Three years ago I operated on a man of 26 with a right cervical rib, an aneurysmal dilatation of the subclavian artery, and thrombosis of the brachial artery with gangrene of three fingertips. The cervical rib was removed as soon as he was seen and a sympathetic ganglionectomy performed. He remained well until a few weeks ago, when on coming home from work he complained of a severe pain in the right arm. He died suddenly at home that same evening. At post-mortem it was found that recent thrombus had begun to form proximal to the aneurysm in the subclavian and that a clot was protruding into the vertebral artery. There was a fresh thrombus impacted in the basilar artery.

The case further points the lesson put forward by Mr. de Villiers that, in all cases of cervical ribs with vascular symptoms, the subclavian artery should be dealt with at the original operation as a prophylactic measure. This case further proves that an extension of thrombosis up the vertebral artery can occur on the left as well as the right side.—I am, etc.,

Southampton. L. AYLWIN RICHARDSON.

Encephalopathy and Fatty Degeneration of Viscera

SIR,—In his article on encephalopathy in children (16 July, p. 135) Dr. D. M. O. Becroft suggested that "the early view that there was a severe metabolic acidosis may be incorrect in those patients with hyperpnoea." I would like to present evidence confirming this suggestion.

Since Reye *et al.* reported this syndrome in 1963,[1] 11 such cases have been recognized in the Edinburgh area. Acid-base measurements were made in six of these soon after admission to hospital. Standard bicarbonate levels were below normal in each case, but the *p*H was normal or above normal in three. In these the respiratory alkalosis due to hyperventilation had compensated, or overcompensated, for the metabolic acidosis which was present. During the course of her illness one patient was believed to have developed alkalotic tetany, the *p*H rising to 7.58, while the P_{CO_2} fell to 11 mm. Hg. The standard bicarbonate level was then 16 mEq/l. It would clearly have been wrong to have treated her with lactate or bicarbonate. Further details of these cases will be submitted for publication in the near future.—I am, etc.,

Department of Child Life and Health, Edinburgh 9. HAMISH SIMPSON.

REFERENCE

1 Reye, R. D. K., Morgan, G., and Baral, J., *Lancet*, 1963, **2**, 749.

Mothers' Choice

SIR,—It is sometimes stated that most confinements should take place in hospital, and, however desirable this may be for the obstetrician, it takes little account of the wishes of the expectant mother. In order to find out the mothers' wishes, 500 consecutive maternity bookings made by me from our group practice in the past 10 years have been analysed and are presented below.

The practice is centred in a semi-industrial small country town a few miles outside of Glasgow. There are no G.P. maternity beds in the area, but within four to five miles there were consultant maternity units in three large hospitals, so that any patient who asked for hospital confinement was able to have this.

No. of Previous Confinements and Place Selected for Confinement

Previous Confinements (No.)	Total	Place for Confinement		No. Directed to Hospital on Booking	No. Choosing Hospital
		Home	Hospital		
0	149	15	134	—	—
1	158	68	90	21	69
2	106	64	42	15	27
3	49	28	21	7	14
4 and over	38	25	13	6	7
	500	200	300	49	117

On making a maternity booking, in every case where it would be the woman's first confinement she was told she should go to hospital, and in other cases this was advised if there was a known obstetric or medical reason for doing so. Thereafter the choice was left to the woman.

The reasons for referral to hospital on initial booking were: previous abnormal deliveries or gynaecological surgery (27), Rhesus incompatibility and previous foetal abnormality (13), severe toxaemia or habitual abortion (5), and general health of mother (4). It will be seen that 15 out of 149 women insisted on having their first confinement at home. Of the other cases where there was a free choice by the mother, 185 (61%) elected to stay at home, and 117 cases (39%) to go to hospital. The greater the experience of the mother (as measured by parity) the more she chose to be confined at home.—I am, etc.,

Kirkintilloch, Glasgow. D. A. A. PRIMROSE.

Treatment of Diverticulitis

SIR,—I have read with great interest the recent correspondence on this subject (11 June, p. 1481). The incidence of diverticulitis also seems to be increasing in general practice, and although treated medically in the early stages the proportion of patients ultimately requiring surgical treatment because of complications is distressingly high. Conventional laxatives cause faecal dehydration and still leave the diverticula susceptible to chronic irritation and inflammation.

Patients benefit from taking any preparation which acts as a faecal softener producing easy and symptomless evacuation, and they then can relax their low residue diet without adverse effects. During the past four years I have treated twelve patients regularly with dioctyl sodium sulphosuccinate (marketed as Dioctyl Forte), which is an anionic wetting agent and is also highly effective as an aid to evacuation of the residual barium paste often persisting in the bowel after barium examinations. I consider it essential to use the simple preparation without the addition of any other laxative, which tends to irritate the already irritable bowel.

None of my patients has experienced any toxic effects with long-term administration of this faecal softening agent, and the regular use of such a preparation may well reduce the incidence of complications of diverticulitis and the need for surgical treatment.—I am, etc.,

Bournemouth. GABRIEL JAFFÉ.

Immunization Against Poliomyelitis

SIR,—You rightly point out the great benefit from the use of vaccines active against poliomyelitis—it would be difficult to successfully contest the fact that where these vaccines are used paralytic poliomyelitis is effectively controlled, and the originators of this form of prophylaxis deserve our gratitude.

Perhaps one reason for the failure to maintain a high level of immunity in the community to which you refer in your leading article (28 May, p. 1314) is the disturbing note struck by my letters,[1] in which I claimed that there is evidence for believing that the immunization procedures then current were both leukaemogenic and carcinogenic in susceptible individuals; and, until this assertion is positively refuted by a more sophisticated survey than mine, uncertainty will remain. The encouraging preliminary report of the Oxford Survey[2] would have succeeded in dispelling all doubts about the safety of inactivated vaccines had not their findings contained what appeared to be an artifact; immunization with tetanus toxoid was apparently negatively associated with leukaemia ($\chi^2 = 6.35$; $P < 0.02$). One is naturally hesitant to accept any inference drawn from "crude totals," and it is likely that only the final results of the survey being conducted by Stewart and Hewitt will restore the confidence in immunization necessary to maintain the level of immunity you advocate, assuming, of course, that I was mistaken in attributing oncogenic potential to some inactivated vaccines.—I am, etc.,

Brisbane, Australia. M. D. INNIS.

REFERENCES

1 Innis, M. D., *Lancet*, 1965, **1**, 605, 867, 1394.
2 Stewart, A. M., and Hewitt, D., ibid., 1965, **2**, 789.

Crohn's Disease and B.C.G.

SIR,—A 14-year-old girl has recently been seen in this hospital in whom Crohn's disease followed quickly upon B.C.G. inoculation. We would be interested to hear if any of your readers have noted the precipitation or exacerbation of Crohn's disease by B.C.G. inoculation.—We are, etc.,

P. G. CAMPBELL.
D. G. SHAW.

University College Hospital, London W.C.1.

Splenomegaly and Anaemia

SIR,—Dr. Z. Farid and colleagues (16 July, p. 153) conclude that a haemolytic mechanism was partly responsible for the anaemia observed in one of their cases of bilharzial splenomegaly. Their own data refute this, since they report a total red-cell volume of 836 ml. when the peripheral venous haematocrit value was 20% before splenectomy, as compared with 696 ml. when the haematocrit value had risen to 37% after

splenectomy. This shows plainly that the bone-marrow was capable of sustaining an adequate red-cell volume before splenectomy, regardless of haemolysis, and it emphasizes the importance of haemodilution by plasma volume expansion.

To infer "pooling" of red cells in the spleen purely on the basis of isolated external surface counts after injection of ^{51}Cr-labelled red cells is also mistaken. Support for such an inference depends on demonstrating a slow mixing time in the spleen in the immediate post-injection phase; this apparently was not done. A high count rate over a big blood-filled spleen is hardly surprising. Conditions here allow ^{51}Cr-labelled blood to circulate in large quantities near the body surface, thus producing the high counts which are found in many (but not all) cases of splenomegaly. Here the operation of the inverse-square law sees to it that splenic counts look impressive when compared with liver and heart counts after the injection of a medium-energy gamma emitter like ^{51}Cr, but once again this is not evidence of "pooling." (The *Concise Oxford Dictionary* defines a pool as "a small body of still water; puddle of any liquid; deep, still place in river.")—I am, etc.,

V. F. WEINSTEIN.

Warneford General Hospital,
Leamington Spa,
Warwickshire.

Labelling Drugs

SIR,—For some years now the Association of the British Pharmaceutical Industry has been advocating original-pack dispensing as the best solution to the problem of drug labelling. This enables the pharmacist to dispense a manufacturer's small original pack, instead of counting tablets or measuring liquid from one container to another. This not only ensures that the pack received by the patient is properly labelled with the name and description of the contents, but also ensures that any special instructions or warnings, which are printed on the pack by the manufacturer, reach the patient. In addition, it ensures that the package which the patient receives is properly designed to provide adequate protection for the particular medicine.

In most European countries the dispensing of original packs has been the general practice for branded medicines for some time, and has proved satisfactory. We are at present looking into the question of how the cost of the pharmaceutical services might be affected by a general change to original-pack dispensing in this country.—I am, etc.,

E. B. TEESDALE,
Director,
Association of the
British Pharmaceutical Industry.

London S.W.7.

SIR,—A detailed examination of the points for and against the labelling of drug containers with the name of the contents reveals a very strong case in favour (Sweetnam[1 2]). Drs. E. B. Jarrett, C. S. Hampton, and R. I. Hargraves (30 July, p. 303) point out that some patients keep their tablets loose or transfer them all into one container. This is an argument frequently raised against labelling and of doubtful validity. Patients do this presumably because the tablets are anonymous. If the containers were labelled it is rational to suppose that they would then keep the tablets in their own separate containers. A person who then habitually mixes his tablets should probably not have charge of potentially dangerous drugs.

A method of indicating to the pharmacist that the name of the drug should appear on the label and which has been in use in this hospital for some years is for the hospital prescription form (or E.C.10) to have *sig.* (*signetur*, let it be labelled) added to the present printed ℞ (*recipe*—take). The prescription would then start with ℞ *et sig.* The name would appear on the label as directed. Practitioners who do not wish the patient to know what drug he is taking or who still cherish the mysticism of prescribing only need to strike out the word *sig.*, in which case the prescription would need to be sealed.

A central Health Services Council report on the treatment of poisoning[3] gave considerable thought to various schemes for the distinctive markings of tablets and capsules. None was found to be really practicable and all expensive. The question of liquids was not considered.—I am, etc.,

W. P. SWEETNAM.

The Royal Infirmary,
Huddersfield.

REFERENCES

1 Sweetnam, W. P., *The Practitioner*, 1964, **192**, 543.
2 —— *The Times*, 19 September 1962.
3 *Emergency Treatment in Hospital of Cases of Acute Poisoning*, Report of the Central Health Services Council, 1962. H.M.S.O., London.

Psychiatry and Psychotherapy

SIR,—Like Dr. S. Bockner (13 August, p. 410) I was most impressed and encouraged by Dr. William Sargant's impressive Watson Smith Lecture. Dr. Bockner insists that psychotherapy still plays an important part in all psychiatric treatment. Of course he is right, but what exactly is psychotherapy? Surely this term covers a wide range of treatment, from the simple rapport situation essential to all good medical practice on the one hand to a complete psycho-analysis on the other. The simple psychotherapy, which includes understanding, encouragement, explanation, and reassurance, takes up very little time and does a great deal of good. This, combined with the physical treatment of depression or anxiety, is the answer to most psychiatric problems which occur in the community. Surely it was the long-term interpretative and analytical forms of treatment which Dr. Sargant felt more ineffective and should be superseded by modern and more rapid physical methods.

In the past I have spent many, many hours on psychotherapy. Looking back I can see that I was very often supporting a depressed patient whose symptoms ultimately resolved by remission, and not thanks to any skill of mine; although at the time I was convinced that the psychotherapy had helped. During some 20 years of psychiatry in general practice, time and again I have seen new episodes of "neurotic illness" recur in patients. I find that these incidents nearly always respond excellently to adequate doses of antidepressant drugs, with far less trouble to the doctor than time-consuming psychotherapy. I am convinced that many patients suffering from anxiety are in fact cases of endogenous depression in need of simple understanding and drug treatment. For more than 30 years Ghon's focus and the syndrome of primary tuberculosis has been accepted as one facet in the natural history of tuberculosis. Tuberculosis can occur in a mild form, but not endogenous depression. There are still many doctors today both in general medicine and psychiatry who cannot see that endogenous depression very often occurs in a mild form when it is almost indistinguishable from a mild neurotic illness. These patients need physical treatment and not long and expensive psychotherapy. They do of course need the simple psychotherapeutic measures implicit in Dr. Sargant's enthusiastic approach.—I am, etc.,

C. A. H. WATTS.

Ibstock,
Leicester.

SIR,—This lecture by Dr. William Sargant (30 July, p. 257) is so steeped in qualifying phrases such as "provided they [the new and mechanistic treatments] really work," and "in patients of previously good personality," that one wonders if it has any scientific meaning. It is necessary to enlarge, for example, on what he means by the previous good personality of schizophrenics. One is tempted to ask if any patients of previously good personality are seen in psychiatric clinics, and if so would they not be better away from psychiatrists to resolve their difficulties in the natural way.

The lifting of a depression, temporarily or otherwise, is one thing. A human being functioning effectively and creatively is another. Dr. Sargant's claims are indeed extravagant if he suggests his patients are fundamentally improved in the areas of vocational, social, and sexual experience, as a result of mechanistic treatments. Such improvement is, presumably, the goal of most therapy. Mechanistic treatments will have much more future when it is demonstrated how they cure people's loneliness and guilt, neurotic or otherwise. Such treatment is little more than the manipulation of the prevailing mood arising out of an individual's life situation. There is a danger for many in having a case put forward with such authority, justifying the use of mechanistic treatments in such disorders where there is a faulty life style underlying serious disorders of relationships.

It is too bad that serious emotional problems can be suppressed so easily with mechanistic treatments, only to erupt later. To be able to look at one's faulty life style may have consequences 20 years later, and at present it is not possible to assess the value of psychotherapy.—I am, etc.,

D. H. G. HOPKINS.

St. George's Hospital,
Hornchurch,
Essex.

Medical Reports

SIR,—In recent months several patients who have been under my care as a whole-time National Health Service consultant have presented me with letters from life assurance companies or from the immigration departments of Commonwealth countries requesting detailed medical reports on previous or current illnesses, and asking for *x*-ray films to be sent to the company or department concerned. At the end of every such letter is a sentence to the effect that any expense incurred is the patient's own responsibility.