being removed in 15 days. In the final chest x ray on 9 September (Fig. 4) there was noted a moderate falling in of the chest wall.

FIG. 3.—Case 2: Collapse of Lung. FIG. 4.—Case 2: On Discharge.

Intermittent positive pressure ventilation is life saving when there is respiratory failure due to chest wall and lung damage.¹ All intensive care units, however, have elderly chronic bronchitic patients so treated whom it has not been found possible to wean off the ventilator. Sputum retention must be treated actively with analgesics, physiotherapy and antibiotics and, if collapse of the lung does occur, then even more active treatment must be instituted as in the patient just described. Neither of these cases were in respiratory failure; their PaCO_2 never rising above 40 mm.Hg. It was noted that moderate paradoxical respiratory movements at this age did not affect their general condition, presumably due to a fixed mediastinum. There was no rise in temperature, probably because of antibiotic therapy. Despite this well-being, with a collapsed lung due to sputum retention, active treatment must be instituted as soon as possible. It appears that tracheotomy repeated suction immediately followed by a few Ambu bag positive pressure inspirations is more likely to produce a live patient than the institution of full intermittent positive pressure ventilation.—I am, etc.,

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REFERENCE

- 1 Griffiths, H. W. C., *Journal of the Royal College of Surgeons of Edinburgh* (1960) 6, 13.

Wigs and Waste

SIR,—Nine months ago, one of my patients, a 17-year-old girl, developed total baldness following treatment with cyclophosphamide for a renal disorder.

Under the conditions of the Health Service I could have ordered a wig at great cost. To do so for temporary loss of hair was in my opinion wasteful, and I considered a nylon acrilan wig costing a few pounds would be adequate. I discovered, however, that there was no source from which this amount of money could be obtained. Finally in exasperation I offered to pay for the wig myself. At this stage a relative lent the patient her own wig and the problem was resolved.

Knowing that this would be a growing problem I wrote to the Department of Health and Social Security. Several letters have been exchanged with little result. It would appear from their last letter that they agree that a cheap wig should be acquired under the above circumstances, the money being taken out of "free monies." Alder Hey

Hospital does not possess "free monies," and so we seem to have reached an impasse.

After this experience I can well understand consultants who "take the easy way out of a difficult situation" (20 December, p. 702).—I am, etc.,

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Minnitt and the End of an Era

SIR,—It was pleasant to read the eloquent and well-deserved tribute to Dr. R. J. Minnitt in your leading article "The End of an Era" (13 December, p. 636). It is perhaps worth pointing out further, however, that the possibility of fetal and maternal hypoxia was much in Dr. Minnitt's mind even in those early days of 1934. Reference to his papers and his book *Gas and Air Analgesia*¹ will show that he did, in fact, carry out blood oxygen studies to an extent certainly not usual for anaesthetists at that time, and so was a pioneer in his recognition of the need for measurement.

That gas and air might not be the all-time final answer was appreciated by Dr. Minnitt for he terminated his first paper on the subject, given at the Liverpool Medical Institution on February 22, 1934, with the following statement "What has been done is not a terminus; it is a thoroughfare to greater possibilities for painless labour."—I am, etc.,

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REFERENCE

- 1 Minnitt, R. J., *Gas and Air Analgesia*, 2nd edition, London, 1944.

The Experience of Time

SIR,—I was interested in your leading article under this title (6 December, p. 575) because, while on the one hand its arguments are well based on empirical and experimental facts, it falls on the other hand short of doing full justice to a wide area of mental activity.

For short, let us call this area "productive thinking." Ornstein,¹ whose new book and interesting theory of time perception are discussed in the leading article, is rightly upheld in his view that not only chemical and rhythmic physiological body functions but also "purely psychological manipulations" are to be taken into consideration. Subsequent passages of the article, however, see mental activity predominantly as a response to stimulation and as information-processing. It would be "timely," in this context, to concede that much "autochthonous" psychic activity concerned with forward planning and productive thinking proceeds in a different pattern. With this area in view, I have² formulated the "time of inner activity" (i.e., the one consumed on intentional attitude formation, planning, and productive thinking in general) as one of the fundamental varieties of human time experience

("the psychoergetic time"). Boldly speaking, "time is worked out in us," I said.

The reference, also in the leader, to the essential link between time experience and memory is very much in place. Here, perhaps, psychopathology should receive a mentioning. The "Korsakov"³ or "amnestic" syndrome is the classical paradigm of the connexion between time experience and memory. In this form of brain-damage the patient has, to use a brief formulation, "lost the continuity" of his time experience and memory. Interpretation of experimental findings in this field has led me to the hypothesis⁴ that in this syndrome it is the "psychoergetic" circuit (conceivably, in this case, subcortical in the organic substrate) which is affected, and which prevents an effective registration of events and their time correlates from taking place.—I am, etc.,

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REFERENCES

- 1 Ornstein, R. E., *On the Experience of Time*. Harmondsworth, Penguin Books, 1969.
- 2 Krauss, S., *Netherlands Journal of Psychology*, 4, 1936, 96-110.
- 3 Korsakov, S. S., *Archiv für Psychiatrie und Nervenkrankheiten*, 1890, 21, 669.
- 4 Krauss, S., *Archiv für die gesamte Psychologie*, 1930, 77, 649.

Pulmonary Sensitivity to Nitrofurantoin

SIR,—I refer to your leading article (20 December, p. 704) to which I should like to add a recent self-observation.

After a week's treatment with nitrofurantoin (400 mg. daily) in October last year, I started a second course after a two-week interval. Nine hours after starting this course tightness in the chest and difficulty in breathing set in suddenly. I felt generally ill and went to bed. I awoke at 4 a.m. with fever, cough, and an intense itching on arms and legs. At 7 a.m. I took the morning dose of nitrofurantoin (100 mg.) and continued to feel ill during the day. In the evening my temperature rose to 104° F. (40° C.), my muscles ached, and a maculo-papular rash developed on all limbs. I had suspected the itching was caused by the nitrofurantoin and had stopped the drug after the morning's dose and twenty-four hours later I was symptom-free.

It was, however, only after reading about the possible side-effects of nitrofurantoin that the association between this drug and my pulmonary symptoms became apparent. In my work in dermatology I come across drug reactions frequently but I have never before seen the skin lesions and pulmonary symptoms in patients on nitrofurantoin before.

After my personal experience I wonder if the condition is perhaps more frequent than the scanty references in the literature suggest. I may add that I have a hyperergic constitution with past incidence of sensitivity to sulphonamides and contact dermatitis.—I am, etc.,

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