

bought the latest Cambridge Transrite electrocardiograph, and have enjoyed immensely my work with it. In detail my answers to his specific questions are as follows:

(1) One does not need to be working in a "centre" to find the benefit of this work. We are two in a partnership here, and although my partner leaves interpretation to me he is learning how to work the instrument so that he can go to a case and bring away the tracing without calling me out.

(2) Do they find them worth while? Yes.

(3) Are they expensive to maintain? The original cost is £275. After that, rolls of paper, tubes of jelly, replacement batteries, etc., are a matter of only shillings a month.

(4) Do they wear out quickly? No.

(5) Savings to other branches of the N.H.S.? The answer here surely is that all these patients would be saved the trouble of referral to hospital and hospital costs thereby reduced.

(6) How often do they need consultant opinion on tracings? So far, not at all (see below).

(7) Can a G.P. learn to interpret the majority? This depends on the G.P. and is really the crux of the problem. Before buying my instrument I had three months' post-graduate instruction in Edinburgh and took the M.R.C.P. (failed, of course). Then I studied for three or four months from the textbook. This is perhaps the only consultant field in which *all* the work can be done from this source. It is very important, in my view, to concentrate at first on the basic physics and physiology (with a dash of anatomy). Any G.P. who hopes to learn to interpret tracings by rule of thumb—that is, by trying to correlate a certain shape of tracing with a certain condition—is doomed to frustration and wasted effort and money. It is essential that as one's eye runs over the tracing a certain pattern of electrical events must be in the background all the time. Wolff's *Electrocardiography* is a difficult book, but to attempt interpretation of E.C.G.s without making oneself its complete master would lead one into a very high incidence of false positives and missed diagnoses. Recently a number of consultants were asked to give an opinion on a number of E.C.G.s. There was a considerable discrepancy between the opinions of different consultants on a given tracing and even a difference in the opinion of a given consultant on the same tracing at different times. The answer to this one, of course, is that the E.C.G. is to be judged, like an x-ray, only in relation to the rest of the picture. In this regard the G.P. should be in a more advantageous position than the consultant, assuming he has a reasonable knowledge of cardiology and has access to other means of investigation—for example, x-rays. If any G.P. thinks that by obtaining an E.C.G. machine he can obtain a short-cut to cardiologic diagnosis, he is doomed to disappointment.

These conditions given, I would say that this work is most rewarding, most stimulating in keeping one's standards at the highest level both in cardiology and in every other field, for one finds that excellence in one field demands similar standards all round.—I am, etc.,

Great Glen,
Leicestershire.

G. A. STANTON.

REFERENCE

- ¹ Wolff, Louis, *Electrocardiography: Fundamentals and Clinical Application*, 2nd ed., 1956. Saunders, Philadelphia.

Arteritis

SIR,—The article by Drs. J. W. Paulley and J. P. Hughes (November 26, p. 1562) is of considerable value in that it draws attention to the importance of arteritis as a cause of many syndromes. The nomenclature is, however, confusing, as in many cases no giant-cell formation can be demonstrated, and, as the authors say, the condition is not confined to the aged, though it is more common in the elderly. In 1946 Gibson, Kersley,

and Desmarais¹ described the widespread arteritis in the muscles in rheumatoid arthritis, and in 1951 I described² the syndrome of muscular pain, raised sedimentation rate, and wasting in the elderly after stress, and attributed it to a rheumatoid-like condition. Rest and, if necessary, A.C.T.H. or steroids were advocated. Excessive fatigue was the commonest trigger factor in our series, with psychological trauma, as suggested by Dr. Paulley, taking second place. The prognosis was moderately good on removal of the trauma. A.C.T.H. was easier to withdraw than steroids when either was necessary. In 1953 Bagratuni published his description of this anarthritic syndrome.³

In the cranial form all clinicians have seen many gradations from "temporal arteritis" to an anarthritic and sometimes an arthritic "rheumatoid" syndrome, usually in the elderly. Headache with raised sedimentation rate is a frequent type of onset, with blindness or diplopia following if treatment is not adequate. The myalgia tends to follow and be very persistent. Do not these two syndromes stem from the same source as many others, and are they not merely manifestations of a much more deeply situated process—perhaps associated with auto-immunology or at least some abnormality of antibody formation, resulting from the effect of stress on some biochemical weakness? Is it not better to consider these conditions of arteritis as just syndromes rather than suggest that they are actual entities?—I am, etc.,

Bath.

G. D. KERSLEY.

REFERENCES

- ¹ Gibson, H. J., Kersley, G. D., and Desmarais, M. L., *Ann. rheum. Dis.*, 1946, **5**, 131.
² Kersley, G. D., *Report of Second European Congress of Rheumatology*, 1951, p. 388. Editorial Scientia, Barcelona.
³ Bagratuni, L., *Ann. rheum. Dis.*, 1953, **12**, 98.

Status Asthmaticus Treated by Hypnosis

SIR,—I have been interested in the history of Dr. A. H. C. Sinclair-Gieben's asthmatic patient who died after hypnosis (December 3, p. 1651), and would like to make an additional comment.

Sudden death is not unknown in asthma, quite apart from status asthmaticus. I described a small series of cases in 1955, and I attempted to discover a means of detecting patients to whom this disaster was liable to happen. Three significant features were found: The only common factor in every case was a profound emotional disturbance which had a clear relation to the onset of asthma. The usual methods of treatment were found to be quite ineffective in every case. The most significant feature was the attitude of the patient to his illness. The average asthmatic learns to adjust himself and to live with the complaint. In this particular group the usual attitude was one of *panic*, which was noticeable even in anticipation of an attack.

The conclusion was that, when an asthmatic patient is found to exhibit this panic reaction, great care should be taken in expressing a prognosis. Of course, sudden death in asthma may be due to common drugs. Of these by far the most dangerous is aspirin.—I am, etc.,

London N.W.1.

JAMES MAXWELL.

REFERENCE

- ¹ Maxwell, J., *Brit. J. Tuberc.*, 1955, **27**, 208.

SIR,—I was interested to read the article by Dr. A. H. C. Sinclair-Gieben entitled "Treatment of Status Asthmaticus by Hypnosis" (December 3, p. 1651). One cannot, however, study this case without making certain

observations. The most remarkable fact of the case comes in the "Final Note," which states, "A few days after discharge the patient died suddenly of acute heart failure."

In recent years there has, quite rightly, been a new awareness amongst the profession of the values of hypnosis in treatment. It is quite obvious that the patient most probably would have died of his status asthmaticus without the use of hypnosis, all other known methods having been tried without avail. Asthma must be considered, however, as a symptom and not a disease. What were the true psycho-dynamics of this patient's asthma? According to Dr. Sinclair-Gieben he was a very well adjusted man. This, with due deference, I question. I am certain that by careful analytical questioning one would find gross emotional upset.

This asthmatic attack was the patient's unconscious means of dying. When the attack was cured he unconsciously realized that this way of escape had been removed, and so three days later he dies of acute heart failure. This case emphasizes that when treating cases of asthma by hypnosis one must endeavour to find the true unconscious meaning of the attacks. In no way am I suggesting that the use of hypnosis in this case led to the patient's death, but I am endeavouring to bring to the notice of all who use hypnosis in the treatment of asthma the tremendous importance of ascertaining a history of its deep-seated dynamics. Unless this precaution is taken other alarming symptoms from time to time will reveal themselves.—I am, etc.,

London W.1.

ALAN AKEROYD.

Is Thalidomide to Blame?

SIR,—I feel that four cases which have occurred in my practice recently are worthy of mention, as they may correspond to the experience of other practitioners. They all presented in more or less the same way—each patient complaining of: (1) Marked paraesthesia affecting first the feet and subsequently the hands. (2) Coldness of the extremities and marked pallor of the toes and fingers on exposure to even moderately cold conditions. (3) Occasional slight ataxia. (4) Nocturnal cramp in the leg muscles. Clinical examination in each case has been essentially negative, and during this time I have not noticed similar cases in my practice.

It seemed to me to be significant that each patient had been receiving thalidomide ("distaval") in a dose of 100 mg. at night, the period during which the drug had been given varying from eighteen months to over two years. Thalidomide is generally regarded as being remarkably free of toxic effects, but in this instance the drug was stopped. Three of the patients have now received no thalidomide for two to three months, and there has been a marked improvement in their symptoms, but they are still present. The fourth patient stopped taking the drug two weeks ago, and it is therefore too early to assess the effect of withdrawal.

It would appear that these symptoms could possibly be a toxic effect of thalidomide. I have seen no record of similar effects with this drug, and I feel it would be of interest to learn whether any of your readers have observed these effects after long-term treatment with the drug. I might add that I have found it otherwise to be a most effective hypnotic with no "morning hang-over" effect. It has been especially useful in patients with skin pruritus and discomfort.—I am, etc.,

Turriff, Aberdeenshire.

A. LESLIE FLORENCE.

Digitalis Poisoning

SIR,—Your contributors (November 12, pp. 1402 and 1409) are to be congratulated on drawing attention to atrial tachycardia with block as a manifestation of digitalis intoxication. Since reading Lown and Levine's description¹ of this five years ago I have noted several examples, one of which has been published elsewhere.²

Perhaps the rather confusing terminology prevents wider recognition. "Paroxysmal," although used by Levine, is not a label that can be given as a result of a single cardiographic study, and seems inappropriate when each "paroxysm" is drug-induced. And surely the time has come to stop trying to make a rigid distinction between atrial tachycardia and flutter which Prinzmetal³ has shown to be essentially the same phenomenon, differing mainly in the rate of discharge of an ectopic focus.

The important point, as Dr. Samuel Oram and his colleagues say (p. 1402), is recognition of the rapid atrial rhythm which is due to digitalis. The curious variability of the auriculo-ventricular block is one of its most suspicious features.—I am, etc.,

St. Helier Hospital,
Carshalton, Surrey.

C. P. PETCH.

REFERENCES

- ¹ Lown, B., and Levine, S. A., *Current Concepts in Digitalis Therapy*, 1955. Churchill, London.
- ² Petch, C. P., *Brit. J. clin. Pract.*, 1959, 13, 266.
- ³ Prinzmetal, M., et al., *The Auricular Arrhythmias*, 1952, 3rd edition. Thomas, Springfield, Illinois.

A Case of Atrial Septal Defect

SIR,—I read with great interest the discussion between Professor J. McMichael and Dr. Monica Bishop about the evidence of carditis in a case of atrial septal defect (November 26, p. 1585), as I happen to be working (with Professor R. Scalabrino) on a very similar instance of Lutembacher's syndrome: a 44-year-old woman, with a story of heart disease, cardiogram showing right bundle branch block and right ventricular hypertrophy, who died from cardiac failure and at whose necropsy a 3.5-cm. wide atrial septal defect, mitral stenosis, and tricuspid lesions were found. Following on serial sections of the His-Tawara bundle, I noticed several round-cell aggregates, fibrosis, and thick-walled, stenotic arterioles at the upper portion of the ventricular septum. The bifurcation and the right branching of the bundle seemed to be involved and damaged. The base of the tricuspid, the walls of the right atrium, and the region of the sinus node showed groups of lympho-histioid elements. No typical Aschoff bodies, however, have been observed.

I would like to point out that such a carditis in Lutembacher's syndrome could be regarded as not uncommon and, sometimes, as responsible for clinicopathological changes (conduction troubles) besides the classic valvular ones.—I am, etc.,

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University of Milan.

LINO ROSSI.

Chemical Diagnosis of Steatorrhoea

SIR,—Although the facts about steatorrhoea determined by Dr. Edward B. Hendry (October 1, p. 975) are mostly unexceptionable, the conclusions are quite misleading. He finds, as do most other investigators, that the 24-hour faecal output of fat is a very reliable method of diagnosing steatorrhoea, whereas values of per cent. of fat in dried stool correlate very