ried out with the patients in group B, except they were told that the new drug was acting and that their blood pressure had decreased.

The true blood pressures, all of which showed decreases, were recorded each day as percentages of the patient's basic systolic and diastolic levels established before treatment began. The mean of these percentages were then taken for each patient in each group and the average of these means taken as representative of each group for comparison with the other group. These showed that in group A at the end of the treatment the systolic blood pressure was 90.8% of the pretreatment level and the diastolic pressure 93.0% of the pretreatment level. The corresponding figures for group B were 95.8% and 97.2%. The differences in the systolic and diastolic values between the two groups were not statistically significant ($P > 0.1$ and > 0.2).

Our results in this short trial show that positive or negative information given to the patient does not influence the changes of blood pressure produced by effective hypotensive agents. Therefore the doctor's attitude toward the patient probably does not affect the evaluation of antihypertensive drugs.—We are, etc.,

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1 Freund, J., Krupp, G., Goodenough, D., and Preston, L. W., *Clinical Pharmacology and Therapeutics*, 1972, 13, 172.

Nitrazepam Nightmares

SIR,—The letter from Dr. Frances M. Taylor (13 January, p. 113), about vivid and painful nightmares following the administration of nitrazepam is interesting, and the occurrence of such effects could, in certain circumstances, have far-reaching consequences. Vivid dreams or nightmares after the taking of nitrazepam are commonly mentioned by patients, and appear to differ from those produced by other hypnotics in being less abstract and more frequently remembered on waking. Many doctors and other professional people who are in the habit of making the overnight journey by rail-sleeper between Scotland and London take nitrazepam to ensure a night's sleep with little hangover, so that they can concentrate at their meetings the following morning. A number have mentioned their vivid dreams. One colleague dreamed a whole lecture which he was going to give the following week and recognized some members of his audience. At a particular stage in this dream one of the audience, who was in a certain position in the front row, disappeared through a hole in the floor, and when my colleague subsequently gave the real lecture he was most interested to see what would rally happen at that point in his peroration. Somewhat to his disappointment the lecture went without a hitch. The dreams sometimes vaguely link up various incidents that occurred the previous day or connect them with occurrences that are known to be about to take place. It is not clear whether diazepam may have similar effects or whether it has been merely coincidence that patients taking diazepam have

been observed to waken during a ward round with similar well-remembered dreams.

The important point, and the reason for the writing of this letter, is to remind physicians treating influential patients that throughout history some men in very important positions have allowed their dreams to influence their actions, and the same is no doubt the case in modern times. If a world leader who was influenced by such fantasies were to dream, as a result of taking nitrazepam or a related drug, not that a member of his audience was going to go through the floor, but that his troops were going to go through a hole in the defences of the enemy or that he himself was divinely inspired to take a certain course of action, the consequences obviously could be serious. The doctor who prescribed the tablets might unwittingly have changed world history, and not necessarily for the better.—I am, etc.,

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Nurses for Nursing

SIR,—Many will admire Dr. R. A. Binning's touching faith in the ability of the Salmon structure to solve the problems of the nursing profession in this country (20 January, p. 176) and some may share his wish to protect the system from all criticism for a three-year period. Those of us who depend on the availability of skilled and highly trained practical nurses to look after our patients are inclined to be less optimistic.

At a time when whole wards are closed and non-emergency admissions are banned in teaching hospitals for weeks on end in winter because of nursing staff shortages one is bound to wonder where all the potential disciples of "teaching, the law, medicine, and industry" are hiding, who should by now have been attracted by the Salmon structure into the nursing profession. I suggest that the nursing profession does not need frustrated lawyers, doctors, and business executives, it needs many more nurses—that is, young women trained in the discipline of nursing sick people.

Many hospital doctors feel that the main reason for the low state of morale and chronic lack of recruitment in the nursing profession is that the only way nurses can obtain promotion or improve themselves financially is by giving up nursing. The top-grade ward sister or the nurse who has taken the trouble to acquire special skills such as intensive care, theatre work, or haemodialysis can advance in her career only by making the decision never to look after patients again. Instead she must sit in an office or walk round the corridors trying to be busy when in reality she is often unhappy and frustrated. A well-trained surgeon might feel similarly frustrated if told that the only way to increase his salary was to stop operating and retire to an administrative desk to make decisions about the distribution of surgical beds or the training of surgical registrars. The problem at the moment is not lack of nursing managers or nursing committees but lack of practical nurses to look after patients. Most wards run very well without the help of a "Salmon 7" provided that the sister is given enough nurses to do the job.

On common-sense grounds it seems likely that one way to increase the numbers of

practical nurses is to provide financial rewards for a continuing career in clinical nursing. The present steady loss of skilled practical nurses into the administrative grades could be halted by giving higher pay and promotion to those with higher degrees of skill and experience. This has been suggested before by experienced members of the medical profession, and as a principle it operates very successfully in other walks of life. I fear that if we take Dr. Binning's advice to sit back and wait three years for the Salmon structure to solve its "teething troubles" we are likely to witness a total collapse of the traditionally high standard of hospital medicine in Great Britain for which the nursing profession has hitherto been in large part responsible.—I am, etc.,

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Care of the Dying

SIR,—Sir Keith Joseph and his Department are to be complimented on the convening of the conference on "Care of the Dying" reported in your issue of 6 January (p. 29). All speakers were agreed on the importance of the problems involved, but they tended to approach them from points of view not easily reconciled. As a silent listener to the speakers, I would agree that we need more suitable hospital accommodation, more education, and more centres of research. All increased provision, however, will be only as good as the sensitivity and competence of the staff allow it to be. We heard much of the failures of the family doctor in this field, no doubt on occasion all too true. Yet some of us could find bereaved relatives, or even patients—not notable or important people—prepared to spell out a success story in what had been achieved by them and for them. On occasion the family doctor has been able to contribute both physical treatment and support of the whole person, knowing him both in vigorous individuality, perhaps over a number of years, and in his present extremity.

The conference failed to distinguish between the various standards and varieties of family medicine available, ranging from the city practice with the surrounding forces of urban depersonalization to the comprehensive medicine practised in more peripheral districts. However, I believe that the key to helping the dying patient lies in well-organized groups of doctors closely in touch with their nurses and able to discuss the day-to-day problems of care in their service to the patient. If to this arrangement is added the bonus of general practitioner hospital beds, it should be possible to manage all but the most difficult cases of terminal care. We shall need more education and sensitivity but I wonder whether a visitor from a specialized hospice or institution would not undermine our own confidence that we can undertake the task. There is much mutual support in a happy group practice, and responsibility is the life blood of medicine.

In brief, then, I believe that an extension of the tendency to form groups of doctors with attached nurses, perhaps some day social workers, could go a long way to improve care of the dying, with availability of hospital beds for family doctors' use. We need to accelerate that tendency which is already in progress, of which too few hospital

doctors and social workers seem aware, as a positive and beneficent force for the good of our patients, living or dying.—I am, etc.,

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Anthrax

SIR,—The article on anthrax (20 January, p. 157) by Dr. Robert Lamb was most disappointing. He refers frequently to the danger of infection from bone meal, but hardly mentions that hides, and hence tanneries, are an ever-present source of infection and patients. In spite of the increasing substitution of plastic materials, a large amount of leather is still used in this country, and since we are not self-sufficient in hides, many have to be imported. One tannery in Leeds when I was working there imported large numbers from Indonesia. The dust from these hides was always teeming with anthrax spores, for hides cannot be sterilized at the docks, like wool and hair. Dr. Lamb rightly stresses that in this country by law a dead infected animal has to be burnt in situ without postmortem examination. But in countries like Indonesia, even if such a law existed, a dead cow lying in the fields would be soon torn apart by vultures and the blood and tissue fluid would soak into the ground to form a long-lasting reservoir of contamination for the hides of other animals.

It is not true to say that there was no other treatment save excision and local phenol therapy before antibiotic days. The use of Sclavo's serum was well described in the surgical textbooks of the 1920s. The organic arsenicals such as neoarsphenamine were specific and were a godsend in the tropics, where, in the absence of refrigeration, supplies of serum were non-existent; I know of one man in Nigeria who owes his life to neoarsphenamine.

The important thing is to expect the disease; the golden rule should be that any worker in a tannery or a bone meal factory with a septic pimple has anthrax until proved otherwise. Any good laboratory can give an answer on a smear within half an hour and on a culture within 24. As soon as the bacteriologist has taken his specimens a massive dose of penicillin should be given, thereby preventing the rapid decline of a patient with an annoying septic pimple into the septicaemic patient in extremis so well described by Dr. Lamb.—I am, etc.,

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Lead Poisoning from Contaminated Opium

SIR,—We wish to record two cases of chronic lead poisoning due to the ingestion of contaminated opium. So far as we know this is the first report of a most uncommon cause of lead poisoning.

The first case was that of a 40-year-old Chinese woman with a two-month history of frequent attacks of severe lower abdominal pain. Her haemoglobin concentration was 9.8 g/100 ml, her reticulocyte count was 5%, and her white blood cell count was normal. A peripheral blood film smear showed some punctate basophilia. The urine was positive for coproporphyrin and the 24-hour urinary lead excretion was 0.26

mg/l. After exhaustive questioning and a visit to the patient's home had failed to disclose a possible source of lead intoxication, she disclosed that she had been an opium addict for the past 10 years—firstly, as a smoker and then, for the past four years, as an eater of opium. She brewed raw opium, obtained illegally, for several hours in a large metal pot in preparation for consumption. Analysis of this prepared opium showed 33.8 mg of lead per 100 g of opium. Analysis of scrapings from the inner surface of the metal pot showed 154 parts of lead per million.

The patient was treated with intravenous 10% calcium gluconate injections and twice-daily intravenous infusions of 500 mg calcium disodium versenate for five days. After three days the 24-hour urinary lead excretion was 2.6 mg/l. She has been lost to follow-up after discharge from hospital.

One month after the above patient was admitted to hospital her father, a 63-year-old unemployed Chinese man, presented with a two-week history of abdominal pain. His haemoglobin was 8.9 g/100 ml, reticulocyte count 3%, and the peripheral film showed punctate basophilia. The urine was positive for coproporphyrin and the 24-hour urinary lead excretion was 1.5 mg/l. Like his daughter, the patient had been ingesting the same home-prepared opium for the past 4 years. He improved with intravenous calcium lactate and calcium disodium versenate treatment.

Unusual and exotic causes of chronic lead poisoning in Singapore have been described. Hawes reported¹ lead poisoning in Chinese girls from face powders apparently made in China and containing lead carbonate. Danaraj reported² six cases of lead poisoning from Chinese folklore medicine adulterated with lead oxide. But so far as we know these two cases of chronic lead poisoning due to ingesting opium contaminated with lead are the first to be reported.—We are, etc.,

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¹ Hawes, R. B., *Malayan Medical Journal*, 1930, 5, 69.

² Danaraj, W., *Proceedings of the Alumni Association, Malaya*, 1954, 7, 261.

Hepatoma and Hepatitis-associated Antigen

SIR,—It was with great interest that we read the report by Dr. E. C. Campion and others (21 October, p. 149) of a case of hepatoma associated with hepatitis-associated (Australia) antigen in a white woman. Alpert and Isselbacher¹ failed to find Australia antigen in 31 cases of histologically proved hepatoma in whites born and raised in the U.S.A.

We have recently treated a 68-year-old white male who came in with a history of cirrhosis of the postnecrotic type and pain in the right upper quadrant. He was found to have Australia antigen and alpha-fetoprotein in his serum, a slight elevation of his serum alkaline phosphatase and aspartate aminotransferase (SGOT) levels, and a defect on liver scan. There was no history of hepatitis, exposure by any means to any hepatitis patient, or raw seafood ingestion

for several years. On biopsy of his liver mass he was found to have hepatocellular carcinoma, and he has responded nicely to 5-fluorouracil infusion.

We feel that this patient probably had anicteric hepatitis due to Australia antigen which progressed to a postnecrotic cirrhosis and eventually to the development of hepatoma. Unfortunately, we have no serum specimen from before his admission to our institution, but the postnecrotic cirrhosis had been documented at another hospital six months previously.

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¹ Alpert, E., and Isselbacher, K. J., *Lancet*, (1971), 2, 1087.

Magnetic Needle Dish

SIR,—Most operations involve some sort of suturing, with the consequence that surgeons have to dispose of the used needles as the operation proceeds. In so doing, needles are apt to go astray by becoming entangled in a swab or a pack or by bouncing off the table on to the floor; operating theatre staff are then diverted from their normal tasks to grovel about the floor seeking for the errant needles. At present there appears to be no organized drill for the collection and tally of needles during an operation, and this absence of system needlessly complicates accounting for the needles at the end of the procedure in the swab and instrument count. Again, needles discarded haphazardly by a surgeon may be difficult to distinguish among the instruments and other paraphernalia of an operation, making it tedious for the theatre sister to keep track of them.

These problems can be reduced by the use of a stainless steel dish 6 in (15 cm) in maximum diameter to the under surface of which a permanent magnet is attached (see fig.). In use the dish, sterilized by auto-

claving, is placed strategically in the operating field or on the Mayo instrument tray, conveniently available to both surgeon and theatre sister. Needles can then be discarded by being placed, dropped, or thrown on to the dish where they remain magnetically attached without the risk of bouncing off and being lost.

This instrument has been developed with the generous cooperation of Mr. R. Pickering of Polymatics Ltd., Tamworth, Staffs,