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.
Dunbury,
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

instances gave rise to suicidal attempts. It was always relieved by discontinuing the drug. A mild, ephemeral depression was also observed in several other patients. The disproportionately high incidence of side-effects as compared with psychotic relapses is very striking. While many of these were undoubtedly due to early inexperience in managing doses, and time intervals between injections, it was felt that they were a considerable obstacle to the widespread acceptance of the drug. We found that acute side-effects generally responded to intravenous procyclidine hydrochloride (Kemadrin), and this treatment is always available at the outpatient department in the hospital; benzhexol (Artane) is used for more chronic Parkinsonian side-effects, and promethazine hydrochloride (Phenergan) for akathisia. It is important to recognize side-effects before these give rise to serious disabilities and possibly hospital admission. We are presently trying out a newer preparation, fluphenazine decanoate (Modectate), reported to give fewer adverse effects.

Close collaboration between the nursing staff and local mental welfare services is essential. Several general practitioners have shown a keen interest and volunteered to give the injections to their patients, but otherwise they are given in the hospital outpatient department. Absentees are immediately notified to the appropriate mental welfare officer, who undertakes to bring the absconder to the outpatient department within the next 48 hours. Dissemination of information about the drug is also vitally important to keep everybody informed, avoid misidentification of the more bizarre side-effects—for example, akathisia, as a recurrence of psychosis; prevent patients on it being given oral phenothiazines in error; and dispel all-too-frequent prejudices and misunderstandings. Detailed bulletins about the treatment method are sent to the appropriate general practitioners in addition to the usual discharge letters. Joint case conferences are held weekly for nursing staff, other hospital workers, and mental welfare officers; there are frequent seminars for the nursing staff, and the patients and their relatives, whenever possible, attend an information/discussion group on the treatment day. The resettlement of schizophrenics in work should be awarded the highest priority, and we arrange for these patients to be given their injections on the wards in the evenings or at weekends.

We were able to achieve a 100% follow-up of these patients by means of a very close liaison between the hospital staff and the mental welfare service. When this is done there seems little doubt that the drug proves a most useful long-term prophylactic measure against relapse in the chronic paranoid schizophrenic, and to a lesser extent in the hebephrenic schizophrenic. With these patients it seems likely that the "revolving door" era of frequent hospital admissions will give place to one of outpatient management after initial inpatient stabilization.—I am, etc.,

M. W. P. CARNEY.

St. Annes-on-Sea,
Lancs.

Needle for Intravenous Infusion

SIR,—The simple device here illustrated is easily prepared from available equipment and works well in practice provided that it is properly cleaned directly after use to prevent rusting.

It consists simply of a pointed outer needle with a rather longer inner needle with a rounded tip which fits closely inside the outer needle. The skin and vein are penetrated with the outer needle projecting over the inner one. Then the inner needle is slid forward to cover the point of the needle. By using needles of suitable bore it is possible to give blood at adequate speed for most purposes.

The inner needle was prepared by rubbing down a pointed needle on an oilstone till a smooth edge was made.

With restless patients the vein wall is soon damaged by a pointed needle. If one introduces plastic tubing through a needle there is always some fear of breakage and displacement into the venous system, particularly if one is using old material. Also blood flows very slowly if fine plastic tubing of adequate length is used.—I am, etc.,

E. A. HARDY.

Victoria Hospital,
St. Lucia,
West Indies.

Headache following Lumbar Puncture

SIR,—For some time I have thought that the characteristic and self-limiting headache following lumbar puncture may be due to a lag in the restoration of the normal balance of fluid pressure between cerebrospinal fluid and brain cells and blood. Interference with the fluid content or pressure in any of these compartments might produce a temporary gradient in either direction between them, and account for the same type of headache arising in such conditions as dehydration, "hangover," premenstrual tension, etc.

A personal observation was that when subjected to lumbar puncture, and at another time myelography, I had no trace of headache. I attributed this to being in a relatively dehydrated state when these procedures were performed, having voluntarily restricted fluid intake for some hours beforehand. A simple trial on this basis might be easily conducted.—I am, etc.,

I. DUNCAN.

Student Health Service,
University of Sheffield.

Tetracycline and Nystatin

SIR,—The last time that one of my colleagues prescribed tetracycline for me I objected that it always gave me diarrhoea. My colleague changed the prescription to Mysteclin (tetracycline, nystatin) and I was impressed to observe that no diarrhoea supervened.

This personal experience gave me a particular interest in the report by the Clinical Trials Subcommittee of the British Tuberculosis Association (16 November, p. 411). In my view the conclusions drawn from this trial are invalid because of a fault in the design of the study. The fault is the inclusion in the trial of patients already suffering from gastrointestinal symptoms before receiving the test drugs. Table III shows that many of the subjects had signs of an alimentary disorder, probably due to infection by micro-organisms such as the currently ubiquitous adeno-, Coxsackie, or E.C.H.O. viruses. The variable course of this infection, likely to be unresponsive to either tetracycline or nystatin, introduces a complication which entirely vitiates any conclusion as to the effectiveness of nystatin in preventing tetracycline diarrhoea. An initially symptomless alimentary tract would appear to be a prerequisite for subjects in any future trials.—I am, etc.,

D. D. ADAMS.

Endocrinology Research Unit,
Medical Research Council of
New Zealand,
Dunedin, New Zealand.

Intermittent Claudication

SIR,—I should like to support the views expressed by Dr. M. D. Churcher (21 December p. 775). I have used chemical sympathectomy in 40 cases of intermittent claudication over the past 15 years. The technique I use is that advocated by H. A. Haxton¹: 4 ml. of 6% phenol is injected after a positive response to a test dose of a similar quantity of 2% lignocaine. The results have been encouraging, and several patients have had repeat injections after one or two years, and have been kept active for many years.

This procedure is done in the outpatient department and is completely safe. The only complication experienced has been some sensory irritation of the first lumbar nerve root in about 10% of patients, and this may last for about three to four weeks.—I am, etc.,

J. W. WARRICK.

Weymouth and District
Hospital,
Weymouth, Dorset.

REFERENCE

¹ Haxton, H. A., *Brit. med. J.*, 1949, 1, 1026.

Methaqualone

SIR,—In recent months I have been asked to see a number of cases of anxiety and depression who in the initial stages of their illness have been prescribed methaqualone for insomnia. I often found it difficult to switch them over to less powerful hypnotics even after the main psychiatric illness had been treated.

I have also noticed that those heroin addicts under my care who had previously been prescribed methaqualone in the course of their wanderings through various doctors' surgeries and outpatient clinics ask for methaqualone in preference to any other hypnotic to deal with their chronic insomnia. When questioned about it they all say it is much better than any other similar drug, and some