health food stores. It was estimated that if the patients adhered to the diet they would receive in the region of 18 g of fibre per day. We do not claim that bran tablets have any "magical," properties that cannot be obtained with a sensible HRD or ordinary miller's bran, but tablets which are specifically prescribed are more convenient for the patient than a diet and are more likely to be regularly taken. For the trial three tablets were taken three times a day (18 g bran/day). The antispasmodic is incorporated within the Normacol granules and is alverine citrate. The dose prescribed was two teaspoonfuls twice a day.

(2) The results shown and the statistical comparison made are within-patient comparisons between control values and values following each of the treatments.

(3) It was not possible to show in this group of 20 patients that one treatment was more pleasant than another, although at least half preferred the taste of bran tablets to either Normacol granules or a rigid HRD.

I TAYLOR
H L DUTHIE

University Surgical Unit,
Royal Infirmary,
Sheffield

Nit-picking?

SIR,—Much as I enjoyed the cross-fire between Dr W F Whimster and Mr C M Heath (15 May, p 1211), and Dr John Apley (24 April, p 999), and would like to pitch in with my own twopennyworth, I feel it is more important to take issue with your own comment.

In stating that "a tooth-comb was in the past an essential weapon in the battle against head-lice" you seem to be satisfied that the battle is won and the tooth-comb obsolete. Reference to the report in 1975 of R J Donaldson¹ on the incidence of infestation in school-children in England and Wales reveals that over 200 000 children are affected and that there is a reservoir of infestation of about 1 m persons. Donaldson's recommendations that a vigorous campaign should be mounted to eradicate the louse while it is still susceptible to malathion preparations seem to have been ignored. As the modern insecticides kill but do not loosen the nit, the tooth-comb is still a vital part of that campaign. It should certainly not be a relic of the past.

T C G SMITH

Lyndhurst, Hants

¹ Donaldson, R J, *The Head Louse in England: Prevalence amongst Schoolchildren*. London, Health Education Council, 1975.

* * * We did not intend to suggest that the battle is over but simply that the tooth-comb no longer stands virtually alone in the front line of the attack.—ED, *BMJ*.

Spares for anaesthetic machines

SIR,—I wish to reply to Dr D W Eyre-Walker's letter (1 May, p 1077) criticising BOC Medishield Ltd's decision "to stop supplying spares for, and maintenance to, anaesthetic machines manufactured prior to 1957."

Production of the machine in question, the Medishield Boyle Basket Model, ceased in

1957, and many examples which continue in use pre-date the second world war. I estimate that no more than 15% of anaesthetic machines in use in the UK are of this type, and many of those are maintained solely in a standby capacity. That the machines are still in good working order is due largely to the fact that we have been able to provide a high standard of servicing and an ample supply of spares. To maintain this supply of spares beyond 1977 would involve extensive retooling costs, which would have to be reflected in the cost of those spares. While it would be possible in theory not only to maintain the machines, but to continue to upgrade them to present-day standards, the cost would, in many cases, exceed that of a new machine of equivalent performance.

Our company's decision has been accepted and welcomed by many members of the profession and hospital supplies officers, and a typical reaction is that of the Midlands Regional Health Authority which appeared in the *Birmingham Mail* on 1 May. The authority is stated to have told that newspaper: "The firm is justified in not trying to perpetuate old models. In a lot of cases these machines should be replaced. Better and more sophisticated models are now available."

Finally, I refer to Dr Eyre-Walker's comment that he and his colleagues "would be prepared to replace our machines gradually over a matter of years." Our original letter of warning regarding the withdrawal of spares and service was issued to the Department of Health and to hospital supplies officers in September 1971. Our most recent warning, advising that July 1977 will be the cut-off date, was issued in February this year.

We believe, as responsible suppliers, that we are totally justified in phasing out what can only be described as vintage equipment not only in our own interests but also in the interests of the medical profession and the patient. Furthermore, we have provided more than ample notice of our intentions.

J E EVERITT
Director,
BOC Medishield Ltd

London W6

Progression and regression of atherosclerosis

SIR,—The pathological observations of Professor CWM Adams (1 May, p 1070) are, of course, relevant as such, but there is some confusion over the issues under consideration which must be seen in perspective. I wrote (20 March, p 710) to fill in what appeared to be an important omission in a discussion on regression of atherosclerosis. The physician is concerned with patients who develop atherosclerosis and its clinical consequences and who need the best available dietetic advice.

The relevant facts are that Western man has made radical changes in the food he eats and they are of a kind highly likely to be atherogenic. The incidence of atherosclerosis varies widely between populations and is closely related to this type of diet. Migrants to high-incidence countries like America from low-incidence countries like Japan, or to Israel from countries with a varying incidence such as the Yemen, Iraq, and Europe, and who change their eating habits develop, in expected sequence and degree after appropriate time intervals, changes in their plasma lipids,

atherosclerosis, and coronary heart disease (CHD). These observations are based on healthy individuals, necropsies, hospital patients, and population surveys.

Patients with familial hyperlipidaemia, precocious atherosclerosis, and premature CHD often also have cutaneous xanthomata. If they are given what is now termed a "prudent" diet the xanthomata regress and, since their lipid composition is similar to that of atheromatous plaques, it is reasonable to expect there will be at least some degree of comparable regression in their arteries.

Non-human primates, very similar to man in the ways I described and not subject to spontaneous atheroma, if given a diet taken by Western man today develop, in expected sequence, changes in plasma lipids, severe atherosclerosis, and its complications. If, however, they are given instead a "prudent" diet only mild arterial changes develop or, if atheroma has been induced, there can be considerable regression.

Finally, patients with atheromatous peripheral vascular disease tend to have similar changes in their coronary arteries and are at high risk of developing myocardial infarction. If changed on to a "prudent" diet widening of the narrowed peripheral vessels occurs as judged by angiography and increased blood flow.

The up and coming high-density lipoprotein story is fascinating and important, but the fact that mechanisms have not yet been clarified does not reduce the importance of the observations referred to above.

All this, of course, may just be coincidence.

RICHARD TURNER

University of Edinburgh

Family pathology and family treatment

SIR,—The articles (17 April, p 947, and 24 April, p 1004) on disobedience and violent behaviour in children heighten my awareness of the need for adult and child psychiatrists to join together in the treatment of the family.

Often disturbed children are treated in isolation while their parents require attention, and the converse also holds true. Treatment of marital problems can just as easily centre on physical, psychiatric, or emotional difficulties which the parents are having with their children, and only on seeing the children with their parents can one get an accurate picture of the problems.

I might add that a new organisation, the Association for Family Therapy, has been formed out of just such a need for increased communication within and between medical and social disciplines.

S LIEBERMAN

Secretary,
Association for Family Therapy

Department of Psychiatry,
St George's Hospital Medical School,
London SW17

Treatment of mania with bromocriptine

SIR,—Bromocriptine is a semisynthetic ergot alkaloid marketed for the suppression of puerperal lactation and the treatment of galactorrhoea, amenorrhoea, and infertility. Bromocriptine stimulates dopamine receptors in the nigro-striatum of the brain in animals,¹ lowers plasma prolactin levels, and has little

direct effect on the uterus or cardiovascular system.² It also acts presynaptically, possibly at pituitary level.³ Prolactin produced via the pituitary gland is a direct precursor of hypothalamic prolactin release-inhibiting factor, which resembles or may actually be dopamine.⁴ Dopamine is the first step in the noradrenergic arousal system, an end product of which, 4-hydroxy-3-methoxyphenylethylene glycol, has been found to be increased in the cerebrospinal fluid in mania.⁵

On these principles lowering of the plasma prolactin level with bromocriptine should prevent the genesis of mania without producing the side-effects associated with phenothiazines or potential toxic reactions associated with lithium. This was found to be so in two patients with long-standing manic-depressive psychosis who developed severe mania and in whom phenothiazines and lithium carbonate were contraindicated. When 5 mg of bromocriptine was given three times a day the symptoms subsided within 48 hours and both patients were able to return to work within 10 days. No side-effects were reported or biochemical or haematological abnormalities noted. Further evaluation of bromocriptine as a possible advance in the therapy of mania is in progress in our department.

C DORR
K SATHANANTHAN

Department of Metabolic Research,
Warlingham Park Hospital,
Warlingham, Surrey

¹ Fuxe, K, *et al*, *Medical Biology*, 1974, **52**, 121.

² Flückiger, E, and Wagner, H R, *Experientia*, 1974, **24**, 1130.

³ Besser, M, *Medicine*, 1975, **7**, 325.

⁴ Pusteels, J L, *et al*, *Annales d'Endocrinologie*, 1971, **32**, 188.

⁵ Wilk, S, *et al*, *Nature*, 1972, **235**, 440.

Bromocriptine and spasmodic torticollis

SIR,—The encouraging results obtained in the treatment of Parkinson's disease with the dopaminergic agonist bromocriptine¹ stimulated the use of this agent in spasmodic torticollis. Ten patients agreed to participate in a single-blind trial. The dosage of bromocriptine was started at 2.5 mg daily and increased every three days by 2.5 mg to the optimum tolerated dosage. Only one patient was taking concurrent medication. Patients were maintained on maximum dosage for at least two months before placebo substitution. All patients were assessed at fortnightly intervals by the same observer, where possible in the presence of one of the patient's relatives. Two of the patients were unable to tolerate more than 15 mg of bromocriptine because of intolerable nausea. The remainder attained doses between 40 and 80 mg without severe adverse effects.

Eight patients showed no improvement on treatment and no change on placebo substitution. One patient with severe clonic torticollis showed marked deterioration in neck movements which subsequently improved on substituting haloperidol 4.5 mg daily.

A 53-year-old docker with both retrocollis and spasmodic torticollis mentioned in a previous trial² had continued on 6 g of levodopa daily since 1972 with complete relief of his retrocollis and improvement in his torticollis. In the last two years, however, he had developed severe choreoathetoid movements of the limbs as a side effect of treatment. The patient refused to discontinue L-dopa at the

onset of the trial, but on attaining a dose of 80 mg of bromocriptine daily he was able to discontinue his levodopa gradually without recurrence of his retrocollis and a gratifying disappearance in choreoathetoid movements. On placebo substitution the patient's torticollis returned.

Bromocriptine at a dose of up to 80 mg daily thus appears to be ineffective in the treatment of the large majority of sufferers from spasmodic torticollis, which remains one of the most refractory of the abnormal movement disorders.

ANDREW LEES
K M SHAW
G M STERN

Department of Neurology,
University College Hospital,
London WC1

¹ Lees, A J, Shaw, K M, and Stern, G M, *Lancet*, 1975, **2**, 709.

² Shaw, K M, Hunter, K R, and Stern, G M, *Lancet*, 1972, **1**, 1399.

Laparoscopic removal of IUDs from the abdomen

SIR,—I was interested to read the letter from Mr D J Pearce (24 April, p 1017) illustrating the use of laparoscopy for the removal of intrauterine devices (IUDs) which have perforated the uterine wall. I would like to add a word of caution. In this hospital we have had three patients this year in whom an IUD had perforated the uterus some time previously. These could not have been recovered with a laparoscope. One of these devices was a Lippe's loop and two were Gravigard Copper 7s, and in all three instances the device was firmly embedded in the omentum. In two cases part of the omentum had to be excised, while in the third case the device was extracted from the omentum but only with difficulty.

While the laparoscope can be used for therapeutic as well as diagnostic purposes, our experience indicates that laparotomy is often necessary for the recovery of an IUD lying outside the uterus. If perforation of the uterus is suspected and attempts to recover the device are made soon after the accident occurs I suspect that removal via the laparoscope will probably be generally possible, but if time elapses before discovering that the device is outside the uterus it may well be trapped in the omentum.

M R FELL

Salisbury General Hospital,
Salisbury, Wilts

Order of Dedicated Doctors

SIR,—I have founded "The Order of Dedicated Doctors" who never contemplate withholding their medical labour for purposes of payment from various authorities. We maintain that all interest in medical expertise is self-sufficient and only when the welfare of patients is in danger does the order contemplate united action to coerce authorities and individuals to diminish such dangers. There are no routine constitutional rules, no meetings, no committees, and no more than personal written communications to me to indicate problems affecting the fellows of the order. Such communications are entirely confidential

and never revealed under any circumstances, but should a fellow require assistance in helping his patients the united action of fellows will be brought to bear unanimously on those capable of solving those problems.

There is no political bias of any kind, and never will be, related to this order. No kudos or reward is ever, or will ever be, given to any fellow in relation to what he achieves. No subscriptions are involved and we are anxious to point out that it is not a "do-good" society for patients as individuals. It is a scientific order devoted to the science of helping patients to lead comfortable, useful lives. No controversial problems such as euthanasia or abortion are ever discussed and only such matters as are described in medical textbooks and journals receive our attention.

W J ATKINSON

Kalmere,
Sheffield Park, Sussex

The pay-bed issue

SIR,—In recalling Aneurin Bevan's offer of pay-beds in 1948 Sir Thomas Holmes Sellors tells only half the story (8 May, p 1144). The other carrot was the promise, via the Spens Report, of distinction awards for the chosen few. Opposition to entry thus disintegrated and the profession was sold to the politicians in exchange for those golden perquisites for the few.

Surprisingly, Sir Thomas firmly believes that morale remained high until the present Government made the decision to separate private practice from NHS hospitals. It is now generally agreed that as a consequence of the Goodman proposals this separation cannot be achieved this century. This is surely the time to get this pay-bed issue into proper perspective and to identify the condition responsible for the fall in morale. This is simply a progressive and continuing erosion of the consultant's position both in relative and absolute terms. Anyone in any doubt about this should consult the Government's annual supplement to *Economic Trends*. This explains that in the period 1948-75 personal incomes in the UK rose ninefold against a fourfold increase in prices. Despite the United Kingdom's poor economic performance R A Butler's prediction that the standard of living would double in 25 years has been confirmed. Where stands the hospital consultant in all this? He stands even further back than he did in 1948 and this must constitute a record in the western world. It could be argued there has been a continuing redistribution of wealth in favour of the lower-paid. This has certainly not been the case within the consultant grade, where differentials in favour of merit award holders have actually widened. Furthermore, the hospital consultant is unique in that on appointment he can opt for either a whole-time or maximum part-time contract, thus adding weight to the widely held belief that fat pickings are always available in private for those sufficiently interested. Despite all the evidence to the contrary, a majority of consultants still believe that the whole-timer has been basking in the part-timer's sunshine all these years.

The future prospects for most of us are bleak indeed if we allow ourselves to be continuously brainwashed in this way. Opening up a glossy package of propaganda this