baby is after all a person to its mother. By using such a degrading description some doctors could be bringing the profession dangerously close to the attitudes of Nazi-ism, where people were considered as "things" of the State, merely numbers and statistics. It could be a dangerous illusion to think that free family planning will cure our pollution problems. There are aspects of our runaway technology that need looking at first.

DR. D. M. BOWERS (Hexham, Northumberland) writes: It would be tempting to analyze in detail the amazing fallacies expressed in the letter, signed by 50 doctors, entitled "Doctors and Overpopulation" (8 January, p. 108). The first paragraph refers to "environmental pollution" and the second refers to "sheer overcrowding." It is arguable, and indeed would seem obvious at a cursory glance, that easily the commonest cause of overcrowding in Britain is the motor-car. Not only can cars be seen to cause overcrowding, but their numbers necessitate car-parks, which reduce living space in towns, and motorways, which are destroying the countryside. On occasion, homes have been destroyed to make room for car-parks and motorways; it would seem logical, therefore, to begin our attack on the problems of overcrowding by attempting to reduce the number of motor-cars. It is significant that there has been no suggestion to this effect from any body of opinion which claims to concern itself with either overcrowding or environmental pollution.

DR. D. HOOKER (Truro, Cornwall) writes: It seems in this generation that we pass from one horror to another. Now a group of eminent doctors advocates abortion as a means of population control (8 January, p. 108) . . . I wonder if these doctors realize the implications of their proposals concerning abortion. Originally this was a therapeutic operation, carried out only occasionally in cases of grave medical necessity, after careful examination of the moral and ethical consequences. Today with the reformed Abortion Law it has become an operation carried out on demand by the patient. In the future, if this group's proposals are accepted, it will inevitably become an operation of compulsion, both for the doctor and for the multigravid patient—for how else can it logically be used as a means of population control? Even without compulsion it would still be ethically wrong to use abortion for this purpose, as every clear-thinking doctor knows. It is time the medical profession stopped being swept along in the stream of so-called "progressive enlightenment" and took stock of its ethical and moral position . . . This group of doctors has its sights set wrong. No mention is made of the permissive society of today, with the rising illegitimate birth-rate despite contraception and abortion. A combined conscious effort by the Church, doctor, and the whole community to bring about moral reformation would be for more positive than the wanton destruction of unborn children. No mention is made of the poorly controlled immigration laws (too much of a "hot potato," I suppose); nor of the vast tracts of land, still underdeveloped and unpopulated, which with a courageous emigration policy could do much to solve the problem of overcrowding in this country.

DR. J. M. STRAITON (London W.1) writes: . . . the real problem is lack of communications in utilizing resources. If India cultivated her available arable land in the same intensive manner as that in Japan, she could provide food for twice the world's present population herself. Surely the emphasis must be on better utilization of our vast potential resources rather than restricting unnaturally the numbers of our young. This would leave us, like unfortunate Hungary, with the lowest birth rate in the world, owing to liberal abortion, where one third of the population is over 65.

DR. J. R. CALDWELL (Newick, Sussex) writes: One contribution we doctors might make to this problem is to try to introduce some reason into our quite Gilbertian legal, fiscal, social, and professional approach to it. If a young person chooses to remain celibate and single he or she immediately suffers a lack of tax rebates and allowances and is barred from such social benefits as housing. Having decided to wed or become promiscuous they will find it extremely difficult to obtain free sterilization, although infertility will be investigated and treated with great enthusiasm on the house. They will also find that, alone of all pharmaceuticals, contraceptives have to be paid for in full. The country having thus encouraged pregnancy now provides free legal abortion to terminate it, so that a slaughter of the innocents occurs daily in our midst compared to which Herod's example pales to insignificance.

DR. I. R. HUMPHREY-EVANS (Dyserth Nr. Rhyl, Flints) writes: I was distressed to read the letter signed by a large number of doctors advocating very materialistic and, in my view, immoral ways of combating what they call "the British disease of overpopulation" (8 January, p. 108). I feel that their suggestions do a disservice to British medicine, and the methods they advocate are ones which have already contributed much to the collapsing moral fibre of the nation, and I hope that the Government will not respond to their suggestions. Apart from the fact that the cry of overpopulation has been raised from time to time since the days of Malthus, I am of the opinion that the danger is overexaggerated; and although I agree pollution is a vast problem a great amount of it is due to industrial products, and surely it is not above the ingenuity of modern technology to overcome this difficulty.

DR. T. D. RICHARDS (Pucklechurch Nr. Bristol) writes: Some 50 doctors in a letter to the *B.M.J.* (8 January, p. 108) are demanding that the Government takes urgent steps to deal with what they call "the British disease of overpopulation." Obviously there must be a limit to how many people can live in this country in reasonable conditions of comfort—but surely we should have taken steps ten years ago, as other countries have done, and that is to have had a much stricter control on the numbers of people coming into these islands. This is a more realistic step than that put forward in their letter which suggests free family planning, more hospital beds for abortion, and a campaign for male sterilization, financed from taxation.

DR. R. F. STRONGE (Rhostryfan, Caernarvon) writes: Few would disagree with the main theme of the letter on overpopulation by a group of doctors (8 January, p. 108) but it is easy to see how some of the methods they suggest to combat overpopulation, if left to individual choice, could lead to immigrants taking over Britain in the foreseeable future. The time will come when it will become advisable for mankind to take his destiny into his own hands and introduce some form of selective breeding. . .

Congenital Dislocation of Hip

SIR,—In 1958 for the first time the annual hospital inpatient inquiry for England and Wales attained national coverage. The Registrar General's office has kindly supplied figures for that year and for 1968 which show that in 1958 the average age on admission of children under 5 with congenital dislocation of hip was about 2 years, and only 12.5% were under 1 year. Ten years later, despite all the propaganda about "instant" neonatal diagnosis, the percentage under 1 year was 21.

These figures of inpatients do not, of course, give the whole picture. The medical records department at Great Ormond Street Hospital has been good enough to give me their figures for 1970. Of 47 children under 5 who attended for the first time 18 were under 1 year, but of these 18 only three were treated as inpatients. In 1960, on the basis of 10 years' experience, I suggested¹ that if early diagnosis of congenital dislocation of hip were regarded as a public health problem then repeated routine examinations in the first year would pay off.

It seems that until regular routine examinations are regarded as complementary and not just supplementary to neonatal examinations we will continue to encounter the inevitable crop of "ones that got away." Further, with the increasing trend to hospital confinement and discharge after 48 hours we can expect more of this type of case. Finally, of the 25 primary patients seen in the past 22 years only four were born at home.—I am, etc.,

R. A. STRANG

Wembley,
Middlesex

¹ Strang, R. A., *British Medical Journal*, 1960, 1, 279.

Coronary Neurosis

SIR,—It has been suggested that patients and potential patients should be educated to appreciate the importance of seeking immediate medical aid when they experience symptoms which they think might be due to a heart attack. However, scant attention has been paid to the extremely prevalent coronary neurosis which already exists in middle-aged and even young adults. A man's usual reaction to a pain in the chest is to assume he has had a myocardial infarct. This may be the case, but often the pain is benign. It is most important that the doctor consulted should avoid making an erroneous diagnosis of coronary disease and perpetuate the patient's fear of impending doom. This unfortunately occurs only too frequently.

Effective reassurance can really be given only after taking a thorough history and making a full examination, including if possible electrocardiography and x-ray examination. The history is most important in elucidating the characteristics of the pain. An essential question when the information is not spontaneously volunteered by the patient is "Have you been worried in case your pain should be arising from the heart?" The answer is almost invariably yes, and the patient is grateful for being given a chance to ventilate his fears. Half-hearted reassurance is worse than useless, leaving the patient with a niggling suspicion that the possibility of heart disease continues to exist. In fact, it seems kinder and less harmful to reassure a patient mistakenly than incorrectly to attach the label of coronary artery disease. In the period of one year angina pectoris accounted for 10% of new outpatient referrals to a medical clinic at the Cumberland Infirmary and fear of heart disease accounted for 5%—fears proved to be groundless.

Almost certainly the increased incidence of coronary neurosis stems from a combination of people's awareness that ischaemic heart disease is common, personal contact with it in the home and at work, and the wide publicity it now receives. Education of the patient to recognize cardiac pain when it

occurs might make a significant impact on the devastating morbidity and mortality of coronary artery disease, but I hope it will not be done at the expense of increasing the already widespread fear of the condition.—I am, etc.,

R. H. SALTER

Cumberland Infirmary,
Carlisle

Natural History of Ventricular Septal Defect

SIR,—Your leading article on the natural history of ventricular septal defect (4 December 1971, p. 571) digresses to make a well-timed and well-justified appeal for primary closure of large ventricular septal defects in infancy. However, it might be misleading to some of your readers in seeming to suggest that primary closure of ventricular septal defects in young sick infants can now be offered at a known low risk in this country. As far as I am aware no such statistics are available, and the results to which you refer from overseas relate to only small numbers of younger infants. Conceivably, also, centralization of this operation for these young and usually very sick infants might not prove practicable. At the present time it would seem that there may still be a place for advising pulmonary artery banding in selected patients.—I am, etc.,

K. A. HALLIDIE-SMITH

Hammersmith Hospital,
London W12 0HS

Psychosis and Ketamine

SIR,—We read with interest the report of a psychotic illness following ketamine anaesthesia (13 November, p. 428).

In February of this year a 23-year-old female was admitted to our burns unit. She had been an inpatient in a mental hospital, suffering from psychotic depression in the puerperal period after the birth of her second child. She had set her bed clothes on fire and sustained 38% deep full-thickness burns of her trunk, right upper limb, and right lower limb. She required three major operations for removal of slough and skin grafting and one minor skin grafting procedure. She also required eleven burns dressings.

The first and the second major operations were performed with conventional anaesthesia using nitrous oxide, oxygen, and halothane. Each of these anaesthetics was complicated by profound hypotension despite adequate blood replacement. It was then decided to perform subsequent skin grafting and the major dressings with ketamine anaesthesia. She had six uncomplicated ketamine anaesthetics. She was premedicated either with pethidine, promethazine, and atropine or with droperidol and atropine, and she was sedated postoperatively with diazepam or chlorpromazine. The maximum dose of ketamine administered was 260 mg during a 90-minute operation. She also had six minor burns dressings with methoxyflurane analgesia.

She never had unpleasant dreams but always complained of feeling detached from herself in the postoperative period. This feeling was less unpleasant when she was sedated with chlorpromazine. Her mental condition while in the burns unit was not upset by ketamine, and her subsequent psychiatric progress has in no way been affected by the use of ketamine.

Our experience with this patient has shown, contrary to accepted opinions, that ketamine can be used with its distinct advantages in patients who are mentally ill. It is necessary to use a premedication and to avoid overdosage with the drug. Postoperative sedation is probably advisable in these cases.—We are, etc.,

S. M. LAIRD

M. SAGE

Plastic and Reconstructive Surgery Centre,
St. Lawrence Hospital,
Chepstow, Mon

Idiosyncratic Responses to Phenothiazines

SIR,—We would like to report three cases in which acute extrapyramidal symptoms developed after treatment for nausea by a single dose of perphenazine. A number of points emerged. Firstly, considerable confusion in diagnosis may arise. In these cases the following diagnoses were considered: epilepsy, hysteria, tetany, and tetanus. Secondly, only a small dose of perphenazine had been given. Thirdly, intravenous benzotropine methanesulphonate gave complete relief of symptoms.

The signs and symptoms of idiosyncratic responses to phenothiazine drugs often cause confusion in diagnosis, for two reasons. Firstly, they are not commonly found as an acute phenomenon. Secondly, in the acute situation the symptoms produced mimic extremely well other serious conditions. Phenothiazine derivatives are well known to cause extrapyramidal symptoms when used over a long period,¹ but there are few reports of an acute episode. R. B. Bradshaw described a case in which symptoms occurred after a single dose.² Diazepam may help to control the spasms but benzotropine methanesulphonate has been shown to be a specific antidote.

We would like to emphasize this bizarre side effect of the phenothiazine group of drugs, and in particular of perphenazine, since it is commonly used as an antiemetic.—We are, etc.,

P. D. RAMSDEN

D. L. FROGGATT

Nuffield Department of Surgery,
Radcliffe Infirmary,
Oxford

¹ Ayd, F. J., *Journal of the American Medical Association*, 175, 1054.

² Bradshaw, R. B., *Journal of Laryngology and Otolaryngology*, 1969, 83, 79.

Haemophilus Epiglottitis

SIR,—We were interested to read about the experiences of Dr. M. G. Addy and others in their paper on *Haemophilus epiglottitis* (1 January, p. 40). We reinforce the authors' emphasis on the fulminating nature of the condition and the need for urgent relief of the respiratory obstruction. However, we cannot agree that there is a need for tracheostomy in all cases. If the larynx can be visualized—and this procedure must be carried out in an area where emergency tracheostomy could be performed—then it is as easy to introduce an endotracheal tube as it is a bronchoscope. Failure of intubation in this condition is a possibility but is rare in our experience. Since antibiotic therapy is rapidly effective if administered parenterally, the artificial airway is needed only for 48–72 hours, and it seems to us a condition

eminently suitable for treatment by intubation with a plastic nasotracheal tube.

The management of tracheostomy and endotracheal intubation is very similar—that is, adequate humidification and routine suction with an aseptic technique. We would be interested to know what form of sedation, if any, was given to these children to enable them to tolerate the procedure of bronchoscopy and tracheostomy. In conclusion, we would reinforce the suggestion that there is a need for every doctor to be aware of the existence of this condition and of the very urgent need for appropriate treatment.—We are, etc.,

JENNIFER M. EDWARDS

KEITH D. ROBERTS

The Children's Hospital,
Ladywood,
Birmingham

SIR,—We are most interested to read the article on *haemophilus epiglottitis* by Dr. M. G. Addy and others (1 January, p. 40), and we would like to reinforce further their statement that the disease is not merely a local inflammation but also a septicaemic condition by describing our recent clinical experience with a child admitted to this hospital with "croup."

A 16-month-old boy was admitted with a history of being unwell for a day and noisy distressed respirations for two hours before admission. On admission he looked ill and ashen with a moderate laryngeal stridor. His temperature was 39.8°C and the respirations were 40 a minute with a moderate subcostal recession. He had inspiratory wheeze with scattered crepitations over the right base. The pulse rate was 156, regular with good volume, and there were no signs of cardiac failure. There was no evidence of meningitis and no other abnormal signs. The Hb was 13.2 g/100 ml, E.S.R. 45 mm in one hour, and W.B.C. 15,400/mm³ with polymorphs 60%, lymphocytes 35%, monocytes 3%, and eosinophils 2%.

The child was treated, as having acute laryngitis, in an oxygen tent with an adequate humidification under cover of ampicillin, cloxacillin, and hydrocortisone. The antibiotics were given six-hourly in doses of 125 mg intramuscularly for two days and then given orally. The patient was afebrile on the second day and out of the tent on the third. He remained so until the fifth day when he became irritable and pyrexial with a few meningeal signs. A lumbar puncture produced a slightly cloudy fluid with leucocytes 810/mm³ (polymorphs 33%, mononuclears 67%), sugar 53 mg/100 ml, protein 140 mg/100 ml, and a growth of *Haemophilus influenzae* type b was obtained. The treatment of the meningitis was begun on the same day with chloramphenicol, sulphadimidine, and penicillin in the standard doses. He responded to the treatment quite satisfactorily and is fully recovered now.

The points we would like to make from this case are that any child with a moderate to severe croup should be treated as for *Haemophilus influenzae* type b infection with adequate doses of parenteral ampicillin or chloramphenicol. Ampicillin, if used, should be given in maximum doses (100–150 mg/kg/day) and parenterally. Once the blood culture becomes positive for *Haemophilus influenzae* type b it is important to change over to chloramphenicol to avoid meningitis.—We are, etc.,

B. WOLMAN

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