financial provision in the event of a compassionate situation arising which forces him to seek resignation within this five-year period.

My own predicament may serve to illustrate the application of these terms of service. On 1 April 1974 formal application was made to resign my commission on compassionate grounds. One hundred and sixteen days later this application was passed to and approved by the Army Retirements Board. At interview with the Army Medical Directorate I was informed that (a) the recruiting booklet is not legally binding and (b) "you don't have to point out the bad features when you're trying to sell something—only the good ones."

While agreeing that it is impossible to include all the detailed rules in a recruiting booklet, I do take exception to the evident lack of concern to explain these matters to those who may reasonably need such information in providing for the welfare of their families. Now, after 12 years' continuous commissioned service I am not eligible for any terminal gratuity since, as a result of advice given at the time, I had served only 4½ years' regular commission.—I am, etc.,

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Diagnostic Test for Multiple Sclerosis

SIR,—In the recent letter from Dr. M. A. Crawford and Mr. A. G. Hassam (18 January, p. 150) which referred to the linoleic acid effects in the macrophage electrophoretic mobility test in multiple sclerosis patients¹⁻³ there seems to be some confusion about the method applied.

In fact, it is not patients' macrophages which are used in the assay, but their washed and separated blood lymphocytes. The incubation of these cells with antigen and the subsequent cytophotometric measurements are carried out in a serum-free medium. The macrophages used are from unimmunized guinea-pigs.—I am, etc.,

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¹ Mertin, J., Shenton, B. K., and Field, E. J., *British Medical Journal*, 1973, 2, 777.

² Mertin, J., et al., *British Medical Journal*, 1974, 4, 567.

³ Field, E. J., Shenton, B. K., and Joyce, G., *British Medical Journal*, 1974, 1, 412.

Hazards of Argyll Trocar Catheter

SIR,—I should like to draw attention to the Argyll trocar catheter that is now widely supplied for use for intercostal thoracic drainage. This consists of a plastic catheter fitted over a pointed bodkin 40 cm long. It is to be found apparently in every ward, casualty department, etc., and though experienced thoracic surgeons are usually too frightened to use this piece of equipment, it is widely used by junior staff, who seem to be unaware of its dangers.

Though the point on the bodkin is now sharper than it used to be, the plastic edges of the tube make it difficult to penetrate the chest wall and considerable force is needed. As there is no flange, there is no means of arresting the passage of the trocar and

cannula and I have now seen a number of instances in which vital organs have been perforated owing to the unchecked passage of this instrument, and indeed such complications should have been anticipated.

A disposable catheter can be used through the normal trocar and cannula, which has a flange and is short.—I am, etc.,

LESLIE J. TEMPLE

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"Locked-in" Syndrome

SIR,—Dr. C. H. Hawkes (16 November, p. 379) ascribes to Dr. F. Plum and me the suggestion that patients with the "locked-in" syndrome and with a kinetic mutism should be grouped under the persistent vegetative state. In fact we stated the opposite, that these conditions should be distinguished from each other. In our description of the vegetative state¹ we stressed that though the eyes might follow objects the patient would never signal appropriately by means of eye movements. The term "locked-in" was indeed coined by Plum and Posner,² and in the second edition of their monograph³ they emphasized that it should not be confused with the vegetative state.—I am, etc.,

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¹ Jennett, B., and Plum, F., *Lancet*, 1972, 1, 734.

² Plum, F., and Posner, J. D., *Diagnosis of Stupor and Coma*. Philadelphia, Davis, 1966.

³ Plum, F., and Posner, J. D., *Diagnosis of Stupor and Coma*, 2nd edn. Philadelphia, Davis, 1972.

Pseudopatients

SIR,—Your leading article (28 December, p. 729) takes a singularly negative view of Rosenhan's paper "On Being in Insane Places."¹ To my mind it would be a pity if this were to deter people from taking the trouble to read an unusual and painstaking study. Rosenhan is meticulous in distinguishing between the facts he reports and the discussion of their implications. Above all, his work displays concern and a sober avoidance of the dramatic and polemical. I am afraid the same cannot be said of your response. Since Rosenhan is trying to widen our knowledge in an area where reliable information is very hard to obtain, we cannot afford to neglect what we get.

Many specific points could be taken up, but I will confine myself to one. The central argument in your article is that no reliance can be placed on conclusions from an inquiry which begins with deceit and lies; at the same time the author is criticized for not providing adequate controls. If one chooses to use such language, surely deceit and lies are similarly the basis for most respectable double-blind trials. I respectfully suggest that we cannot have it both ways. The actual findings of the study do not particularly surprise me after 15 years' experience in psychiatry.

I could take issue with Rosenhan in respect of his tendency to under-rate the degree of agency exercised by patients themselves. In my experience they often know as much and sometimes more than the staff

about how the mental hospital really functions. Patients play an active rather than a passive role in maintaining the unhappy situation in which they live.—I am, etc.,

D. C. WALLBRIDGE

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¹ Rosenhan, D. L., *Science*, 1973, 179, 250.

Unusual Reaction to Pentagastrin

SIR,—May we report an unusual reaction to a subcutaneous injection of pentagastrin? A male patient of 40 with a chronic duodenal ulcer received 500 µg of pentagastrin by subcutaneous injection during the course of a test to estimate the peak gastric acid output. He had not received a previous dose of this agent so far as we are aware. There were no immediate effects and the test was completed normally. Approximately 17 hours later he woke with intense itching of his trunk, arms, thighs, and legs associated with periorbital oedema. The skin was covered with a blotchy erythematous rash but there were no systemic abnormalities and the pulse and blood pressure were normal. He was given an antihistamine and within approximately 10 hours, the rash had faded. He did not receive any other medication whatsoever before the development of the rash. It is unlikely that he was sensitive to some component in his bedding as the rash did not return after it had faded.

We report this incident as it is the only reaction of this type that we have seen in over 300 of these tests.—We are, etc.,

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Nerve Lesions and Finger Wrinkling

SIR,—Following Mr. S. O'Riain's interesting study (22 September 1973, p. 615) on the loss of skin wrinkling in response to hot water in peripheral nerve lesions, in which this sign seemed to correlate well with denervation, we studied this association in patients referred to the electrodiagnostic department. Their symptoms were suggestive of the carpal tunnel syndrome, but none had marked wasting of the thenar eminence or complete loss of sensation in the median territory.

The nine patients studied had definite median nerve compression at the wrist with increased motor latencies and delayed, reduced, or absent antidromic sensory volleys. In none of these was there evidence of decreased finger wrinkling in the area served by the median nerves compared with the ulnar territory after immersion in hot water at a temperature of 40–45°C for 30 minutes.

I suggest therefore that decreased skin wrinkling is an insensitive sign of denervation. It has been demonstrated only in cases in which other signs were sufficient to allow the surgeon to operate without E.M.G. confirmation and it is certainly not reliable in diagnosing difficult peripheral nerve problems.—I am, etc.,

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