Psychosis and Ketamine

SIR,—Dr. M. W. Johnstone (12 February, p. 442) states that premedication with nitrazepam 10 mg and droperidol 20 mg enables minor surgery to be accomplished under anaesthesia without troublesome postoperative sequelae. This is not unexpected since Bovill *et al.*¹ have previously shown that a combination of diazepam and droperidol is a most effective premedication in preventing postoperative delirium and unpleasant dreams. Moreover, the satisfactory results reported by Dr. Johnstone do not take into account the importance of the duration of the procedure. The longer the operative procedure the better the results, irrespective of premedication.²

The letter from Drs. C. L. Brewer and J. R. T. Davidson (same issue, p. 442) is somewhat misleading. A large proportion of E.C.T. is undertaken in nervous and anxious outpatients. Are they suggesting that intramuscular ketamine is suitable for outpatient E.C.T.? The recovery time is usually prolonged with intramuscular ketamine, and the patient must, therefore, remain under observation for much longer periods than with conventional induction agents such as propofol or methohexitone. We find it hard to understand the rationale behind the recommendation that ketamine is the drug of choice for E.C.T. procedures when presumably a short acting relaxant such as suxamethonium is also employed. (They do not mention the relaxant though there is no suggestion that it be omitted.) By using ketamine one exposes the patient not only to the disadvantages of a long recovery period but also the possibility of unpleasant dreams and delirium, which do not exist with conventional anaesthesia for E.C.T.

We should also like to point out that when ketamine is the anaesthetic of choice it is best used without any depressant premedication, otherwise its distinct pharmacological properties will be reduced and recovery prolonged. The unpleasant post-operative sequelae can be effectively blocked by the use of diazepam 1 mg/6 kg given at the end of operative procedure.³—We are, etc.,

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¹ Bovill, J. G., Clarke, R. S. J., Dundee, J. W., Pandit, S. K., and Moore, J., *British Journal of Anaesthesia*, 1971, 43, 600.

² Bovill, J. G., Coppel, D. L., Dundee, J. W., and Moore, J., *Lancet*, 1971, 1, 1285.

³ Coppel, D. L., Bovill, J. G., and Dundee, J. W., Paper accepted for Fifth World Congress of Anaesthesiologists, 1972.

Staffing Our Asylums

SIR,—I feel I must add a comment to your leading article on "Staffing Our Asylums" (26 February, p. 523).

It is not only in the narrow therapeutic sense that chronic patients are suffering in large psychiatric hospitals through the official policy dealt with in your article. My husband is on the staff of such a hospital and, since we first came here, the programme of patients' daily life has greatly changed. Then there was a patients' social club; a patients' monthly magazine; a staff and patients' choir and orchestra; weekly poetry readings in the library; and monthly illustrated art lectures. The life-blood of these activities was provided by the élite among the patients—the

young "acutes," the neurotics, the psychopaths, and offenders—but the long-stay patients could and did take part in them. In my opinion, this stimulating programme did much to prevent their institutionalization.

Now, owing to the shift in emphasis towards short-term psychiatry, not one of these activities remains. The chronic patients still receive the skilled care of all staff concerned. What they lack is the advantageous relationship with the short-stay patients.—I am, etc.,

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Shipboard Medicine on Package Cruises

SIR,—Dr. John W. Carter's account of his experiences at sea (26 February, p. 553) is a timely reminder to doctors of the hazards likely to be encountered by the elderly and infirm embarking on cheap Mediterranean package cruises. This is a problem which has long been recognized by those doctors concerned with maritime medicine in this country but in the desire by holiday makers to obtain the cheapest value for money has been largely overlooked.

However, there are still many cruise liners operating under the British flag where medical care of the highest standard is provided by doctors experienced in nautical medicine, supported by medical teams of nursing sisters, hospital dispensers, and medical attendants. A wide range of drugs is available conforming to British standards. Hospitals are well equipped with full operating-theatre facilities in addition to x-rays and electrocardiography in many vessels. Doctors in British ships are senior officers who advise the ship's master on all aspects of the health and safety of crew and passengers. Not only are they concerned with treatment but increasingly with the prevention of disease. Far from leading a life of leisure, ending in alcoholic debauchery, as described, the present day ship's surgeon is a highly competent and experienced doctor able to act on his own initiative with the changing medical problems encountered at sea.

The situation described by Dr. Carter is clearly that which results when there is no organized company medical service and where operational costs are reduced to the minimum. The old adage that you get what you pay for regrettably applies even to medical care. Doctors should use caution in advising their aged or convalescent patients before they set out on such cheap holiday cruises. A modest additional expenditure may provide a full supporting medical service with the confidence and certain knowledge that they will be well cared for should the need arise. Such facilities may contribute to a relaxing and enjoyable vacation rather than one ending in illness, costly repatriation, or even death.—I am, etc.,

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SIR,—I should like to congratulate Dr. John W. Carter (26 February, p. 553) on bringing to the attention of medical practitioners some of the problems which confront both passengers and medical staff on certain cruises.

Having been a ship's doctor myself I have had many similar experiences. One of the most frustrating exercises is seeing for the first time a patient who is already taking a wide variety of toxic drugs that are not accompanied by any means of identification. Furthermore, very few passengers suffering from serious illnesses have in their possession a doctor's letter outlining their condition and current treatment. Yet it is often the case that the doctor may have recommended this type of holiday as a means of convalescence in the first instance.

Practitioners should certainly be made aware of the stresses which often occur, especially on the smaller ships in bad weather. The strain of seasickness and the physical effort of manoeuvring against the constant movement of the ship may be potentially disastrous to a patient who has had a recent myocardial infarction or undergone major surgery. Those who are dependent on steroids or who are being treated with anticoagulants are particularly hazardous problems when they are suffering from the mal de mer.—I am, etc.,

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Abortion in Perspective of Family Planning

SIR,—Dr. Stella C. Lewis and others (4 December, p. 606) convey the essential difference between abortions performed by doctors in hospital and abortions performed by the illegal practitioner. By this I mean the consideration of the patient and her general medical and obstetric future. Dr. Lewis and colleagues' preoperative approach in considering the merits of each case—particularly in regard to the patient's opinions about whether or not to have a general anaesthetic—the proffering of contraceptive advice for the future, the encouragement for her not to hesitate to discuss any anxieties both before termination and after, and an excellent follow-up are worthy of imitation by all who carry out this procedure. The six-week follow up of 87% of their patients places abortion in its correct perspective vis-à-vis family planning.

I would like to comment on an important point in the procedure as outlined in the paper. The Karman catheter used had a pair of eyes, and it was found to be an advantage when the rear eye was enlarged. This appears to me to be of great importance for the avoidance of a too deep curettage. It has been my impression that the infertility caused by synechie is greater in North America than in Europe and the aetiology of this condition is frequently associated with routine postabortion curettage with a sharp curette. In my day at the Rotunda Hospital we taught that even the Rheinstadter blunt flushing curette was dangerous.

A further point that may be pointed out at this time is the desirability of prophylaxis against Rhesus sensitization. It is a routine of our small local hospital that all patients who are Rh negative are given anti-D globulin postoperatively unless contra-indicated.

The authors' observations with regard to analgesia are of great value and importance and the only criticism I would make is why were those admittedly anxious patients not