followed by succinylcholine. The duration of the operation was one-and-a-half hours and it was performed on a hot, humid day with an operating room temperature of 32°C. (90°F.). The patient's temperature, as measured by a thermistor probe in the oesophagus, 20 minutes after the commencement of the operation was 40°C. (104°F.) and despite cooling with ice and fans it remained between 39° and 40°C. throughout the procedure. No abnormal bleeding was encountered during the operation. Her temperature remained elevated in the immediate postoperative period and four hours later, despite the presence of suction drains in the deep tissues of the neck, she developed extensive swelling and ecchymoses in the neck extending from the ears to the clavicles. Although the haematoma was mostly in the superficial tissues it was sufficient to give a minor degree of respiratory obstruction.

Her neck was reopened under general anaesthesia and a considerable quantity of semi-liquid blood clot was evacuated from the tissue plane between the platysma and the strap muscles. There was a general ooze from all the surfaces within the wound and many bleeding points were coagulated with diathermy. Two suction drains were inserted and the wound closed. There was a steady stream of blood along these drains, and at this time a defect in the clotting mechanisms was strongly suspected.

At the time of this emergency 5 ml. of venous blood was allowed to stand in a clean, dry, glass test-tube. Within three minutes it had clotted firmly. However, after a further 10 minutes the clot had completely liquefied and subsequently remained in this state. In this way a diagnosis of fibrinolysis was made. On the assumption that she had circulating fibrinolysins, the patient was given 500 mg. of Dicyclic (cyclonamine) intravenously. Four hours later there was serum only in the drainage tubes and no further bleeding occurred. The drains were removed the following day and she made an uneventful recovery with a cure of her hyperparathyroidism.

In this case a presumptive diagnosis of fibrinolysis was made on the appearance of whole-clot lysis. It is appreciated that this simple test did not distinguish between primary and secondary fibrinolysis but the subsequent beneficial effects of Dicyclic make the former more likely. We suggest that the high temperature in the operating theatre resulting from lack of air conditioning may well have caused or contributed to this patient's hyperthermia.

We wish to thank Professor C. E. Dent and Mr. D. R. Davies for allowing us to report on this patient who was under their care, and to Dr. Enid Bennett for her helpful advice.

—We are, etc.,

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Psychiatric Drugs Left at Home

SIR,—Lately (17 August, 1968, p. 424) we drew attention to a potential danger

awaiting psychiatric patients in their homes after discharge from hospital—namely, drugs acquired in the course of previous treatment and not destroyed.

The study suggested an association between age, affective disorder, recent physical illness, and drug leaving. It was also noted that a simple written appeal did not diminish the number of patients leaving drugs at home. Following the completion of the study therefore at the general hospital psychiatric unit concerned, a systematic attempt was made to collect the drugs of patients on admission, and the nursing staff continued inquiries until either a positive statement was obtained from the relatives that there were no drugs at home, or the drugs themselves were collected.

Last year 14% of relatives with medicines at home admitted to 2 bottles, 4.5% 3 bottles, and 3.5% to more than three. In the current analysis of the initial 71 patients 25% had 2 bottles, 21% 3 bottles, and 11.5% more than 3 bottles, suggesting that larger quantities were kept than admitted on a single inquiry. Altogether over the period examined 565 bottles containing 16,762 items were collected. A similar operation on a national scale would therefore remove from circulation something like 8 million items. Roughly 4% of the bottles examined contained mixtures of tablets, thus making a nonsense of the instructions on the bottle label. Of the tablets collected were 3,730 phenothiazines, 3,432 tricyclic anti-depressant tablets, and 3,307 azepide tablets. Surprisingly only 899 were barbiturate

tablets, and 1,107 tablets of all types usually prescribed as night sedation. It may be that a ratio of 10 psychotropic drugs to one of night sedation is as prescribed. On the other hand, it seems possible that night sedation is more often actually used as prescribed. The ratio is certainly consistent with the shift which has been observed in recent years in the type of medication used in self-poisoning.

In our operational study previously mentioned of 330 patients first admitted to hospital 147 were found to have drugs at home one week after admission, the source of prescribing being the general practitioner five times more frequently than the hospital service. Six months later 148 patients were found to have drugs at home, the ratio of general practitioner prescriptions to hospital prescriptions now being exactly one to one. Having now prescribed them, in view of the frequency of readmission in psychiatric illness, the hospital psychiatrist clearly has an extra responsibility to ensure that unused drugs are not overlooked and left in the patient's home in the course of later treatment.

We are indebted to Miss R. M. Tinker, F.P.S., and her staff for their analysis of the substances collected during a period of just over a year.—We are, etc.,

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Hospital Staffing Structure

SIR,—You kindly published a letter from the consultant staff of the Kettering and District General Hospital (26 July, p. 236) in which we rejected the report *The Responsibilities of the Consultant Grade*.¹ Since then many other doctors, as individuals, grades, and whole staff committees, have expressed similar views and rejected the document.

We were therefore most relieved to observe in the *Supplement* (27 December, p. 79) that the Central Committee for Hospital Medical Services on 12 December carried a motion by a large majority completely rejecting the report *The Responsibilities of the Consultant Grade* as a basis for discussion.

We are, however, extremely concerned to note that despite general opposition voiced in your columns, and despite the motion in the Central Committee for Hospital Medical Services, the identical proposals feature in the progress report on discussions between representatives of the Health Department and Joint Consultants Committee (*Supplement*, 6 December, p. 53). It is clear to us that the basic propositions are directly descended from *The Responsibilities of the Consultant Grade*. Worse still, they form the template for the manpower projection by the Department of Health and Social Security (*Supplement*, 6 December, p. 55).

After consideration of the progress report we remain equally concerned and equally opposed to the basic propositions. The figures of the manpower projection by the Department merely confirm our worst fears and suspicions. The proposals of the progress report, if implemented, would certainly alter drastically the nature of the consultant's job as we know it today. Further, the progress report does not seek to correct the imbalance between the members in training grades in various specialties; it does not realize that surgical

divisions will shortly become ineffective through lack of anaesthetists, and medical departments made ineffective from lack of radiologists and geriatricians. These major problems of staffing deficiencies in less-popular specialties and also in less-prosperous areas of the country remain unrecognized and unsolved.

We realize that a reorganization of hospital staffing is urgently required, but feel that the progress report is based on the same unacceptable principles as its immediate predecessor, and that it too should be completely rejected as a basis for discussion. We suggest that a fresh working party drawn from the Central Committee for Hospital Medical Services should be set up having a more representative and more informed membership to develop a realistic and generally acceptable staffing structure.—We are, etc.,

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- The Responsibilities of the Consultant Grade*. Department of Health and Social Security, Department of Health for Scotland. London, H.M.S.O. 1969.

SIR,—Though the document entitled *Responsibilities of the Consultant Grade*¹ has been rejected as a basis for further discussion, the Health Departments are recommending its terms in relation to the staffing of new hospitals. The progress report (*Supplement*, 6 December, p. 53), which has been discussed in the regions was to be de-