as in the white.[3] This shows that the diagnosis of varicose veins under the dark skin cannot long continue in doubt.

I assume that a fair number of cases of varicose veins occur in Ghana, and I should be somewhat disconcerted if this were not the case. In a forthcoming work Dr. G. D. Campbell and myself advance the view that varicose veins are part of a much more comprehensive disease, which includes such conditions as dental caries, peptic ulcer, and diabetes, all due to the consumption of refined carbohydrates. It is therefore highly relevant that the late Professor A. A. MacGregor, in his 1964 report of a survey on dental disease in Ghana,[4] was able to correlate very closely the presence of dental caries with the consumption of these foods—so it would be surprising, on this view, if there were not already cases of varicose veins in the Ghanaians. If not, I am afraid there soon will be, and I fear they will not long remain only "clinical impressions."—I am, etc.,

Fareham, Hants. T. L. CLEAVE.

REFERENCES

1 Dodd, H., *Lancet*, 1964, **2**, 809.
2 Barker, A., ibid., 1964, **2**, 970.
3 Cleave, T. L., *On the Causation of Varicose Veins*, 1960. J. Wright (U.S.A., Williams & Wilkins Co.).
4 MacGregor, A. A., *Ann. roy. Coll. Surg. Engl.*, 1964, **34**, 179.

Trasylol and Acute Pancreatitis

SIR,—The letter of Dr. D. M. Goldberg and Mr. A. D. Roy (16 October, p. 943) is timely. Acute pancreatitis is a grave disease with a high morbidity and mortality, and their suggestions about the effective dosage are therefore most important. We have carried out a double blind trial on 50 cases using Trasylol in acute pancreatitis. Exactly like Dr. A. Skyring and his colleagues (11 September, p. 627) we have found that Trasylol in the dosage suggested does not influence the disease in any way at all. This report is now awaiting publication.

We are writing this letter to those who are using this treatment for pancreatitis to say:

(1) That at the dosage of 20,000 units daily we have found it produces no effect.

(2) We have been unable to find any toxic effects arising from intravenous Trasylol at this dosage.

(3) We have no experience of the much larger dosage up to 200,000 units per day which has been suggested by some workers.

(4) It is important that anyone using such dosage should report any toxic effects which may occur.—We are, etc.,

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Sheffield Royal Hospital. C. H. TALBOT.

Phenylbutazone-induced Pericarditis

SIR,—The paper on phenylbutazone-induced pericarditis by Dr. J. Shafar (2 October, p. 795) and related leading article re-emphasize the need for careful observation of patients under treatment with phenylbutazone, the therapeutic effectiveness of which is somewhat counterbalanced by its reaction potential.

Undoubtedly, at the time he submitted his report Dr. Shafar was unaware of an annotation by Dr. J. Edelstein, St. Francis General Hospital, Pittsburgh, Pennsylvania.[1] In it Dr. Edelstein tells of an elderly female patient who died suddenly following a femur fracture. At necropsy "the heart revealed extensive perivascular lesions characterized by a granuloma-like appearance." Some of the lesions simulated the Aschoff nodule but lacked its characteristic fibrinoid necrosis and multinucleated cells.

Of further interest is a report by Dr. David Nathan and his associates of the Mount Sinai Hospital, Miami Beach, Florida.[2] At necropsy of the patient described in this report, a 60-year-old female, the heart revealed perivascular lymphoid cell infiltrates with scattered macrophages, degenerative and focal necrotic changes in the arterioles and venules of the myocardium, as well as perivascular degeneration of collagen in the myocardium. While the pathologic diagnosis was "non-specific subacute myocarditis," the histologic description resembles those in Dr. Edelstein's cases and in the second case of the reference cited by Dr. Shafar as the only "other report of cardiac complications attending phenylbutazone therapy."[3]—I am, etc.,

Kansas City, Missouri, U.S.A. GEORGE X. TRIMBLE.

REFERENCES

1 Edelstein, J. M., *Amer. Heart J.*, 1965, **69**, 573.
2 Nathan, D. A., Meitus, M. L., Capland, L., and Lev, M., *Ann. intern. Med.*, 1953, **39**, 1096.
3 Hodge, P. R., and Lawrence, J. R., *Med. J. Aust.*, 1957, **1**, 640.

Epidemic Collapse

SIR,—The descriptions of "epidemic collapse," "vomiting and collapse," and "the Royal Free Disease" featured in letters in your issue of October 30 (p. 1062) remind us that we have still much to learn about neurotropic viruses. Dr. A. Melvin Ramsay's reference to the Royal Free Disease as having been endemic in north London since 1955 reminds me of an outbreak of neurotropic virus disorder which I saw during 1946 in N.W. Middlesex[1] which showed symptoms ranging from encephalitic and severe lymphocytic meningitic features at one end of the scale to abortive infections with headaches, stiff neck, sore throats, chest and muscle pains, or diarrhoea in the milder cases. Even in this latter group transient mental confusion and excitement were occasionally noted, and no doubt there were many less severe cases occurring at the time in the same area for which hospital admission was not considered necessary.—I am, etc.,

Bushey Heath, Herts. G. H. JENNINGS.

REFERENCE

1 Jennings, G. H., *Lancet*, 1947, **1**, 471.

Depression of Erythropoiesis with Methyldopa

SIR,—I wish to report a case of depression of erythropoiesis with Aldomet (methyldopa). J. M. has benign essential hypertension; the relevant investigations are as follows: blood-pressure 240/130; grade II retinopathy; electrocardiogram shows S-T and T wave changes consistent with left ventricular hypertrophy; chest *x*-ray film shows some degree of cardiac enlargement; no albuminuria; blood urea 40 mg./100 ml. His blood-pressure being uncontrolled with sedation, rauwolfia products, and guanethidine, methyldopa 750 mg. daily was prescribed in conjunction with a barbiturate sedative. Three months later he started to feel weak and to perspire easily. Examination at this time revealed essentially a severe anaemia and glycosuria. Laboratory investigations were as follows: haemoglobin 7.0 g./100 ml., W.B.C. 7,050/c.mm., lymphocytes 38%, monocytes 1%, neutrophils 60%, eosinophils 1%, platelets—normal. P.C.V. 26%. M.C.H.C. 32%. Fasting blood sugar 110 mg./100 ml. Methyldopa was omitted and his blood picture responded as follows: 9 days, haemoglobin 9.7 g./100 ml., 16 days 11.3 g./100 ml. His haemoglobin has remained in the normal range for the last two months. There was no clinical evidence of haemolysis, and his serum bilirubin (0.2 mg./100 ml.) and reticulocyte count (<1%) taken 14 days after cessation of methyldopa were normal.—I am, etc.,

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Royal Medico-Psychological Association

SIR,—I am writing to express disquiet at certain of the proposals just submitted to members of the Royal Medico-Psychological Association by its council relating to a change in structure of the Association. The adjourned annual general meeting to consider these proposals is on Saturday 20 November, so time is short for public discussion.

The proposals amount to a change to collegiate structure without change of title, together with the setting up of a higher qualification, it being hoped that this would be an appropriate preliminary to petitioning for a change in status and title to Royal College some time in the future.

Most disquieting are the proposals for fellowship in the first ten years of the new structure. The fellows will properly predominate in council and in the important executive committee. The proposed court of electors will be composed exclusively of fellows. During this initial decade, apart from foundation fellows, the only other fellows will be such as are elected by decision of the proposed court of electors.

The qualifications proposed for foundation fellows include having been a member of the association for ten years and a practising consultant psychiatrist for five years. A consultant appointed less than five years before the date of inception of the new structure will proceed automatically to fellow by seniority only after a further ten years, so that he may not become a fellow for as much as 13 or 14 years after his appointment as a consultant. Other members who become collegiate members by taking the examination will also proceed to fellowship by seniority after ten years.

The proposed by-laws and inception procedure do provide for consultants who fail to qualify for either fellowship or collegiate membership by reason of a time clause to be elected by decision of the court of electors, but these provisions could in practice exacerbate rather than ease the impression