-operation, 3; depression, 1; glaucoma, 1. Thus 73 (80%) are presently continuing on the drug, all of them outside hospital except two patients readmitted for social reasons. With 36 of these the following difficulties were experienced, severe enough in 17 cases to cause short-term readmission: extrapyramidal side-effects, 27 patients; psychotic relapse, 3; depression, 4; lack of co-operation, 2.

Thus the total incidence of the extrapyramidal side-effects was 40% (36 patients); of depression (occurring coincidentally with the drug) 6% (5); and of psychotic relapse 8% (7). The depression was moderately severe, and in two