seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment") was clearly applicable in the case of this patient. It followed therefore that as the conduct was caused by brain damage, the Act required the classification to be that of "psychopathic disorder" and not "mental illness," with the consequences which are set out in your correspondent's article.

I seriously doubt whether any mental disorder which is a disability of the mind caused by brain damage can be classified as "mental illness" for the purposes of the Act. This would not prevent a classification of "mental illness" if such a patient suffered from some secondary disorder also (such as dementia), amounting to mental illness.

The position of a patient who suffers from mental illness which results in "seriously irresponsible conduct," etc., is unclear, having regard to the watertight compartments laid down in section 4. It is difficult to see how a classification of "mental illness" in such a case could be faulted.—I am, etc.,

JAMES A. COOKE

Chairman,
Mental Health Review Tribunal for the
South-west Metropolitan Regional Hospital
Board Area

London W.C.1

¹ In re V. E. (Mental Health Patient) *The Times*,
7 July 1972 (1972) 3 W.L.R. 669.
² *All England Law Reports*, 1972, 3, 373.

Deaths Associated with General Dental Anaesthesia

SIR,—Dr. M. P. Coplans and Mr. I. Curson (13 January, p. 109) report that evidence at a coroner's court is seldom adequate for determining the precise cause of death in these cases; if the investigator is to make a valid diagnosis, they suggest, it has to be supplemented through personal communication with those present in the surgery when the collapse occurred.

With this I entirely agree. Applying this principle I have, over the years, investigated a considerable number of these fatalities and very rarely indeed has the correct explanation emerged from the coroner's court. Often the inquest is delayed several weeks, by which time the evidence of those most closely involved in the shattering catastrophe tends to be influenced by hindsight and other considerations. Nor is the expert witness always as informed and impartial as the coroner may suppose. And since nearly all the victims of this sudden unexpected collapse are young and healthy, necropsy is essentially negative. The pathologist will report oedema of the lungs and congestion of the viscera, which are common findings, but to explain the death he has recourse to such suggestions as asphyxia (even though there had been no cyanosis or other sign of suffocation under the anaesthetic, only pallor), idiosyncrasy to one of the agents used (nitrous oxide, trichlorethylene, halothane, and methohexitone have all been blamed), "anaesthetic shock," vagal inhibition associated with thymic hypertrophy, or even (in 1970) "status thymolymphaticus."

Truth and science would be better served were a panel of experts, at least two in number and of the highest academic standing, commissioned the moment a death associated with general dental anaesthesia was notified to hold an immediate on-the-

spot inquiry and duly report to the coroner.—I am, etc.,

J. G. BOURNE

Salisbury, Wilts

Anthrax

SIR,—Dr. Robert Lamb's article on anthrax (20 January, p. 157) mentions the disinfection of imported hair and wool, which has recently been discontinued.

The Government Wool Disinfecting Station in Liverpool was opened in 1921 but was closed some two years ago. The reasons given by the Department of Employment for its closure were that considerable quantities of imported hair and wool were coming in through other ports, and that the manufacturers of these raw materials were now sufficiently equipped to cleanse the consignments of hair and wool as part of the manufacturing process. During its existence the station dealt with many hundreds of consignments of imported hair and wool. These were tested bacteriologically before and after being treated by the Duckering process. Very many of the consignments were heavily infected with anthrax spores on receipt. However, the process was so effective that I cannot recall a positive result after the material was treated.

As these infected consignments of wool and hair are now being widely distributed to various parts of the country I would think it worth while for the Department of Employment to prepare a list of manufacturing processes in which these potentially infected materials are used so that doctors seeing patients working in these processes may be alerted to the anthrax hazard. If it is important, as our tropical disease colleagues exhort us, to ask the patient "Where have you been?", I would suggest that for any patient visiting his doctor with an inflammatory skin lesion it is equally important for the doctor to ask "What materials do you handle at work?"—I am, etc.,

ANDREW D. SEMPLE

Port Health Authority,
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Suicide Rate

SIR,—The suicide statistics of the past decade are remarkable for the steady decline in the suicide rate, beginning in 1964. That decline is present in all age and sex groups (see table); the young have not been excluded as Dr. D. Lester (9 December, p.

Suicide Rates in England and Wales per 100,000 by Age and Sex, 1963 and 1970^a

Age (years)	Men			Women		
	Rate		% Change	Rate		% Change
	1963	1970		1963	1970	
15-24	6.9	6	-13	3.1	2.6	-16
25-44	14	10	-29	9.6	5.9	-39
45-64	26	16	-38	17	12	-29
65-74	34	21	-38	20	15	-25
75+	39	24	-38	18	9.7	-46
All ages	14	9.5	-32	9.9	6.6	-33

612) states, provided we look at the most recent statistics.¹ It is true that the suicide rate for the 15-24 age group has not gone down as much as the older age groups' suicide rates, but it would be hasty to infer,

as Dr. Lester would, that difficulty in treating psychological disorder in the young is the explanation. Trends in admission rates for the younger age groups in fact run counter to those for the older part of the population. Between 1964 and 1970 first admission rates for the 15-19 age group increased² while rates for the other age groups decreased. Secular trends in suicide statistics are often easier to observe than explain.—I am, etc.,

B. M. BARRACLOUGH

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Chichester, Sussex

¹ Registrar General, *Statistical Reviews for England and Wales*, 1963 and 1970, London, H.M.S.O., 1965, 1972.

² Department of Health and Social Security, *Psychiatric Hospitals and Units in England and Wales*, Statistical and Research Report Series No. 4, 1970, London, H.M.S.O., 1972.

Radiological Pseudotumour in Chronic Ulcerative Colitis

SIR,—In two cases of ulcerative colitis radiological evidence indicating stricture due to tumour formation was obtained. In neither case was a tumour or stricture found to be present at operation; nevertheless, histological examination at these sites showed cancer to be present.

Case 1.—A woman aged 34 known to have had ulcerative colitis for 11 years was having six to eight bowel actions a day at the time of her admission to hospital. The stools were fluid, containing blood, pus, and mucus. She had colicky pain in the right iliac fossa. On examination no abdominal tumour could be felt. A barium enema showed extensive ulcerative colitis of long standing with a constant stenotic lesion at the hepatic flexure (fig. 1). This lesion

FIG. 1.—Barium enema showing changes of chronic ulcerative colitis with constant stricture at the hepatic flexure. Case 1.

was still present at a second barium enema undertaken a month later. Panproctocolectomy was therefore performed. At operation neither stenosis nor tumour could be found, though the whole colon was markedly thickened, with increased vascularity. Examination of the colon after removal revealed no evidence of cancer either as a stricture or a tumour. Histological examination showed a moderately well-differentiated adenocarcinoma to be present at the site of the radiological tumour. No penetration of the bowel wall had occurred and no lymph nodes were involved. She remains well after 17 years' follow-up.

Case 2.—A 28-year-old man developed septic

arthritis of the right hip. It was then discovered that he had had mild diarrhoea for over 10 years. On examination there were no significant abnormal physical signs except restricted movements of his right hip; no abdominal tumour could be felt. Sigmoidoscopy revealed a moderate degree of proctitis and biopsy showed the features of chronic ulcerative colitis, but there was no premalignant change in the rectal mucosa. Barium enema revealed extensive ulcerative colitis with a constant stricture in the transverse colon (fig. 2). At operation under-

FIG. 2.—Barium enema showing changes of chronic ulcerative colitis with constant stricture in transverse colon. Case 2.

taken for removal of the large intestine no tumour could be found; the bowel showed only mild changes on the serosal surface of some increase in vascularity. Likewise examination of the specimen revealed no evidence of a stenosing tumour. Histopathological examination, however, revealed areas of premalignant change and of definite cytological malignancy without invasion.

The absence of a tumour after persistent radiological evidence poses a dilemma for the surgeon, who, when confronted with negative laparotomy findings, may consider panproctocolectomy to be unnecessary. In both cases the disease had persisted for more than 10 years. Case 1 was seen before premalignant changes were described by Morson and Pang¹; premalignant changes were present in case 2 but not on rectal biopsy. In the event the radiological changes proved to be correct and the absence of tumour to be seen by the naked eye to be misleading. The absence of tumour in the presence of such obvious radiological change is inexplicable, but this combination has proved to be associated with early malignancy and the radiological sign may be an important indication of this change.—We are, etc.,

BRYAN N. BROOKE
DAVID CAVE

St. George's Hospital, London S.W.17

¹ Morson, B. C., and Pang, L. S. C., *Gut*, 1967, 8, 423.

Sponsored Hospitality

SIR,—I very recently received notification of a meeting of a medical association regional branch. I am a little disquieted to see that refreshments, which are basically wines and

a little food, are to be provided by a commercial firm. The proper relationship between us doctors and the drug houses is a matter of real difficulty, however careful we are to maintain our independence. It is inevitable that a large part of our approach to new drugs should be influenced by the approaches of their representatives, who are, indeed, extremely well informed and tell us of particulars in the therapeutic field which are often of great value to our patients.

In these circumstances it is specially important that we should try to retain a full independence of judgement. If I accept hospitality from a commercial organization it is hard not to accept the idea that I will consider their products favourably. To do so restricts that independence of judgement which my patients and the Department of Health expect me to exercise on their behalf. To deny such bias, on the other hand, seems unfair to the drug companies. Whatever the rights and wrongs of our remuneration, it cannot be said that the medical profession is a group of impoverished persons. Can we not afford to pay for our own refreshments?—I am, etc.,

KEITH NORCROSS

Birmingham

Anticholinergic Blocking of Prostaglandin-induced Bronchoconstriction

SIR,—Drs. A. P. Smith and M. F. Cuthbert (22 July, p. 212) noted a decrease in specific airway conductance following inhalation of prostaglandin $F_{2\alpha}$ ($PGF_{2\alpha}$) in healthy subjects. Bronchoconstriction started after a short latent period and usually reached its maximum 4–6 minutes after inhalation. The immediate effect of inhalation was pharyngeal irritation and coughing. They thought that the bronchoconstriction was not due to an irritant effect of $PGF_{2\alpha}$ because there was a short latent period between the inhalation and the onset of bronchoconstriction, and because earlier inhalation of atropine methonitrate did not influence the reaction.

An open assessment of the preventive effect of the anticholinergic drug Sch 1000 (Boehringer Ingelheim) on $PGF_{2\alpha}$ -induced bronchoconstriction was carried out on 16 asthmatic patients (10 males and 6 females, aged 18–67 (mean 37) years). Bronchial hyper-reactivity had been demonstrated in each case by means of a histamine inhalation test. After peak expiratory flow (PEF) had been recorded the patient inhaled five tidal breaths in a standardized manner from a DeVilbiss no. 40 nebulizer containing 0.1% $PGF_{2\alpha}$ in saline. With an airflow of 5 l./min the nebulizer delivered approximately 0.4 mg $PGF_{2\alpha}$ /min. PEF was measured again five minutes after the inhalation. If the fall in PEF was less than 20% of the basal value the patient inhaled a further 20 tidal breaths of $PGF_{2\alpha}$, and PEF was again measured 5 minutes later. The experiment was performed twice on every patient with one or two days interval, once without pretreatment and once 20 minutes after inhalation of two puffs (40 μ g each) of Sch 1000, the order of the two experiments being varied. The mean basal PEF was 398 l./min when no pretreatment had been given and 438 l./min after inhalation of Sch 1000.

The smaller dose of $PGF_{2\alpha}$ was followed by a mean decrease of 25% in PEF (S.E. of mean 4.1%). The fall in PEF was mark-

edly less ($P < 0.02$) when the patients were pretreated with Sch 1000 (mean value 15%, S.E. 3.4%). A fall in PEF exceeding 20% of the basal value was obtained in 10 patients with the smaller dose of five breaths of $PGF_{2\alpha}$ and in the remaining six patients with the larger dose of 5 + 20 breaths. Five healthy volunteers inhaled a dose of 45 breaths without developing bronchoconstriction, the fall in PEF ranging from 3% to 7%.

Our findings seem to support the hypothesis that the bronchoconstrictor effect of the inhalation of $PGF_{2\alpha}$ is partly mediated via the vagus nerves, and they differ in this respect from those reported by Smith and Cuthbert. The marked local irritant effect, often accompanied by paroxysms of cough, is compatible with the existence of a reflex action component, although Smith and Cuthbert found the response to $PGF_{2\alpha}$ to be less immediate than that reported for other inhaled irritants. Asthmatics were found to be much more sensitive than healthy subjects to inhalation of $PGF_{2\alpha}$.

Prostaglandin was kindly supplied by the Upjohn Company.

—We are, etc.,

KARI ALANKO
HAKAN POPPIUS

University Central Hospital,
Helsinki, Finland

Working of Health Centres

SIR,—We are writing to ask if any of your readers would give their views for a survey concerning health centres being undertaken by the King's Fund Hospital Centre and the Health Services Research Unit of the University of Kent. This study follows from expressions of concern by certain professional organizations that, with so many health centres open or being planned, little had been done to study their effect on the delivery of health care. Consequently a short-term inquiry is under way to try to identify topics that are thought to need further investigation and to present them in some order of priority.

We are asking for broad details of any studies in this field and for any suggestions for the questions that should be asked about the working of health centres, with particular reference to organization and planning. We have already circulated a request for information to a large number of statutory bodies, as well as contacting relevant central government departments, universities, and professional organizations. However, we thought that some of your readers with experience of working in health centres might care to write to either of us giving their views on any studies they think would be valuable regarding the use of health centres.—We are, etc.,

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24 Nutford Place,
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MICHAEL WARREN,

Director, Health Services Research Unit,
University of Kent

Canterbury

Afternoon Surgeries

SIR,—I think Dr. R. B. Smith's (20 January, p. 177) local executive council is quite right to refuse his request to change his evening