abandoned after a short trial owing to the time-consuming nature of the shunt procedure, as well as the emotional problems associated with patients under these conditions. General anaesthesia was then offered as the only alternative. As is well known, there are many problems which confront the anaesthetist involved in these cases, not least of which must be mentioned the possibilities of anaemia, metabolic acidosis, and electrolyte imbalance, especially involving serum potassium levels. To complicate the issue further these patients tend to vomit, and have an unstable response to variations in circulating fluid volume.

At the Royal Free Hospital shunts are inserted using local analgesia at the site of insertion, with the occasional demand for general anaesthesia in certain patients. In view of the problems just mentioned, for the last six months we have used dehydrobenzperidine (Droperidol) combined with local infiltration of lignocaine at the shunt site as a preferable alternative to general anaesthesia. The advantages of this scheme are that it calms very apprehensive introspective patients; it has minimal effects on blood pressure; patients are co-operative; and their reflexes remain fully active. The anti-emetic effect of this drug is a considerable advantage, and its length of time of action (8-12 hours) ensures adequate operating conditions for what is often a lengthy procedure. Early discharge from hospital is possible.

Initially these patients are given 5-10 mg. dehydrobenzperidine orally one to two hours before the procedure, and a further dose of 5 mg. is repeated intravenously in theatre if required. Local infiltration of 2% lignocaine without adrenaline at the shunt site is then performed. This procedure has given such satisfactory results that it is now used routinely for the insertion of all shunts in this hospital.—I am, etc.,

DOREEN R. G. BROWNE.

Royal Free Hospital,
London N.W.3.

REFERENCE

- ¹ Royal Society of Medicine, Meeting 5 April 1968, unpublished.

Monoamine Oxidase Inhibitors

SIR,—Your article on monoamine oxidase inhibitors (*Today's Drugs*, 6 April, p. 35) particularly stresses the interaction with other drugs and foods. However, it appears that patients are still not sufficiently warned about these dangers, nor of the importance of telling other doctors that they are taking monoamine oxidase inhibitor drugs.

An apparently intelligent woman was recently admitted to this unit for a varicose-vein operation. She told the house-surgeon that she was on pills for her irregular periods, which he initially assumed to be a hormone preparation, but, on further questioning the evening before operation, she admitted they were called Nardil (phenelzine). She had not told the ward sister that she should not be given cheese or Marmite for her meals, although she said her general practitioner had told her about this. She denied, however, being warned that there was a danger in having an anaesthetic or other drugs, and she had been given phenelzine while on the waiting-list for operation.

We have had another similar case in the last few months. Surely the practice of giving the patient precise instructions and a

card to carry should by now be universal, as with anticoagulants and steroids?—I am, etc.,

ALAN G. JOHNSON.

West London Hospital,
London W.6.

SIR,—I should like to comment on your recent article on monoamine oxidase inhibitors (6 April, p. 35). Some drugs and foodstuffs which may lead to hypertensive crises when given to patients receiving monoamine oxidase inhibitors are listed in the article. There is reason to believe that in these circumstances other more readily available sympathomimetic amines may cause a similar marked rise of blood pressure. This possibility was suggested by the work of Ellis and others¹ on the amine phenylephrine which is normally inactivated by monoamine oxidase present in the walls of the intestine. A marked and rapid rise of blood pressure occurred when subjects taking monoamine oxidase inhibitors were given phenylephrine by mouth.

Phenylpropanolamine is another sympathomimetic amine, related to ephedrine, which is a constituent of a number of proprietary preparations for the relief of cough and symptoms of the common cold. Observations on healthy volunteers in this department have shown that 50 mg. of phenylpropanolamine hydrochloride produces little change in the blood pressure when given orally, either in a gelatin capsule or in a slow-release form combined with an atropine-like compound (Procol capsules). These findings are in agreement with those of Mitchell.²

In a subject (resting blood pressure 120/80) receiving the monoamine oxidase inhibitor tranylcypromine (Parnate) 30 mg. daily a substantial rise of blood pressure did occur when one capsule of Procol or phenylpropanolamine alone was taken orally. The blood pressure rose to 150-160 mm. Hg systolic, 95-100 diastolic, 90 minutes after taking one capsule of Procol (phenylpropanolamine hydrochloride 50 mg. and isopropamide 2.5 mg. in a slow-release form) and remained at this level for approximately two hours before returning towards normal. However, when the subject took 50 mg. phenylpropanolamine hydrochloride orally in a gelatin capsule and on another occasion the same dose contained in a proprietary cough linctus there was a dramatic and progressive rise of blood pressure which reached a level of 200-210 mm. Hg systolic, 130-140 diastolic, two hours after ingestion. In the last two of these three experiments on the same subject it was necessary to reduce the blood pressure to normal levels by the intramuscular injection of 5 mg. phentolamine hydrochloride.

While it is not clear whether acute hypertensive reactions were responsible for the symptoms which occurred with the taking of Procol capsules by the two patients on monoamine oxidase inhibitors reported by Tonks and Lloyd,³ it does appear that in the presence of these drugs the pressor effect of phenylpropanolamine can be potentiated to a marked and potentially dangerous degree.—I am, etc.,

M. F. CUTHBERT.

London Hospital Medical School,
London E.1.

REFERENCES

- ¹ Ellis, J., Laurence, D. R., Mattie, H., and Prichard, B. N. C., *Brit. med. J.*, 1967, 2, 75.
² Mitchell, C. A., *Curr. Ther. Res.*, 1968, 10, 47.
³ Tonks, C. M., and Lloyd, A. T., *Brit. med. J.*, 1965, 1, 589.

Suicide in Pregnancy

SIR,—With reference to Dr. Michael F. Burke's letter (6 April, p. 49), an article by Muller and Graham¹ is of interest. These authors traced from the literature eight infants born alive following serious maternal carbon-monoxide poisoning at various stages of pregnancy between the second month and term. All infants suffered from serious psychomotor defects, and most exhibited more than one defect. These included five cases of spasticity, one of athetosis, two of hydrocephaly, one microcephaly, one case of softening of the basal ganglia, one mongol, and two with absent cry and sucking reflex, etc.

It is debatable whether these foetal defects result from carbon-monoxide poisoning of the foetus or the severe foetal anoxia resulting from the maternal poisoning.—I am, etc.,

London W.1.

H. E. REISS.

REFERENCE

- ¹ Muller, G. L., and Graham, S., *New Engl. J. Med.*, 1955, 252, 1075.

Heart Transplant Publicity

SIR,—Everybody will congratulate the team who carried out the so far successful heart transplantation at the National Heart Hospital.

But why is such blatant publicity considered necessary? It cannot be to advertise the well-known surgeons; that would be quite unethical. It cannot be to advertise the hospital, which is well known. It cannot be to obtain donors. It may be necessary for South Africa to boost its surgical skill, but surely British surgery does not require a boost. Every week hundreds of life-saving operations are performed in this country without mention in the press. I much regret this, to me undignified, publicity.—I am, etc.,

Oxford.

MALCOLM DONALDSON.

SIR,—It is interesting to compare the rather disturbing publicity accorded to Britain's first heart transplant operation with the sober treatment of another great occasion in the history of medicine 122 years earlier.

Four days after the event the *Daily News* (25 December 1846), one of the few papers to comment at all, announced: "We have been informed that two operations without pain were performed by Mr. Liston at University College Hospital on Saturday last while the patients were under the stupefying influence of the vapour of ether."

A somewhat striking contrast to recent events.—I am, etc.,

London W.1.

MASSEY DAWKINS.

Ethchlorvynol Withdrawal Symptoms

SIR,—This report illustrates symptoms which followed the abrupt withdrawal of ethchlorvynol. This drug, which was introduced in North America in 1955, is a halogenated acetylenic carbinol whose anti-convulsant properties were originally discussed by P'an *et al.*¹

A man aged 67 was admitted to the Royal Infirmary, Sheffield, on 3 November 1967 for

the investigation of suspected myelomatosis. His formal intelligence, as assessed by medical testing, was diminished. He failed the Babcock sentence seven times and could only repeat five numbers forwards and four backwards after several attempts. On the other hand, he had a ready wit and a sharp repartee. His affect was normal. No local abnormalities of the nervous system were detected. There was a vague history of taking quinalbarbitone, amylobarbitone, or carbromal, and also Serensil (ethchlorvynol). After admission he was given no drugs.

Three days later he had his first convulsion without premonition. A tonic phase during which he was cyanosed lasted a few minutes. There was faecal, but not urinary, incontinence. After the fit he was confused and disorientated in time and space, with immediate preictal amnesia. Later the same day he had a second fit and was subsequently given phenobarbitone. Postictal examination of the central nervous system showed hypertonicity and hyperreflexia. The gait was ataxic. No focal abnormalities were found. For four days after the convulsions there was marked mood change and confusion, his affect swinging between ebullience and aggression. He swore at the nurses and tried to strike them and had visual and auditory hallucinations. Eleven days after the fits, on discharge, his mood was normal. Tests following the convulsions—serology of the blood and C.S.F., estimation of the blood bromide, skull x-rays, E.E.G., echogram, and gamma scan—showed no significant abnormality.

His general practitioner later gave us a complete drug history. The patient had been taking various barbiturates for insomnia until April 1967, when they had been discontinued for fear of addiction. Some non-barbiturate hypnotics were tried unsatisfactorily until Serensil, 1 g. *nocte*, was introduced in June. By October he was taking at least 1.25 g. a day.

We believe this to be the first report in Great Britain of ethchlorvynol withdrawal symptoms, although the effects of overdose have been previously described here.¹

We should like to thank Dr. E. K. Blackburn, under whose care this patient was admitted, for allowing us to report the case.

—We are, etc.,

H. T. ABUZAHA.
M. ROSSDALE.

Royal Infirmary,
Sheffield.

REFERENCES

- ¹ P'an, S. Y., Markarian, L., McLamore, W. M., and Bawley, A., *J. Pharmacol. exp. Ther.*, 1953, 109, 268.
- ² Kuenssberg, E. V., *Brit. med. J.*, 1962, 2, 1610.

Benign Sixth-nerve Palsy in Children

SIR,—Your leading article (27 April, p. 190) on this subject draws attention to the paper by Knox, Clark, and Schuster,¹ who report ten patients with unilateral benign sixth-nerve palsy seen in 13 years. These figures from a large paediatric clinic emphasize the rarity of the condition.

We have recently seen a boy aged 8 years with bilateral (complete) sixth-nerve paralysis. At the onset he had complained of headache as well as double vision, but there was no evidence of infection. The x-rays of the skull and chest and the spinal fluid were normal. The palsy on the right side recovered in a month and the left side began to improve after a month and resolved after two months.

This case further illustrates your point that in an isolated sixth-nerve palsy, even if bilateral, provided that simple tests are negative, it is better to wait for a few weeks

before embarking on special neuroradiological investigations.—I am, etc.,

BRYAN ASHWORTH.

Department of Neurology,
Royal Infirmary,
Manchester 13.

REFERENCE

- ¹ Knox, D. L., Clark, D. B., and Schuster, F. F., *Paediatrics*, 1967, 40, 560.

War in Mesopotamia

SIR,—In reviewing *Surgery on Trestles* (30 March, p. 825) Sir George R. McRobert kindly states "the motorized ambulance performed such prodigious feats." It seems desirable to state that the Army Service Corps drivers and workshop staff were entirely responsible for this. I do not think enough credit has ever been given to the

Army Service Corps supply units, whose returning empty vans almost certainly carried as many wounded and sick casualties as the medical motor ambulance units in Mesopotamia.—I am, etc.,

Edinburgh 9.

W. K. MORRISON.

Prescription Charges

SIR,—In the lists of categories exempt from prescription charge I find no mention of schizophrenia. There are in my practice numerous schizophrenics controlled and at work on large doses of various drugs. These patients are very reluctant to take medication under normal circumstances; if they have to pay 7s. 6d. per prescription I am convinced they will not bother.—I am, etc.,

Sutton in Ashfield,
Notts.

G. STEIN.

Electrocardiograph Service for General Practitioners

SIR,—The letter from Dr. D. S. Short (24 February, p. 507) demands a reply lest it damage a useful service to the public. He claims that there are "serious limitations" to this service, and concludes that a "great deal more knowledge is needed . . . before such a service as this can be unreservedly recommended."

The service is designed to extend the diagnostic powers of the general practitioner in the field of cardiovascular disease and in some other fields such as endocrinology. This object it shares with radiology, haematology, and biochemistry. I suppose it is fair to say that "a great deal more knowledge is needed" in any of these specialties, but it is a *non sequitur* to argue that they can therefore not be unreservedly recommended. What is relevant is to point out that any clinical finding is useless without knowledge on the part of the doctor. An essential part of this service is the provision of courses in E.C.G. interpretation and, possibly more important, a continued co-operation between general practitioners and the local cardiology department.

Dr. Short points out that heart disease can occur with a normal E.C.G. I think it would be difficult to escape this conclusion if one had attended a course such as I have suggested, but the cardiologist must avoid the temptation to sell the E.C.G. to his simple colleagues as a magic black box which will

answer any question. It is more helpful to stress its limitations. I am sure that if Dr. Short is prepared to operate an E.C.G. service in this way he will not only be able to recommend it unreservedly but will wonder how the department ever managed without the co-operation of the local general practitioners.—I am, etc.,

Gleadless Medical Centre,
Sheffield, Yorks.

IAN ROSS-SMITH.

Group Practice Payments

SIR,—The letter of Dr. R. L. Luffingham (20 April, p. 180) on the new criteria for group practice will evoke a very sympathetic response from many group practitioners in the country whose practice conditions cannot easily be made to conform to a uniform code imposed by the Minister of Health. The Charter, which was to revive the spirit and tradition of general practice, is turning sour on us, and the blame rests fairly and squarely on the shoulders of the Ministry of Health. Our negotiators must stand firm at this crucial stage and make it quite clear to the Government that if this policy of equivocation is to continue the flight from general practice will be accelerated.—I am, etc.,

Winster, Derby.

A. D. STOKER.

Points from Letters

Deaths from Asthma

Dr. ALAN AKEROYD (London W.1) writes: The interesting article by Dr. F. E. Speizer and others on asthma (10 February, p. 335) set off a whole series of problems and apparently unsuccessful and dangerous methods of treating the illness, leading to several letters entitled "Deaths from Asthma." . . . The age groups of 10 to 14 and 5 to 34 as mentioned in the original article are not without significance. When will our profession realize and accept that the most effective treatment of asthma is hypnotherapy? Obviously not all cases benefit, but certainly in the age groups mentioned above a very high percentage get considerable relief, and many a complete cure. All allergic conditions have behind them a strong neurotic basis. . . . May I once more urge my colleagues who treat

asthmatic cases to think firstly of the underlying psychological problems of the patient and see this as the primary cause. . . .

Pensions

Dr. J. SHAW (Winchcombe, Glos.) writes: I was interested in the letters by Drs. G. N. Fox, D. R. MacDonald, and J. S. Jones (27 April, p. 245) with regard to pensions, and am surprised at the apathy of the profession and their representatives on this matter. Do they realize that any pension granted to them may become niggardly with increasing inflation, and that they may come to look with envy on those of bank managers and even policemen? . . . I certainly think this is a matter of urgency, not only to us "old 'uns," but to the future doctors now in the embryo stage. . . .