is poor and on the verge of disintegration. The key figures in the service, the consultants, are being treated like serfs and the whole set-up is reminiscent of a sinking ship. Moreover, the salary for these proposed co-ordinators was to be a consultant's starting salary. How could one offer less? A first-year full-time consultant like myself would find that the nine-to-five office worker was drawing the same salary with no clinical responsibility and the vaguest of notions of job description. Many of the applicants did not even know what the job entailed. One stated that she had no experience in the subject but was "willing to learn."

I believe that the time has come to stand out against this whole farce. I propose that each consultant nominated to serve on the committee for appointment of a community health specialist veto the appointment with every power at his disposal. The time for these dilettante appointments may arrive if and when the N.H.S. has a more logical financial structure. Until then let us have bread before caviare.—I am, etc.,

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Metoclopramide and Facial Dyskinesia

SIR,—Dystonic reactions due to metoclopramide have been reported in five children, all under the age of 11 years.¹ We report here two cases of acute facial dyskinesias in adults during treatment with this drug.

Case 1.—An 18-year-old man complained of nausea after developing aphthous ulceration of his mouth. His doctor prescribed metoclopramide 10 mg thrice daily. On the third day of treatment he presented with his head tilted backwards and to the side, his eyes rotated upwards and fixed towards the side, and facial muscle dyskinesia. A slight extrapyramidal tremor was the only other neurological finding. Ethylbenzotriphenine 5 mg was given intramuscularly and within 15 minutes all the neurological signs had gone. There were no recurrences.

Case 2.—A 34-year-old healthy woman was prescribed metoclopramide 10 mg thrice daily for a gastrointestinal upset. After she had taken three tablets she suddenly had difficulty in closing her eyes and a feeling of stiffness around the mouth. On examination she had an immobile Parkinsonian facies with staring eyes and was unable to smile or bare her teeth. A slight extrapyramidal tremor was present in the upper limbs. Examination findings were otherwise normal. Ethylbenzotriphenine 5 mg intramuscularly was given and within 20 minutes the tremor disappeared and the facial muscles returned to their normal relaxed state. Metoclopramide was stopped and there were no recurrences.

Metoclopramide has been reported to cause fleeting feelings of drowsiness and restlessness, very rarely with increased salivation.² Cardiac arrhythmia has been reported as a side effect,³ and the drug has been found to be a potent stimulator of prolactin release in men and women.⁴ The cases of the two adult patients here reported, with acute facial dyskinesia and mild extrapyramidal tremor after relatively small oral doses of metoclopramide, seem to be unique and may signify an individual sensitivity to the drug. Nevertheless, patients given metoclopramide should be warned of the possibility and asked to report such an untoward effect forthwith.—We are, etc.,

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- ¹ Casteels-van Daele, M., et al., *Archives of Disease in Childhood*, 1970, 45, 130.
- ² Bar, J., *Thérapie*, 1966, 21, 349.
- ³ Shakai, M. J., Pinkhas, J., and de Vries, A., *British Medical Journal*, 1974, 2, 385.
- ⁴ McNeilly, A. S., et al., *British Medical Journal*, 1974, 2, 729.

Diphosphonate Therapy in Deafness Associated with Paget's Disease

SIR,—Dr. W. H. Moffatt and others (26 October, p. 203) described a case of deafness associated with Paget's disease of bone which was substantially improved by calcitonin. Shai et al.¹ found audiometric abnormalities, with greatest impairment in the higher frequencies, in six patients with Paget's disease. Calcitonin treatment significantly improved the air conduction component of hearing in three of these patients.

We report here the preliminary results of six months' administration of disodium ethane-1-hydroxy-1,1 diphosphonate (EHDP) to five volunteer patients, aged from 50 to 70 years, suffering from active generalized Paget's disease with deafness due to involvement of the skull. They were given 1.2 g of EHDP daily for 180 days. They had not had any previous treatment for bone disease. Audiometry was carried out in each patient before starting treatment, after three months, and at the end of treatment. The pure-tone audiogram findings showed a significant improvement in the air conduction component of greater than 15 dB in three out of the five patients. The results were substantially similar to those obtained with calcitonin treatment. Improvement was more marked in the lower frequencies and less evident in the higher frequencies. The clinical and laboratory findings concerning skeletal metabolism will be reported elsewhere.

EHDP inhibits bone turnover, relieving pain and lowering plasma alkaline phosphatase and urinary hydroxyproline levels. Its effect on deafness in Paget's disease could be due to a reduction of the distortion of the temporal bone. The promising results obtained in our patients suggest that it may prove a useful treatment.—We are, etc.,

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- ¹ Shai, F., Baker, R. K., and Wallach, S., *Journal of Clinical Investigation*, 1971, 50, 1927.

Cardiac Perforation by Temporary Pacing Electrodes

SIR,—We feel we should record three cases of cardiac perforation by 100-cm Cordis No. 5 bipolar temporary electrodes which have occurred here within the past three months. Their excellent surface and extra stiffness make these electrodes easy to use and therefore particularly attractive to the occasional operator. However, especially in such hands perhaps, they may be more inclined to traverse the thin right ventricular wall.

In two cases subclavian introduction and initial placement were easy, by skilled operators, and the pacing threshold was 0.5 V or less. In one patient, a 72-year-old man with trifascicular block and Adams-Stokes syndrome, the temporary system was installed on the day of admission but there

was exceptional delay in proceeding to permanent pacing. He acquired septicaemia due to a sensitive staphylococcus and, in spite of massive doses of penicillin and cloxacillin, died on the 12th day. Temporary pacing failed shortly before death. At necropsy the distal 4 cm of the electrode was found to be in the pericardial space (which contained purulent fluid), having perforated the apex of the right ventricle. Myocardial softening due to infection could have been a factor here.

In another patient, a 52-year-old woman with aortic valve disease, complete heart block, and Adams-Stokes attacks, the tip of the electrode was found to have penetrated the wall of the right ventricle and to be lying in the pericardial space when aortic valve replacement was undertaken only two days after institution of temporary pacing.

In the third case unsuccessful attempts were made to establish temporary pacing in a 78-year-old woman who suffered failure of her permanent pacemaker system. She died some four hours later and at necropsy the temporary electrode was found protruding 2 cm through the right ventricular wall, which was 4 mm thick and of normal texture and colour. Nevertheless, some reduced resistance to myocardial penetration may have been a factor here in so far as the soft, helical, permanent electrode also had penetrated the wall obliquely for 1.5 cm (over a period of 10 days perhaps), the terminal stimulating portion being just in the epicardial fat and presumably unable therefore to stimulate the heart.—We are, etc.,

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Zuckerman Report and Radiology

SIR,—Dr. W. R. R. Thursfield and others (7 December, p. 593), who have set up a regional radiological advisory committee in the Wessex Region separate from the regional scientific committee, invite the views of other radiologists.

In East Anglia a regional radiological advisory committee to the now defunct regional hospital board existed for many years, and in the light of this long experience we firmly believe that such an advisory structure is best suited to the radiological needs of our patients. This East Anglian committee, with some modifications, is continuing as the advisory committee to the regional health authority—either directly or via the regional medical committee—on all matters related to the allocation and management of clinical resources in diagnostic radiology, ultrasonics, and radioisotope imaging techniques which fall within the province of radiology.

Diagnostic radiology is primarily a clinical discipline. Indeed, the Zuckerman Report¹ did not include radiology in the list of hospital scientific and technical services. Though at present one member of our radiological advisory committee sits on the regional scientific advisory committee the latter in East Anglia consists of representatives of disparate scientific and technical disciplines and is disabled by its very constitution from performing a corporate ad-