long stay wards and hospitals. We fail to use the most effective therapeutic weapons we have—civilized and interesting conditions in which to live and meaningful things to do. We cannot plead a poverty-stricken society but like to think in terms of irresponsible families. There is no evidence of irresponsible families.^{3,4} We cannot really face the issue of deterrence. The workhouse setup appeared to work in the past only because of the compulsion of the Poor Law, and to expect it to work on a voluntary basis in an affluent society at the end of the 20th century is ludicrous.

What Drs. Hodgkinson and Jefferys do not appear to recognize is that the "social dehiscence" which they try so hard to avoid, but are not very clear about, has nearly always occurred already. It is the commonest single reason that brings people to hospital. It is a gaping, a bursting open, and not a withering. The metaphor is crucial because on it hangs the validity of their paper.

We have two geriatric units side by side in very similar areas but using very different methods. There is no way of finding out from present statistics what happens to people who pass through hospital except in a very general way. This would appear to be an excellent opportunity for a research project and we should welcome this.—I am, etc.,

F. A. BINKS

Edgware General Hospital,
Middlesex

1 Goffman, E., *Asylums*, Harmondsworth, Penguin, 1968.

2 Millard, P., in *Conference on Future of Geriatrics*, British Geriatric Society, 1971.

3 Isaacs, B., Livingstone, M., and Neville, Y., *Survival of the Unfittest*, London, Routledge, 1972.

4 Shanass, E., et al., *Old People in Three Industrial Societies*, London, Routledge, 1968.

Sheep's Head as a Source of Orf Infection

SIR,—Orf is a virus infection affecting sheep. In humans it is not uncommon in shepherds and veterinary surgeons, but one could be excused for not thinking of the diagnosis in patients with the ordinary occupations found in an urban community.

In 1972 the diagnosis was made in three patients who used almost the same words to describe the source of infection—namely, "cleaning out a sheep's head for the dog."—I am, etc.,

J. SAVAGE

Royal Infirmary,
Doncaster

Aleutian Mink Disease

SIR,—May I write to correct a possible error in your Christmas Quiz? (23 December, p. 722). One of the very few answers I thought I knew was to the question on Aleutian mink disease. You stated that it was an animal model for human autoimmune disease. However it has been shown to be caused by a persistent virus infection.¹ There is an incubation period of 5-6 months before sterility, fever, weight loss, and renal involvement occur. Lymph node and splenic enlargement occur, as does a pancytopenia.

Viruria persisted for 136 days after inoculation of the virus into ferrets.² The disease is transmissible from mink to mink by crude organ suspensions and cell-free filtrates of diseased tissue.³ The pathological

changes in the mink are characterized by generalized lymphocytic and plasma cell proliferation with hypergammaglobulinaemia, glomerulonephritis and necrotizing arteritis.⁴

Aleutian mink disease is significant not only as an example of a persistent virus infection but also as an example of such a disease possibly occurring in man.⁵—I am, etc.,

L. HERZBERG

Royal Infirmary,
Dundee

1 Trautwein, G. W., and Helmboldt, C. F., *American Journal of Veterinary Research*, 1962, 23, 1280.

2 Kenyon, A. J., Helmboldt, C. F., and Neilsen, S. W., *American Journal of Veterinary Research*, 1963, 24, 1066.

3 Henson, J. B., Gorham, J. R., Leader, R. W., and Wagner, B. M., *Journal of Experimental Medicine*, 1962, 116, 357.

4 Karstad, L., *Canadian Journal of Comparative Medicine*, 1965, 29, 66.

5 Chapman, I., and Jimenez, F. A., *New England Journal of Medicine*, 1963, 269, 1171.

Conscience of the Profession

SIR,—Some years ago it was my regular evening duty to prescribe thalidomide sedation for insomniac patients on a maternity ward. Perhaps as a consequence I cannot help but reflect on the current harangue between the public and the Distillers Company for a just monetary compensation for iatrogenic malformations and the total lack of involvement of the medical profession in a similar dispute.

Let me make an analogy. If a manufacturer of meat pies makes pies which are harmful to the public, then it is the manufacturer rather than the shopkeepers who distribute them who is held responsible by the public. I cannot accept that the distribution of a harmful drug by doctors is a comparable situation. I cannot accept that doctors are tradesmen. The essence of a profession is not merely that its members should be skilled, but that they should acknowledge a moral responsibility for their actions and the trust placed in their judgement. The responsibility for the welfare of a patient must rest primarily with his attending physician. It does not lie primarily with a drug firm whose product he has taken it upon himself to recommend to his patient.

At the time thalidomide was distributed to the public its dangers were not known, or at least not appreciated. The Distillers Company and the medical profession are therefore not guilty of criminal negligence. The Distillers Company have offered millions of pounds in compensation. Although individual doctors may have saved their consciences in their own ways, the medical profession as a body has admitted nothing and given nothing. This makes me sad.—I am, etc.,

A. J. BARSON

Manchest.

Side Effects of the Pill

SIR,—I would recommend Dr. D. A. Varvel (23 December, p. 729) to use the progestogen-only pill for his patients complaining of a reduction in libido, and withdrawal headaches. In trials using the single-hormone micro-pills it has been particularly encouraging to find these and other side effects conspicuous by their absence.

The main disadvantage, as mentioned in Dr. Varvel's letter, is the poor cycle control.

As to contraceptive failure, the present continuous low-dose progestogen pills on the market offer good use effectiveness. A recent article giving the clinical and laboratory findings in a trial of Norgestrel quoted 1.3 pregnancies per 100 woman-years in terms of the Pearl index.¹ This compares favourably with the pregnancy rate quoted for intrauterine devices. The later reports show an improvement over earlier figures.²—I am, etc.,

K. M. HUNTINGTON

London S.W.3

1 Eckstein, P., et al., *British Medical Journal*, 1972, 3, 195.

Anaesthesia by Acupuncture

SIR,—I have received many replies to my letter (16 September, p. 703) asking how the Chinese had overcome the basic problems of an open chest and collapsed lung while performing a pneumonectomy solely with the aid of acupuncture anaesthesia (Dr. S. G. Hamilton and others, 5 August, p. 352).

It would seem that the operation is performed on patients who have good lung function but are suffering from infective lesions such as tuberculosis or bronchiectasis.¹ Selection of patients is such that those with reduced lung function or who are mentally unsuitable to undergo such a procedure are eliminated. This excludes at least 20% of patients (Mr. I. Capperault, 28 October, p. 232).

Two weeks preoperatively an artificial pneumothorax is induced on the affected side. The patient then undergoes breathing control exercises and becomes accommodated to respiring on one lung.² Immediately preoperatively a sedative is given. The chest is entered with the aid of local anaesthesia and intravenous pethidine (Dr. D. Saltoun, 9 December, p. 612). On opening the chest the lung is already collapsed. The mediastinum does not shift as it is fixed by adhesions. Little analgesia is required while working in the chest cavity.

What about acupuncture? The Chinese report that they initially had to place needles into 40 different points on the body. Over the years this number has been slowly reduced, until now only one needle is required, inserted into the deltoid muscle.¹ One wonders whether this technique would still be successful if the final reduction were made and no needles inserted.—I am, etc.,

MICHAEL A. E. RAMSAY

The London Hospital,
London E.1

1 *Peking Review*, 1972, 15, nos. 7-8 (February).

2 Lisowski, F. P., (University of Hong Kong), personal communication.

Congenital Tuberculosis Successfully Treated

SIR,—We wish to report a proved case of congenital tuberculosis (fulfilling the necessary criteria as laid down by Beitzke¹) which was treated successfully.

A premature male infant of Indian parentage was born following an assisted breech delivery to a primiparous mother. Gestation was estimated at 32 weeks and the baby weighed 1,690 g. The Apgar scoring was 7 at one minute. Clinical examination at birth was negative and the infant was immediately transferred to the special baby care unit and nursed in an

incubator. He had no direct contact with his mother after birth.

At six weeks he was noted to have occasional cough. The chest was clinically clear, W.B.C. 23,000/min³ with 40% neutrophils and 56% lymphocytes. Mantoux test was negative. Chest x-ray showed inflammatory changes at the right base. He was therefore started on a mixture of ampicillin and cloxacillin. His general condition was static and his temperature fluctuating.

A week later he developed a firm, smooth swelling in the right anterior triangle of the neck, followed a few days later by a similar swelling on the left. Shortly afterwards he developed an ear discharge. At this point the spleen was just palpable and liver 1½ (3.75 cm) below the costal margin. His general condition was deteriorating. A swab from the ear discharge grew *Escherichia coli*, but Ziehl-Neelsen staining showed acid-fast bacilli resembling *Mycobacterium tuberculosis*. Culture and guinea-pig inoculation of this specimen later was positive. The cerebrospinal fluid contained 36 W.B.C. and 20 R.B.C./mm³, protein 119 mg/100 ml, sugar 42 mg/100 ml, and no organisms (including Z.N. film). He was started on isoniazid, streptomycin, and PAS. Repeat chest x-ray showed consolidation of the right upper lobe. At this time he was breathless on feeding. He started to improve and to gain weight at three months. Repeat Mantoux test was negative until the 14th week of life, when it became weakly positive. Culture and guinea-pig inoculation of gastric washing, cerebrospinal fluid, and urine were negative.

The tuberculous nature of the illness in the infant was proved by examination of the ear discharge. This, to our knowledge, has not previously been reported. At the time of writing the infant, now aged 3 years, is doing well.

The mother, as is often the case, died of tuberculous meningitis 10 weeks after delivery in spite of antituberculosis chemotherapy. At postmortem evidence of tuberculosis was found in the meninges, subcarinal and porta hepatis lymph nodes, peritoneum, liver, uterus, and one fallopian tube. Histologically these organs showed typical tuberculous granulomata. No acid-fast bacilli, however, were found in any of the tissues.—We are, etc.,

D. C. GORDON-NESBITT
G. RAJAN

Staincliffe General Hospital,
Dewsbury, Yorks.

¹ Beitzke, H., Cited by Harris, E. A. *Journal of Pediatrics*, 1948, 32, 311.

Problems with Ketamine Anaesthesia

SIR,—Austin and Bevan¹ and more recently Lt.-Col. C. K. Davies (21 October, p. 178) have drawn attention to two of the problems associated with the use of ketamine: (1) the need for atropine premedication to prevent excessive salivation; and (2) the inadvisability of using ketamine where the mouth cannot be kept clear of blood or other fluid.

I have had a similar experience to that of Lt.-Col. Davies. A child of 1 year weighing 10 kg was operated on for skin grafting of two fingers. No premedication was given; the child had been starved for eight hours. Anaesthesia was induced with a single intramuscular dose of 50 mg of ketamine (5 mg/kg). During the grafting the child salivated profusely and respiratory arrest occurred 13 minutes after induction. This happened in an anaesthetic room and all was well after intubation. For a subsequent grafting on the same child atropine premedication (0.6 mg)

was given intramuscularly 70 minutes before induction with intravenous ketamine 20 mg (2 mg/kg). This time ketamine was uneventfully used as the sole agent in a total dosage of 100 mg.

Resuscitative facilities must be available when ketamine is used alone but ketamine is invaluable for changing burns dressings on the ward and putting burned patients into the bath, as was also found by Boyd *et al.*² This may safely be done with atropine premedication and in the presence of basic resuscitative equipment.

A recent article by Baraka *et al.*³ prompted the use of ketamine as an induction agent for elective caesarian section. Ketamine produces very little respiratory depression. An acceptable technique was found to be atropine (0.6 mg) premedication—pre-oxygenation—ketamine (1 mg/kg) intravenously—pancuronium (10 mg)—intubation and ventilation with oxygen—nitrous oxide. One full-term normal infant delivered by elective section by this technique gasped immediately and had an immediate Apgar score of 8. However, for the next 3½ minutes frothy fluid welled up from the infant's trachea. The heart rate fell to 60/minute. The fluid was sucked out and the child intubated and ventilated with oxygen, and is well. Presumably this fluid was a mixture of air and liquor inhaled during delivery. It may be that the use of ketamine, with its lack of respiratory depression and its circulatory stimulation, caused or, more correctly, allowed this inspiration due to the stimulus of delivery.—I am, etc.,

K. C. MACINTOSH

British Military Hospital,
Hannover, Germany

- ¹ Austin, T. R., and Bevan, D. R., *British Medical Journal*, 1971, 2, 709.
- ² Boyd, N. A., Barry, N. A., and Davies, A. K., *Annals of the Royal College of Surgeons of England*, 1971, 49, 291.
- ³ Baraka, A., O'Brien, M., Aslaman, E., and Saade, R., *British Journal of Anaesthesia*, 1971, 43, 609.

Drugs in Infertility

SIR,—Some of the comments of Dr. G. I. M. Swyer (18 November, p. 425) are not consistent with our experience of the use of mesterolone, both as regards its clinical role as an androgen and its effects on endogenous testosterone levels both in plasma and urine and on urinary luteinizing hormone (L.H.) and follicle-stimulating hormone (F.S.H.) excretion.

Two groups of hypogonadal patients were treated with 200 mg of mesterolone per day. The first group of four patients had not been on androgen therapy previously. All had a good clinical response to the dose used, with a noticeable increase in shaving frequency from once to three times per week. Liver function tests were normal throughout, and the longest period of treatment has been two years. There was no change in testosterone levels in some patients; in others, however, there was approximately a 30% drop during treatment, with no apparent change in urinary LH and FSH. These findings have been confirmed in six normal subjects given mesterolone 200 mg daily over three weeks.

The second group of patients have all been on testosterone propionate implants for various lengths of time. Of eight patients, five responded satisfactory on conversion to

oral mesterolone and maintained normal libido and hair growth on long-term treatment. In three cases, however, this conversion was not clinically adequate; the patients felt increasingly tired and apathetic, with a reduction in the frequency of shaving.

In conclusion, mesterolone appeared to act as an active androgen in nine of 12 hypogonadal patients studied and has the advantages of oral administration with no long-term effects on liver function, no apparent reduction in gonadotrophin levels, and a small effect on endogenous testosterone production. We hope to present more detailed data on these points at a future date.—We are, etc.,

E. W. BARNES
W. J. IRVINE

Department of Therapeutics,
Royal Infirmary

A. A. A. ISMAIL

M.R.C. Clinical Endocrinology Unit,
Edinburgh

Nutritional Value of School Meals

SIR,—In their survey of school meals, Messrs. D. P. Richardson and M. Lawson (23 December, p. 697) have established that the possible calorie and protein intake is adequate and compares favourably with food brought from home or bought elsewhere. But they have not taken into account what every teacher knows—that there is a considerable wastage of unpopular items. In particular green vegetables and protein sources other than meat tend to be left, and puddings are not favoured by teenage girls. Therefore unless the amount of school meals which is actually consumed is calculated, no recommendations can be based on this study.—We are, etc.,

SUSAN M. BATESON
MALCOLM C. BATESON

London S.W.19

Referring Patients for Electrolysis

SIR,—I am grateful for the opportunity provided by my friend Professor P. J. Hare (16 December, p. 672) to highlight some of the problems relating to the removal of superfluous hair, particularly from the face. I regret that my original letter (2 December, p. 551), which included verbatim my committee's draft to the B.M.A. Central Ethical Committee and which explained the questions he raises and our disagreement with some of the statements made in *So Now You Know about Your Skin*, had to be drastically shortened, at the Editor's request. We found nothing offensive in this booklet, and are grateful to Professor Hare, for example, for further condemnation of the electrolytic pencils for home use which have regrettably been flooding a desperate market.

But the patients we see in our hospital clinics are the hypersensitive, paranoid, or even suicidal women who have tried all the depilatory creams, epilating waxes, abrasive pads, and plucking tweezers, and in whom reassurance very carefully given that they are not becoming male is promptly and totally destroyed if one should then—as so often happens—mention the word moustache, beard, or razor, which last by no pretty-name will smell the sweeter, even if used by all the film stars.