

## Points

### McIlroy was here. Or was he?

Dr C E DICK (Dublin 6) and Mr J R NIXON (Holywood, Co Down) write: We read the paper "McIlroy was here. Or was he?" by Drs C A Pallis and A N Bamji (14 April, p 973) with great interest. We were medical students resident in separate Dublin hospitals in 1966. At this time McIlroy appeared at the casualty department of the Royal City of Dublin Hospital complaining of chest pain. One of us (JRN) was connecting him to an ECG machine which required to be earthed. Unfortunately, this was not done and the patient obviously experienced an electric shock. He leapt from the trolley and, putting his finger over his tracheostomy, confirmed in no uncertain terms that this was the case. He took his own discharge. Later that evening this somewhat ruffled student called at the Adelaide Hospital three kilometres or so away. There CED was found to be examining McIlroy, still complaining of chest pain but not referring to his recent experience. When he saw JRN he had the grace to look a little embarrassed. The ECG machine in the Adelaide Hospital evidently caused the patient no further upset—and the tracing showed no abnormality. Nevertheless, he spent a comfortable night in hospital and subsequently took his own discharge. There is no doubt in our minds that this man was McIlroy. . . .

Dr C C SMITH (Newbury, Berks) writes: . . . It was ten years ago, when I was a medical student at Fulham Hospital, a hospital not mentioned in the list by Drs A N Bamji and C A Pallis (14 April, p 973), that Mr McIlroy presented at the accident and emergency department, where I clerked him in. . . . The main complaint was of paraesthesia of the left side of his face and an absence of sweating on the left side of his face, symptoms which themselves caused some suspicion. . . . He never actually became an inpatient. While waiting to be taken to the medical ward he demanded pethidine. The casualty officer's previous suspicions were reinforced . . . and since his wishes were not complied with he left.

Drs I M O'BRIEN, G D SUMMERS, and J E NEILD (St Thomas's Hospital Medical School, London SE1 7EH) write: We are pleased to inform Drs A N Bamji and C A Pallis (14 April, p 973) that McIlroy, or William Scott as we know him, was alive in June 1978. He collapsed at Waterloo Station on 20 June and was admitted to us with his customary signs of a left hemiparesis and aphasia. His clothes bore the name of William Scott and J Stonehouse. Fortunately he was recognised by an agency staff nurse and later by one of our own medical staff. He was seen by a clinical photographer and vanished shortly afterwards. As far as we know he has not been readmitted to St Thomas's since.

Dr P O G EHRHARDT (Manchester Royal Infirmary, Manchester M13 9WL) writes: William Scott (14 April, p 973) was around more recently than a year ago. As a new house physician, on my second night in the hospital, I found myself at 3 am on the main corridor attempting to persuade him not to discharge himself from Hope Hospital, Salford. I was no match for Mr Scott. Later that morning (3 August 1978) he turned up in the casualty

department at Ancoats Hospital, Manchester, under a different name.

Drs N M C MAYNE and T P ORMEROD (Cheltenham General Hospital, Cheltenham, Glos GL53 7AN) write: . . . May we add two more hospitals to the list of hospitals attended by McIlroy? In about 1964 he was admitted to Westminster Hospital and in about 1970 to Cheltenham General Hospital.

Dr V E LLOYD HART (Leighton Buzzard, Beds LU7 0BS) writes: . . . I have noted one frequent feature in patients with Munchausen's syndrome, which is often of help. They are almost always on a journey when their illness occurs, and are often extremely reluctant to give a firm address from which they came, or to which they are going. They know that if the correct diagnosis is suspected inquiries will show that at least part of their story is untrue; here I have always found the police extremely helpful. . . .

Dr M JANOSI (East Ham Memorial Hospital, London) writes: McIlroy (or Mr William Taylor as he then was) was brought to this casualty department in August 1977, having had a "stroke" while walking in the main street. He also complained of left-sided chest pain radiating to his arm. The history was very much as Drs A N Bamji and C A Pallis describe. . . . As I am a little suspicious by nature, we decided to find out more about his background before investigating him in any detail. Anyway the "hemiparesis" miraculously cleared in a couple of days; the only problem we encountered was the angry response on stopping the Fortral (pentazocine) he demanded for "frequent chest pain" and substituting paracetamol. He discharged himself quite suddenly a month after admission and we have not heard from him since. . . .

### Drug-induced cardiovascular disease

Dr M K THOMPSON (Croydon, Surrey CR0 7HL) writes: I was interested to read Professor Alasdair M Breckenbridge's article "Drug-induced cardiovascular disease" (24 March, p 793), in which he mentions the hazard of ventricular fibrillation when administering digoxin. I recently came across an old copy of the *Therapeutic Review* . . . and was surprised to find that more than 52 years ago this hazard was first described by Gallavardin<sup>1</sup> in a fashion that could not be bettered today.

<sup>1</sup> Gallavardin, L, *Presse Médicale*, 29 December 1926, 1637.

### Oral temperature and hypothermia

Dr E LL LLOYD (Princess Margaret Rose Orthopaedic Hospital, Edinburgh EH10 7ED) writes: A great deal of "heat" has been generated over the value of an oral temperature reading in hypothermia since the mouth does not always give a true "core" reading in the cold situation (Drs K J Collins and A N Exton-Smith, 31 March, p 887), though it does in fevers. However, most of the controversy is due to the artificial definition that hypothermia is only present if the temperature of the core is below 35°C, which unfortunately seems to suggest that a person with a "true core" temperature of 34.9°C is hypothermic and therefore in grave danger, whereas at 35.1°C

he or she is safe. . . . Probably the lower the mouth temperature the more severe the effects of the cold stress and the greater the danger for the person whether official hypothermia is present or not.

### Psoriasis and cancer

Mr FRASER M HADDEN (Ninewells Hospital, Dundee DD2 1UB) writes: I understand the term "genetic advantage" to mean "reproductive advantage"—in terms either of increased fertility per se or of increased survival rates up to the reproductive age. As the bulk of malignancies occur in the postreproductive years, it is difficult to see how relative freedom from them in psoriasis (7 April, p 941) could be postulated to confer other than a minimal "genetic advantage," though such a freedom is a decided phenotypic advantage, of course.

### Swallowing pills

Mr J S PHILLPOTTS (Guildford, Surrey GU4 8PW) writes: Mr Peter Wescott (14 April, p 989) quite rightly draws attention to the difficulty many people experience in swallowing pills and capsules. . . . Normal people, however, can swallow quite a large bolus of food owing to the lubricant action of mucus which is produced in larger quantities during eating than during drinking; and advantage can be taken of this fact by advising patients to take their pills or capsules with some attractive food, when their difficulty will usually disappear.

### The natural history of windows

Dr R D MARTIN (Edinburgh EH13 0DR) writes: . . . I have just one reservation to make about Lord Taylor's article (31 March, p 870). The reference to Dr Rollier and heliotherapy is hardly fair. Rollier<sup>1</sup> treated patients suffering from non-pulmonary tuberculosis on open balconies, not in glazed rooms, since ordinary glass is impervious to ultraviolet light. Duration of exposure to sunlight was carefully regulated to ensure gradual acclimatisation in each patient. Erythema was to be avoided. The results were good and were duplicated in sanatoria in the British Isles. . . .

<sup>1</sup> Rollier, A, *Heliotherapy*, 2nd edn. Oxford Medical Publications, 1927.

### Recall fees

Dr D E B POWELL (Bridgend General Hospital, Bridgend, Mid Glam CF31 1JP) writes: Mr Russell Hopkins in his comments (14 April, p 1022) on my letter (24 March, p 825) takes up 12 column inches of your space in another apology for the new contract. He asks for my answers. It is depressing that one of our negotiators cannot, or will not, take the point. The objection is not primarily to recall fees as such, but to their introduction in anticipation of the new contract. Mr Hopkins says that they are not "part of the recent contract negotiations." The *BMJ* of 7 April (p 5 of the Report of Council) states categorically that the emergency recall fees "are part of the proposed new contract," and the Review Body will surely treat them as such. . . . Is money all that matters? Do consultants really have to be paid more to overcome their "increasing reluctance to attend their hospitals in unsocial hours" and raise their "standards of patient care"?