Medical Management of Transient Ischaemic Attacks

SIR,—Your leading article on transient ischaemic attacks (15 February, p. 352) drew attention to this important manifestation of cerebrovascular disease and gave a valuable account of the clinical picture and the appropriate investigations. However, the final paragraph on the management of patients considered unsuitable for surgery was a little unhelpful. This syndrome is thought to have an annual incidence of 183.5 per 100 000¹ and is about a third as common as the "typical stroke." Accordingly, great efforts are being made to find drugs which will inhibit the formation of platelet aggregates, certainly one of the causes of recurrent emboli to the brain.

Anticoagulants appear to have little to offer: they require supervision and are potentially dangerous. Many drugs may alter platelet function and two groups—namely, non-steroidal anti-inflammatory drugs and the pyrimido-pyrimidine compounds—have been used clinically in patients with platelet thrombo-embolic disorders.² Dipyridamole (Persantin) is probably the best known of the pyrimido-pyrimidine derivatives. It has been shown to reduce thrombosis and increase platelet consumption associated with renal transplant rejection and cardiac valvular prostheses, though it does not appear effective in cerebrovascular disease.² However, several of the non-steroidal anti-inflammatory drugs alter platelet function, and aspirin and sulphinpyrazone (Anturan) have both been shown to be of value clinically and therefore merit further consideration. Aspirin reduces the frequency of attacks of amaurosis fugax and in some studies has reduced the incidence of venous thrombosis in susceptible patients.² Sulphinpyrazone prolongs platelet survival and decreases platelet turnover in patients with prosthetic heart valves,² inhibits clotting in arterio-venous shunts,³ reduces thrombosis,⁴ and also reduces the frequency of transient ischaemic attacks⁵ and of amaurosis fugax.⁶ The time has surely come to assess these two drugs and perhaps others in the large group of patients who suffer from recurrent emboli to the cerebral circulation, bearing in mind their uncertain prognosis.⁷—I am, etc.,

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1 Acheson, J., Acheson, H. W. K., and Tellwright, J. M., *Journal of the Royal College of General Practitioners*, 1968, 16, 428.

2 Mustard, J. F., et al., *Annals of the New York Academy of Sciences*, 1972, 201, 343.

3 Kaegi, A., et al., *New England Journal of Medicine*, 1974, 290, 304.

4 Steele, P. P., Weily, H. S., and Genton, E., *New England Journal of Medicine*, 1973, 288, 1148.

5 Evans, G., and Gent, M., in *Platelets, Drugs and Thrombosis*, p. 258. Symposium, Hamilton, Ontario, 1972.

6 Evans, G., *Canadian Medical Association Journal*, 1973, 108, 463.

Involuntary Facial Movements

SIR,—I was surprised that your leading article on this subject (1 March, p. 476) made no reference to the dyskinesia associated with the use of metoclopramide. This agent is becoming widely used and, while the observation that it may cause involuntary movements is not original,^{1,2} I suspect that it is not sufficiently recognized.

I have recently seen two cases involving young women. In both instances the patients had been on therapeutic doses, for three and four days respectively. The condition caused extreme anxiety to both the patients and their relatives. As is often the case with the dyskinesia associated with phenothiazines, it ceased almost instantly following the injection of benzotropine 1 mg intravenously. —I am, etc.,

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1 Casteels-van Daele, M., et al., *Archives of Disease in Childhood*, 1970, 45, 130.

2 Melmed, S., and Bank, H., *British Medical Journal*, 1975, 1, 331.

Administrative Gobbledegook?

SIR,—The welcome good sense of Dr. G. Dunea's Personal View (1 March, p. 509) could hardly have been more perfectly emphasized and complemented than by the following advertisement in the same issue

MICHAEL PRENDEVILLE

Paris

Consultant Contract

SIR,—Because I count on the digits of one hand the years to retirement the outcome of the consultants' dispute with the Government is of no personal interest. On appointment as consultant in 1951 (and how lucky I was) I entered wholeheartedly into the spirit of the N.H.S., splendid as that spirit then was, never counting the hours spent on the job. I am certain that I share my sentiments with a majority of my contemporaries, both full-time and part-time. Now in response to the call for sanctions from our negotiators I have deliberately reduced my work load not because I expect or deserve any personal advantage after the dispute but because I consider it my duty to support my younger colleagues and, perhaps more important, the present senior registrars and their successors, who are all owed by us a legacy worth leaving.

It is claimed by the Government and others that money lies at the root of our dispute and that once the Review Body has announced its findings all will be sweetness and light. I beg all members of our profession not to be dazzled by a big award in April. With taxation and inflation any increment can be—indeed will be—reduced to a negligible amount, if not this year then next. Far more important than increment is the conditions of work. Until the contract is satisfactorily settled we must continue the fight. It might be appropriate to continue sanctions until the whole N.H.S. be improved—in fact, our present sanctions are probably saving the hospital service from collapse.

What is the problem? Many of my contemporaries are content with their contracts, especially the pre-1955. The B.M.A. made a serious error in agreeing to the newer contract, but even that is acceptable so long as it be interpreted liberally. So there we have the crux of the matter; with a co-operative and understanding regional board, few problems arose. I understand that many consultants have less happy relations with their boards (and I know of no evidence to suggest that reorganization has helped in that, as indeed in any other, respect). Others

(p. xxxviii) for "Specialists in Community Medicine."

"Health Care Planning and Information Services. This post offers vast opportunities to make advances in this new field. It comprises health care planning with evaluation and the setting up of information systems with links, where practical, with the systems being developed in the three constituent Boroughs."

"Medical Staffing. This post comprises liaison on medical staffing and the co-ordination of the planning of medical staffing in the Area in conjunction with the Area Personnel Officer and the District Community Physicians and the District Management Teams. The post will encompass health care planning particularly in relation to the above and may later include the co-ordination of the Area occupational health services which are based on Districts."

The writers of the announcement deserve our critical praise. It would be difficult to convey more clearly the obvious truth of yet more purveyors of administrative gobbledegook undergoing the regular and statutory binary fission, seeking likely lads to join in the spanner-throwing.—I am, etc.,

have intolerable inadequacies of staff and of facilities. A new contract will not improve any board's attitude, indeed it can destroy liberty altogether; it will do little if anything to relieve the staffing problems, and again may only produce more money for taxation. It will certainly not improve any buildings, though I put buildings last in our needs—good work can be done in a tent given good morale.

Certainly I write as a part-timer, and I understand the frustrations of full-timers mainly in respect of the unfairness of our tax system, for gross incomes of one group compared with gross incomes of the other group are not on average greatly disparate. In spite of the differences I note, in Southampton at any rate, that there is almost complete unity between the two groups, a unity achieved by the arrogant behaviour of Government ministers.

The conditions we fight for are for our juniors; let us not desert them who in turn see the way ahead, present-day juniors being much more far-sighted than I ever was. Let us not be led astray by the gold to be debased next year. And let not the lunacy of the recent agreement so suspiciously speedily made between the junior doctors and ministers blind the juniors to their future problem, an acceptable contract.—I am, etc.,

T. ROWNTREE

Southampton

SIR,—I am a part-time consultant and am writing to you concerning the letter (18 January, p. 154) from my whole-time colleagues Dr. R. S. Francis and others. They refer to the "tax advantages" of the part-time consultant "amounting to a considerable extra emolument" and later in their letter state that they "understand the significance of the whole-time commitment allowance." I believe they do not understand clearly their present position, let alone their possible future position, and should reconsider their statements and the advantages of their present open-ended but