measured with a low-reading thermometer over a five-min period. The outside temperature was very high and the room temperature was above 27°C. She was covered with two cellular blankets and allowed to rewarm spontaneously. At 6 pm her rectal temperature had returned to 35.6°C and her pulse was 60/min; by 10 pm her temperature was 37.2°C and her pulse 81/min, with an improvement in her level of consciousness.

The nitrazepam was stopped, but on the night of 29 July a night nurse mistakenly gave the patient another 5-mg dose. The following morning at about 10 am she was found to be drowsy again, her pulse was 60/min, and her rectal temperature 35°C. She was treated in the same conservative way and by 2 pm her rectal temperature was 35.6°C. This patient has remained well ever since.

At the time of this occurrence there were another nine patients aged 67-92 (mean 80) years in the long-stay wards who were receiving 5 mg of nitrazepam nightly at 10 pm. The rectal temperature of each of these patients was measured at 6 am and 10 am on eight consecutive days. In no case was a reading below 36.2°C recorded.

The Committee on Safety of Medicines has records of one case of a 58-year-old woman with moderately severe disseminated sclerosis who developed hypothermia at home with a temperature of 29.5°C after being prescribed nitrazepam 5 mg as night sedation. The manufacturers of the drug know of one case in an elderly patient in hospital several years ago who had received a 10-mg dose of nitrazepam and had later developed hypothermia, but no further clinical details are available. It would appear that this patient of ours is the first case of nitrazepam-induced hypothermia to be reported in the medical literature.

Although this complication of nitrazepam therapy may be unusual, we wish to draw the attention of the medical profession to its occurrence, especially now that the "hypothermia season" is about to begin.

M IMPALLOMENI
RAMSAY EZZAT

Geriatric Department,
North Middlesex Hospital,
London N18

Intravenous cytarabine in treatment of herpes zoster in haematological malignancy

SIR,—Disseminated herpes zoster occurring in a patient with leukaemia or lymphoma has a poor prognosis. Cytarabine has been judged to be a potent anti-herpes virus drug in vitro, as it inhibits nucleoside reductase and DNA polymerase,¹ but two controlled in-vivo studies have failed to prove its efficacy against zoster infections.^{2,3} Stevens,² who found a greater duration of zoster dissemination in the treated group, correlated it with a cytarabine-induced depression of antiviral defences, among which are two major factors, local interferon production and humoral antibody.⁴ Furthermore, the drug showed some myelotoxicity.

Cytarabine can be delivered in a non-toxic way by a single rapid intravenous injection, 15 min after which the drug is undetectable in the blood.¹ Juel-Jensen⁵ claims that such injections in modest doses—3 mg/kg on the first day and 2 mg/kg on the next three days—are remarkably effective. We decided to deliver these doses by single daily intravenous rapid injection, with no other treatment except local antiseptics, to any patient with leukaemia or

lymphoma presenting with disseminated zoster.

In two years 10 patients entered the study, three women and seven men aged 9-72 (mean 37) years. Nine were receiving chemotherapy when zoster appeared, directed against acute lymphoblastic leukaemia (four patients), Hodgkin's disease stage III Bb and acute myeloblastic leukaemia (two patients each), and IgG myeloma (one patient). Chemotherapy was stopped during the four days of cytarabine treatment except in one patient with Hodgkin's disease who was in very poor condition. In the tenth patient chronic lymphoid leukaemia was first diagnosed when disseminated zoster developed. Treatment was started as soon as we saw the patients—that is, on the second day of the eruption in three, the third in four, and the seventh, 11th, and 15th days in one patient each.

Extension of the zoster eruption ceased within two days of starting treatment in nine patients but continued to the sixth day in the acutely ill patient with Hodgkin's disease. Flattening and drying of the vesicles began within four days of starting treatment in all except the same patient with Hodgkin's disease, in whom it was delayed until the ninth day. In no case was there visceral involvement. The complement-fixing antibody level could be determined in six patients; it was no different from that seen in zoster patients not receiving the drug. We were not able to measure local interferon production. Finally, no patient showed evidence of myelotoxicity.

The nine good results obtained in this small series of 10 cases enable us to hope that a controlled, randomised trial of this treatment will definitely prove its efficacy.

S KERNBAUM

Hopital Claude Bernard,
Université Paris VII,
Paris

¹ Weinstein, L, and Chang, T W, *New England Journal of Medicine*, 1973, **289**, 725.

² Stevens, D, et al, *New England Journal of Medicine*, 1973, **289**, 873.

³ Davis, C, Van Dersal, J, and Coltman, C, *Journal of the American Medical Association*, 1973, **224**, 122.

⁴ Stevens, D, and Merigan, T, *Journal of Clinical Investigation*, 1972, **51**, 1170.

⁵ Juel-Jensen, B, *British Medical Journal*, 1973, **1**, 406.

Ethics of industrial action

SIR,—The medical profession has been in conflict with the Government for the past year and grave anxiety has been expressed by doctors in national newspapers, the *BMJ*, and other medical periodicals that the consultants' work-to-contract and the junior hospital doctors' recent restriction of service to "emergencies only" are not ethical courses of action.

Few would doubt that events of the past year have damaged the status and integrity of the profession, but no protective action whatever has been taken by the Central Ethical Committee of the BMA. It is very difficult for doctors in conflict with the State to make up their minds whether industrial action or resignation is the right course to pursue without consulting a reasoned statement of the ethical and moral position prepared by men experienced in ethical problems. Why have we not had this advice?

I understand that there is to be a meeting of the Central Ethical Committee in early February, although I urgently requested one early in December 1975. As consultants have had to commit themselves to the ballot in January on a matter fundamental to the whole future of medicine in Britain many will deeply regret that they have voted without the benefit of sound ethical advice.

No army can fight with a guilty conscience. I believe our cause is just. Provided the methods

we use to defend it are honourable our profession will emerge unscathed.

P A T WOOD

Chairman,

Fellowship for Freedom in Medicine

London W1

Goodman proposals

SIR,—We are being asked this week our views on the results of the negotiations reached as a result of Lord Goodman's intervention into the present dispute between the Government and the profession.

It is our view that the Goodman proposals are fundamentally unacceptable as they breach the important principles that have been reiterated again and again. If they are accepted by the profession then its independence is once more jeopardised. It is vital for all of us to look at the long-term future of the profession if the present proposals were implemented, and it is our view that, with particular reference to the more junior members of the profession, the Goodman proposals simply delay the achievement of a full-time salaried medical profession. The advice of the Independent Hospital Group also undermines the position of the profession and is not, in our view, at all helpful.

The consultants in this district have indicated their feelings in no uncertain fashion by submitting their undated resignations to the chairman of the local medical committee.

M WALLACE

Chairman,

Consultants Action Committee,
East Berks District

Windsor, Berks

Whole-time consultants group

SIR,—At meetings of the consultant staff in this district during the past year it has been obvious that there are differences of opinion between whole-time and part-time consultants as regards the terms of service which the Hospital Consultants and Specialists Association and the BMA should propose when negotiations are resumed with the DHSS. While it may be sensible not to overemphasise differences within the profession it seems to us pointless to ignore them, and at a time when we are being asked to embark on a form of industrial action in opposition to the consultative document many of us would like to know that our views will not be disregarded by our negotiators later on. We have therefore formed a whole-time consultants group in this district with a view to crystallising our own ideas and to draw up a list of demands which we shall ask the HCSA and BMA to accept as a basis for negotiation with the Department. We hope that similar groups will be set up in other districts and we ask any such groups already formed to get in touch with us.

We should like to emphasise that it is not our intention to set up a third negotiating body but to remain within the HCSA and BMA and to strengthen these organisations by assuring the leadership of the determination of their members and by assuring the ordinary members of the willingness of the leadership to act in accordance with their wishes.

J A AGER

and 26 other signatories

Princess Margaret Hospital,
Swindon, Wilts