servation as inpatients for periods varying from 14 weeks to 38 years (mean 12.6 years) before treatment. One improved in gait and arm after seven days of treatment, but another showed no improvement until after two months, when walking improved, but not until four and a half months later was improvement seen in the spasticity of the arm.⁴

Dosage reported by the authors varied from 2.5 mg. daily to 105 mg. in divided doses. Single massive doses of from 750 mg. to 1.8 g. were given by Livingston¹ and produced recovery. Dosage must be adjusted carefully for each patient, for if too great a dose is given the muscles of a sound leg may lose some of the normal tension and falling may occur.

The degree of spasticity may vary slightly from time to time, showing that a psychological element may be added to the organic basis. This is specially the case in children. Crosland⁵ describes children with arms apparently almost useless and in the usual hemiplegic state, who, when believing they are unobserved, can handle objects in which they are specially interested "with quite reasonable dexterity." Observation before treatment is necessary to determine any emotional overlay.

This letter is written to draw attention to the fact that not only may chlorthalidose improve spasticity at any age but also in muscles other than those involved in paraplegia. Improvement may persist after cessation of treatment, particularly in patients receiving high doses and long treatments.—I am, etc.,

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Diplopia and Oral Anticoagulants

SIR,—The following brief case summary may be of interest in that it illustrates how the use of an oral anticoagulant may produce an unexpected clinical response.

The patient is a male now aged 48 years. In 1959 he complained of attacks of diplopia occurring off and on for the preceding nine months, and lasting approximately five minutes each. He also had two attacks of blindness affecting the right eye for a few minutes, with full recovery subsequently. Both these symptoms occurred spontaneously with no precipitating causes. Full investigations, including clinical examination, electrocardiogram, cerebrospinal-fluid examination, bilateral carotid angiograms, and air encephalograms, were all normal. It was therefore decided to keep him under observation without any definite diagnosis being made.

In 1964 he suffered an anterior myocardial infarction. Diplopia, which had continued to occur off and on, now disappeared as soon as therapy with anticoagulants in the form of phenindione was instituted for the infarction. Since then diplopia has recurred on several occasions, on either reducing the dose of phenindione or stopping it, indicating a definite correlation. There has been no ocular weakness, and tests for myasthenia gravis are negative.

It would seem in retrospect that this patient is suffering from vertebrobasilar artery insufficiency and has benefited from taking oral anticoagulants in an unexpected way. If indeed this is so, several interesting

questions arise. What is the mode of action of the anticoagulant in this patient? Should he be subjected to another series of investigations? What does the future hold for him?—We are, etc.,

Scunthorpe,
Lincs.

J. P. M. PENNEY.
V. K. JAIN.

Amphetamine Prescribing

SIR,—Dr. F. S. Reed rightly questions (8 April, p. 108) the therapeutic value of the amphetamines in current medical practice. That a variety of firms should make a multiplicity of products, all but minor variations of each other, and all containing a potent habit-forming drug, is astonishing enough, but that these products should presumably still be prescribed at a time when their potential dangers have been amply demonstrated and publicized, and when increasing amphetamine misuse causes public concern, is incredible.

The therapeutic value of any drug must ultimately depend upon its uniqueness (or relative efficacy) and its safety, and, except for those instances quoted by Dr. Reed, the amphetamines, I would suggest, have long been supplanted.—I am, etc.,

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Narcosis for Chronic Tension

SIR,—In a paper published last year, Dr. W. Sargent and others (5 February 1966, p. 322) observed that some chronologically tense patients of good premorbid personality, referred for consideration of a leucotomy operation, made very encouraging improvement when given modified narcosis combined with either electroconvulsive therapy or antidepressants. The authors write that their treatment "... seems to constitute, if confirmed, a real advance in the treatment of a group of often seemingly hopeless illnesses," and later, "It seems certain from the figures that patients having narcosis with E.C.T. and combined antidepressive drugs do much better than those having E.C.T. and drugs alone."

However, examining the Table quoted, the number of patients who received narcosis and who became symptom-free, or had only minimal symptoms (26 out of 36), is not statistically significantly greater than those in the same categories who did not receive narcosis (23 out of 37). It can also be seen that the material is further classified in terms of the length of follow-up. Significantly more of the cases showing a poor response to treatment are in the long follow-up group, and this group is under-represented in those who received the treatment which Dr. Sargent and his colleagues feel is superior. The trend towards a better response to treatment in the narcosis group could therefore be due to the significantly shorter follow-up in these patients. While not wishing to dispute the good results reported by Dr. Sargent and his colleagues with these generally intractable patients, it would be invaluable to know whether the trend they noted in respect of modified narcosis has been confirmed by further studies. Since over a year has passed since the paper was published, it may be pos-

sible for the authors to add further cases to the otherwise small number (eight) who received narcosis and who were followed up for more than 18 months.

Sleep may knit up "the ravell'd sleeve of care," but before psychiatrists round the world begin subjecting these chronically sick individuals to the potential hazards of four weeks' obfuscation such additional data would be desirable.—I am, etc.,

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Pressurized Aerosols in Asthma

SIR,—I was most interested to read the correspondence in the *British Medical Journal* (4 March, p. 563; 25 March, p. 756) concerning the possible harmful effects of the frequent use of pressurized aerosol sprays in asthma. Some of us in Australia have expressed similar views in letters published in the *Medical Journal of Australia*.¹⁻⁵ In addition, it appears that in some States in this country the death rate from asthma is rather dramatically increasing. Both of these subjects are being investigated and the findings both here and in the United Kingdom should prove most interesting. In the meanwhile I would like to add a further plea for great care in the prescribing of "do-it-yourself" therapy such as aerosol sprays.—I am, etc.,

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R. MUNRO FORD.

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Leucocyte Ascorbic Acid Levels

SIR,—The ascorbic acid studies reported by Dr. J. M. Williamson and his colleagues (1 April, p. 23) are extremely interesting. We have been studying leucocyte ascorbic acid levels with particular reference to alimentary disease. In patients with malabsorption our results have been similar to those reported by the Glasgow group. In the patients who have had gastric surgery our findings are different. We found similar depression of leucocyte ascorbic levels, but when the results were divided into those from a group of symptomless patients and those with post-operative clinical syndromes then a different pattern emerges. Our preliminary results are shown in the accompanying table.

	No. Studied	Leucocyte Ascorbic Acid ($\mu\text{g./10}^8$ W.B.C.)	
		Mean $\pm$ I.S.D.	Range
Healthy adults	25	28.71 $\pm$ 8.08	18.72-53.53
Duodenal ulcer patients	20	11.31 $\pm$ 6.14	4.47-35.28
Patients operated and symptomless	20	22.89 $\pm$ 3.81	9.33-39.00
Postoperative syndromes	20	13.57 $\pm$ 7.42	3.03-27.86

In the group of twenty patients who were symptom-free and who were studied at a routine attendance at the gastric surgery