Fourthly, it must be a folder that will be adequate not just for five or ten years but for much longer.

As far as the first and second criteria are concerned this means that the folder must be big enough to take international paper size A4, $8\frac{1}{2} \times 11\frac{1}{2}$ in. (21×30 cm.), which means a folder of approximately $8\frac{1}{2} \times 12\frac{1}{2}$ in. (22×31 cm.); sizes A5 and A6 are certainly too small. The Tunbridge Report leaves no doubt that international paper sizes are coming, and it is essential to anticipate this fact. We are aware of the obvious objection that filing systems all over the country are designed on the basis of the present forms E.C.5 and 6. Nevertheless, a clean break from this size is essential sooner or later, and it is better to adapt shelves or filing cabinets than accept a records system that is second rate because it is forced to conform to a size of 5×8 in. (12.7×20 cm.).

Finally, there is the sentence in Dr. Kuenssberg's paper: "for many of us mechanical handling of records could be 10 years or less away." Although it does not say so explicitly, we suspect this is part of the widespread myth that medical records will all be stored in computers some time soon. Our opinion, shared by many others currently examining the problem, is that, though computers or other mechanical aids may well play a part in recording some key details such as immunization status, blood groups, and so on, the major part of day-to-day clinical records will not for many years, probably at least 25, be generally handled in this way. It follows from all this that the present system must be changed and that the change must really be revolutionary. Our criticism of the scheme described by Dr. Kuenssberg is that it is not revolutionary enough.—We are, etc.,

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General Practitioners and Community Psychiatry

SIR,—In their article "Participation of General Practitioners in Community Psychiatry" (20 April, p. 168) Dr. A. R. May and Miss E. Gregory state that "under two-thirds of the doctors interviewed had a sound knowledge of the use and action of psychotropic drugs," and this is linked with the finding of Shepherd *et al.*, 1966, "where records suggested unsystematic prescribing and inadequate and haphazard treatment of minor psychiatric illnesses."

Examination of their own figures, however, reveals that of 69 general practitioners interviewed 42 (61%) had a good knowledge of psychotropic drugs and prescribed them, while a further 9 (13%) had a good knowledge of these drugs but did not prescribe them. Thus 74%, or three-quarters of those interviewed, showed a sound knowledge of psychotropic drugs.

Apart from this extraordinary factual misrepresentation the very considerable divergences of opinion (often televised) among

psychiatrists themselves on what constitutes the proper use and action of psychotropic drugs surely goes some way towards explaining a certain confusion in the minds of general practitioners on the subject. The survey was conducted in an urban area in 1963-4. But today, with ever-increasing numbers of group practices and health centres, realistic ancillary staffing, attachment of health visitors and district nurses, and close and frequent contact with psychiatric and other social workers, the situation in general practice is very different, and altering rapidly. Indeed, I would suggest that the Ministry of Health expectations of general practitioners co-ordinating community psychiatric care are already being filled in the majority of smaller towns and rural areas (including I hope my own) where there are definable communities.

It is precisely in large urban areas, where definition of communities to care for is so much more difficult, that real and very complex community care problems will continue to lie. For these reasons I feel it is unfortunate that this important subject should have been illustrated by a survey based on a London area and undertaken four years ago, especially since it seeks to draw general conclusions about the capabilities of general practice.

I hope that it is not now so "unrealistic to expect more from general practice in this field."—I am, etc.,

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Koro in Britain

SIR,—I was interested to read an account of epidemic koro in Singapore by Dr. Chang Tong Mun (9 March, p. 640). I should like to describe such a case seen by me in 1961 while working as a senior house-officer at the General Hospital, West Hartlepool, Co. Durham.

Around midnight I was called to the casualty department to see a Chinese boy who was working in a local Chinese restaurant. I saw that the boy, aged about 18 years, was holding and pulling at his penis with his hands. While passing urine he felt that his penis was shrinking, and he feared that it would disappear into the abdomen. Having never seen or heard of such a condition, I thought it to be psychogenic. He was reassured, and was sent away after being given a hypnotic. He again came after about two weeks, and was seen by another resident (Dr. Riazuddin) this time, and again sent away after reassurance. Because he came around midnight on both occasions, and because this condition was unknown to us, we considered the possibility that the patient was wilfully mischievous.

Now, having read Dr. Mun's letter about koro, I at last know that such a condition really occurs in the Chinese. It may be more commonly seen in areas where Chinese form the bulk of the population, so that such misconceptions are widely known. Apart from the various exotic conditions that must already be borne in mind while

dealing with immigrant patients, one will now have to add yet another which may be seen in Great Britain with its fair share of Chinese.

—I am, etc.,

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Unusual Complication of Epidural Anaesthesia

SIR,—We would like to report a complication of epidural anaesthesia which does not appear to be recorded in the literature.

A patient aged 19 years, a gravida one, was admitted in labour at term with an occipito-posterior position. The first stage was prolonged, and after $19\frac{1}{2}$ hours epidural analgesia was induced on account of severe pains with contractions and slow progress in labour. A Lee catheter was introduced into the epidural space through a Tuohy needle, through the L4-5 interspace. Before withdrawing the needle 20 cm. of the catheter was introduced without difficulty, and 15 cm. remained after withdrawal of the needle. It was 50 minutes before adequate analgesia was obtained, and a total of 27 ml. of Marcain (bupivacaine 0.5% with adrenaline 1 in 200,000) was required. Analgesia and relaxation were good subsequently, a living male infant being delivered by forceps four hours later.

Difficulty was experienced in withdrawing the catheter after delivery. It came out easily until 5 cm. remained, and then stuck. Traction threatened to break the catheter, and it was only after first flexing the patient's spine and then extending it that the catheter could be withdrawn. On examining the catheter it was found to have a knot 1 cm. from its tip, as shown in the accompanying Figure.

It is thought that the knot was caused by the catheter forming a loop in the epidural space, then doubling back on itself and through the loop. This complication could be avoided by not introducing more catheter than is necessary to leave about 2.5 cm. within the canal after withdrawal of the needle.—We are, etc.,

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Factor IX Levels and Oestrogens

SIR,—In asking if we can tell whether the effect of factor IX levels in the puerperium is the same with a total dose of 54 mg. as with 180 mg. Miss A. M. Dickens (20 April, p. 175) raises an important point. At present we cannot provide a useful answer.

Our work in recent months has been to study the effects on coagulation of stilboestrol given in amounts which we had shown to cause an increase in the incidence of puerperal thromboembolism. Although a variety of other effects on coagulation have been found, the effect on factor IX has been by far the most marked. We now have in hand a series of studies to elucidate the effect of