available and these were cleared up within the hour. I have more trouble with obscure pot plants with esoteric names which have been sampled by children than I do with chemicals.—I am, etc.,

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Poisoning by Tricyclic Drugs

SIR,—The treatment of overdose with tricyclic antidepressants has recently been reviewed in *Prescribers' Journal*.¹ To summarize, the article stresses the importance of treatment of any respiratory or circulatory failure. It emphasizes that sympathomimetics must be given with great caution because of the pre-existing danger of cardiac irregularity, and indicates the importance of E.C.G. monitoring until well after apparent recovery. The treatment of convulsions is also considered.

I feel that this article is incomplete insofar as an important, though little appreciated, aspect of the syndrome has been omitted. Severe cases may show a profound metabolic acidosis often with considerable hypokalaemia, both of which further predispose to major cardiac dysrhythmias. Treatment, as expected, should be with alkali and intravenous potassium, often in massive quantities.² Thus it is strongly recommended that frequent electrolyte and blood gas analyses are made in all such cases, so that supportive therapy may be given where indicated.

I write this letter because the aforementioned journal does not publish correspondence.—I am, etc.,

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¹ Matthew, H., *Prescribers' Journal*, 1971, 11, 120.
² Dannert, F., and Rosen, A., *Läkartidningen*, 1967, 64, suppl. 4, p. 80.

Transrectal Prostatic Biopsy

SIR,—We read with interest the article on transrectal prostatic biopsy by Mr. W. F. Hendry and Mr. J. P. Williams (4 December 1971, p. 595). We have been using the Silverman needle for taking prostatic tissue for biopsy by the transrectal route. This we do with the patient in the lithotomy position after giving droperidol 20-30 mg intravenously. The operation can be done as an outpatient procedure and causes minimal discomfort to the patient.

The needle is fixed to the palmar aspect of the gloved right index finger by means of two rubber bands, the end of the needle stopping $\frac{1}{2}$ in (12.7 mm) short of the finger tip. A split P.V.C. tubing covers the needle and finger as they are inserted into the rectum so as to prevent damage to the rectal mucosa. Suspicious areas of the prostate can be felt with the finger tip, the needle is inserted into the parenchyma of the gland, and only then is the harpoon advanced. By this technique tissue for biopsy can be taken from specific points of the prostate under direct finger control.—We are, etc.,

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Psittacosis

SIR,—The statement in your leading article (1 January, p. 1) that "British budgerigars seem rarely to cause human infections" may be true, but it rather distracts attention from the leading role of these common household pets as causes of clinically significant human psittacosis. Among 48 cases diagnosed over 20 years in this laboratory whose probable sources of infection were traced budgerigars were incriminated in 28, pigeons in 10, parrots in two, and miscellaneous animals in eight.¹ Budgerigars also led the field in the analyses of cases in the United Kingdom and in the Republic of Ireland during 1970² and (under the synonym "parakeets") in the U.S.A. during the same year.³

The budgerigars associated with the cases diagnosed here had often been recently purchased and usually, when traceable, were bred in this country. One family outbreak of four cases, one of them severe, was caused by a budgerigar which sickened after being purchased and brought to Glasgow from Newcastle upon Tyne.⁴ The bird originated in a well-managed breeding establishment in the south of England. Occasional deaths had occurred among the breeding stock but no necropsy examinations had been made.

It is apparent that psittacosis is endemic in at least some breeding stocks in Britain, as elsewhere, but causing little disease under well-managed conditions. The latent infection is likely to be activated by the stress of transportation to the dealer. A "spot of antibiotic" in the drinking water is recognized to reduce mortality from infections in recently received consignments of birds, but is unlikely to succeed in eradicating (as opposed to suppressing) activated psittacosis, which may recrudescence after sale of the bird. Attempts to make friends with a recently purchased pet, which may be too unwell to avoid the new owner's close advances, lead easily to mouth-to-beak intimacies well calculated to transmit psittacosis, or other infections for that matter. Common-sense hygienic practices and particular caution in dealing with recently-purchased birds are necessary to minimize the risks of acquiring serious infection from these attractive domestic pets.—I am, etc.,

NORMAN R. GRIST

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¹ Grist, N. R., in *Annual Report on the Work of the Infectious Diseases Hospitals and their Associated Laboratory Services*, ed. T. Anderson. Glasgow Western Regional Hospital Board, 1969.
² *British Medical Journal*, 1971, 2, 539.
³ *Morbidity and Mortality, Weekly Report*, 1971, 20, 295.
⁴ Pinkerton, I. W., in *Annual Report on the Work of the Infectious Diseases Hospitals and their Associated Laboratory Services*, ed. T. Anderson. Glasgow Western Regional Hospital Board, 1965.

SIR,—In your leading article (1 January, p. 1) on psittacosis you drew attention to the risks of exposure to diseased birds and the inhalation of dust from their excreta. A more direct method of human infection is from the bite of a bird.

A woman aged 40 purchased two yellow-backed lorykeets (originating from Malaya), from a pet shop on 30 September 1971. Shortly after purchase the birds appeared to be sick, and they died on 2 and 3 October respectively. One of them bit her on the right forearm on 1 October. Two days later she be-

came ill with fever, shivering, headache, cough, and chest pain. She improved on tetracycline. On 6 October a chest radiograph showed a segmental pneumonia in the left upper lobe. Serial complement fixation tests showed rising titres for psittacosis: 11 October, positive 1/20; 18 October, positive 1/40; 2 December, positive 1/320. She was not seriously ill at any stage and received no further antibiotic treatment after a week. The pneumonia cleared gradually, and by 2 December resolution was complete. The incubation period after infection by inhalation is usually regarded as 7-14 days. The shorter incubation period of two days in this case may be explained by the infected beak of the diseased bird having transferred bedsoniae directly into the blood stream.

Though reports of cases of psittacosis in Britain are relatively uncommon the disease is probably more prevalent than is realized. In a study carried out in one chest clinic in the South Bedfordshire and North Hertfordshire areas during 1954-65 100 cases of bedsonial infection were diagnosed, most occurring in a single outbreak in 1956. The commonest source of infection was the budgerigar.¹ There are some six million budgerigars in Britain and probably one household in every six has one. Prophylactic antibiotic treatment suppresses bedsonial infection but may not completely eradicate it, and shortly after the purchase of the bird the antibiotic effect passes off and the disease flares up.² Though these birds are attractive they may be highly dangerous, especially when recently purchased, and this needs to be more widely recognized by the public. Currently there is no adequate control of the importation and supply of birds to pet shops in Britain, and I consider that a more positive preventative approach is needed.—I am, etc.,

ALEX SAKULA

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¹ Erooga, M. A., in *Some Diseases of Animals Communicable to Man in Britain*, ed. O. Graham-Jones, p. 143. Oxford, Pergamon Press, 1968.
² Bisseru, B., *Diseases of Man Acquired from his Pets*, p. 121. London, Heinemann, 1967.

Leukaemia on Myeloma

SIR,—Dr. I. C. Quirt and others (22 January, p. 248), in their first and last sentences, state that acute leukaemia arose following melphalan therapy. It also followed extensive radiotherapy and an unstated amount of cyclophosphamide.

Surely the implication that the leukaemia resulted from melphalan is unwarranted?—I am, etc.,

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Head Injuries in Children

SIR,—I was disappointed when reading your otherwise excellent leading article on "Head Injuries in Children" (22 January, p. 196) to find no mention of the part played by skull x-rays in the management of this very common but, happily, often trivial injury. Every child who comes to hospital after a head injury has a skull x-ray and when asked about the purpose of this procedure the doctor who ordered it invariably replies "for medicolegal reasons."

In my view routine skull x-rays are not