for established left ventricular failure or given in the late afternoon to prevent paroxysmal nocturnal dyspnoea. The need for potassium supplements is governed by many factors, such as the potassium content of the diet, the presence or absence of primary or more commonly secondary hyperaldosteronism. It must be remembered that severe sodium restriction is a powerful stimulant to aldosterone secretion; therefore, if dietary sodium is restricted, potassium supplements are likely to be needed.

Finally, Dr. Susan Cotton and I¹ did not report occasional evidence of mild liver dysfunction in patients treated with guanoxan, but five cases of frank hepatitis with jaundice, one of them fatal, in addition to laboratory evidence suggestive of hepatic dysfunction in a third of the first 100 treated patients.—I am, etc.,

E. MONTUSCHI.

Whittington Hospital,
London N.19.

REFERENCE

- ¹ Cotton, S. G., Lovel, T. W. I., and Montuschi, E., *Clinical Trials Journal*, 1967, 4, 707.

SIR,—The first article on hypotensive drugs, *Today's Drugs* (10 May, p. 365) will be of considerable value in guiding practitioners in the prescribing of drugs for the treatment of hypertension. It is unfortunate, therefore, that an error has crept into the Table indicating the daily doses of some of the more commonly used hypotensive agents. The dose of chlorthalidone (Hygroton, Geigy), is given as 100–200 mg. per day. This dose grossly exceeds that which is recommended—namely, 50 mg. per day. There is evidence¹ that little benefit is to be obtained in the use of a larger dose than 50 mg. daily in the maintenance of the majority of hypertensive patients.—I am, etc.,

J. DOMENET,
Medical Department,
Geigy Ltd., Pharmaceuticals Division,
Macclesfield, Ches.

REFERENCE

- ¹ Cranston, W. I., et al., *Lancet*, 1963, 2, 966.

* * We have shown Dr. Domenet's letter to our contributor who replies: "The daily dose of 100–200 mg. of chlorthalidone was based on a majority opinion taken from the literature. The observations of Cranston and his colleagues, cited by Dr. Domenet, were that 50 mg. daily produced a mean blood pressure fall of 17.9/8.9 (systolic/diastolic) mm. Hg, 100 mg. daily produced a mean fall of 27.5/13.9, and 200 mg. daily a fall of 29.8/14.7. The wide range of variation of individual patients and the relatively small numbers in the trial make statistics scarcely applicable, but the general trend of the results was the same for chlorthalidone as for the two thiazides tested. Most trials of chlorthalidone in hypertension have used daily doses between 100–200 mg. daily, but if one desires a slightly smaller hypotensive effect with a corresponding reduction in cost and possible complications of therapy then it is very reasonable to use 50 mg. daily, which certainly has a measurable and significant hypotensive effect, even though it is only about two-thirds of that achieved with 100 mg.

"Dr. Domenet, however, does us a useful service in emphasizing the way in which the

dose/response curves for diuretics in the treatment of hypertension tend to become relatively flat in the higher dose range, so it may well be correct that there is little virtue in giving the full dose of 200 mg. of chlorthalidone or 10 mg. daily of bendroflumazide when nearly as good blood pressure reduction can be achieved with considerably smaller doses."—Ed., *B.M.J.*

Miliary Tuberculosis

SIR,—In the article on miliary tuberculosis in adults (3 May, p. 273), the difficulty was stressed of making the diagnosis in elderly patients. This is also the case in young children. Bentley, Grzybowski, and Benjamin¹ showed there had been a failure to diagnose the condition radiologically in nine out of 28 children found to have miliary tuberculosis at post mortem. Occult or cryptic miliary tuberculosis can present considerable diagnostic difficulty in small children with tuberculosis complicating kwashiorkor. A high index of suspicion for the condition should be kept by those working in a famine area.—I am, etc.,

J. M. WEDDELL.

Medical Research Council,
Epidemiological Research Unit
(South Wales),
Cardiff.

REFERENCE

- ¹ Bentley, F. J., Grzybowski, S., and Benjamin, B., *Tuberculosis in Childhood and Adolescence*, 1954. London, National Association for the Prevention of Tuberculosis.

Metabolic Response in Ethnic Groups

SIR,—May we reply briefly to Dr. D. Craddock's criticism (26 April, p. 247) of our paper (22 March, p. 748)?

First-cousin marriages are very common among Moslem Indians in Johannesburg, occurring in about 60% of unions in one study,¹ and it is reasonable to postulate that genetic factors play some role in their metabolic responses, including the fact that they suffer from diabetes mellitus more frequently than do whites.

We have no wish to get involved in the "sugar controversy," but we must point out that sucrose is not absent from the diet of Johannesburg Africans. There are no accurate figures on the sugar consumption of these people, but there is no doubt that their intake of sucrose, both as such and in the form of jams, cold drinks, confectionery, etc., is substantial.

Our subjects were matched in respect of their physical characteristics, and at the same time were representative of their respective population groups, which explains why the whites were taller and heavier than the Africans. However, as indicated in our paper, when the weights were expressed as percentages of ideal body weight there was no significant difference between the groups.—We are, etc.,

H. C. SEFTL.
A. H. RUBENSTEIN.

Department of Medicine,
University of the Witwatersrand
Medical School,
S. Africa.

REFERENCE

- ¹ Seftel, H. C., *Medical Proceedings*, 1967, 13, 3.

Treatment of the Phobic Anxiety State

SIR,—I refer to the article "Anxiety Neuroses and Phobic States. II—Diagnosis and Management" by Professor Martin Roth and Dr. D. H. Myers (1 March, p. 559). There is clearly a difference of opinion between these authors and Dr. William Sargent (5 April, p. 49).

Professor Roth and Dr. Myers state "dangerous interaction may occur between a M.A.O.I. and any of the following drugs: the opiates, pethidine, local anaesthetics, sympathomimetic amines, methyl dopa, and the tricyclic antidepressants. M.A.O.I.s are inactivated slowly: for this reason these foods and drugs must be avoided both during treatment and for 14 days afterwards."

Dr. Sargent, on the other hand, specifically uses tricyclic antidepressants to establish a normal sleep pattern. "If the patient's sleep is impaired, specially by early morning waking, then we consider that monoamine-oxidase inhibitor drugs should be given during the day and a tricyclic antidepressant should also be given in the evening to try and get a return to normal sleep pattern."

When one specialist in psychological medicine advocates a method of treatment which is stated to be frankly dangerous by another, could a non-specialist like myself kindly ask for clarification?—I am, etc.,

GEORGE C. WILSON.

Kogarah Bay,
N.S.W., Australia.

Bilateral Posterior Dislocation of Shoulders

SIR,—In view of the low incidence of posterior dislocation of the shoulder, compared with that of anterior dislocation, it would seem justified to report an interesting case of bilateral posterior dislocation which recently presented in the accident room of this hospital.

The patient was a woman of 68 years who was otherwise healthy and gave no history of previous dislocation of the shoulder. She had been cleaning her electric fire the previous evening without having first taken the precaution of switching it off. While doing so she rested her left hand on the fire frame and then accidentally touched the element with her right hand. The shock she received made her fall backwards against her bed, and subsequently she found that she could move neither arm. She remained like this during the night, apparently in surprisingly little pain, before attending the infirmary the following afternoon.

On examination there was obvious deformity of both shoulders, and both arms were held immobile by her sides—a posture that would be instantly recognizable again. The only other physical signs were almost complete inability to move either shoulder and a small patch of erythema on her right hand, which was the site of contact with the hot element. She otherwise appeared healthy.

Radiographs subsequently demonstrated the presence of bilateral posterior dislocation of the shoulder, and she made a good recovery following reduction. The mechanism of dislocation here was presumably spasm of the posterior shoulder girdle muscles forcibly pulling the humeral heads posteriorly, owing to the electric current passing across the body from one arm to the other as one hand was

earthed and the other was in contact with the element.

Apart from independent trauma to both arms simultaneously, it is difficult to conceive of other circumstances in which bilateral dislocation can occur.—I am, etc.,

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Royal Infirmary,
Manchester.

Pustular Psoriasis and Amyloidosis

SIR,—I read with interest the article on this subject (10 May, p. 351), and wish to comment on it. The author postulates that pustular psoriasis may predispose to the development of secondary amyloidosis by prolonged stimulation of the reticulo-endothelial system, but although post-mortem studies were carried out on the two patients described there is no mention of the histological findings of the bone marrow, lymph nodes, etc. Isolated reports have described changes in the reticulo-endothelial system affecting the bone marrow¹ and lymph nodes² which require confirmation. It would be interesting to know the immunoglobulin levels in the two patients described which might give support or negate the immunoglobulin theory put forward in the article.

There is strong evidence favouring mucopolysaccharide as the link between amyloid and psoriasis. Recent evidence³ has demonstrated that in secondary amyloidosis there is a complex of amyloid deposits of protein and sulphated mucopolysaccharide suggesting that acid mucopolysaccharide is intimately involved in the formation of amyloid. Increased deposits of mucopolysaccharide are found in psoriatic lesions and it has recently been proposed⁴ that sulphated mucopolysaccharide may be a stimulant to epidermopoiesis resulting in the fundamental defect in psoriasis.—I am, etc.,

L. STANKLER.

Royal Infirmary,
Aberdeen.

REFERENCES

1. Ruszczak, Z., and Prószyńska-Kucynska, W., *Przegląd Dermatologiczny*, 1965, 52, 117.
2. Toruniowa, B., *Przegląd Dermatologiczny*, 1965, 52, 497.
3. Pennock, C. A., Burns, J., and Massarella, G., *Journal of Clinical Pathology*, 1968, 21, 578.
4. Roe, D. A., *British Journal of Dermatology*, 1969, Suppl. No. 2, 81 p. 49.

Attitudes to Breast Feeding

SIR,—May I endorse the final statement in the leading article on attitudes to breast feeding (19 April, p. 131) that "the medical profession should be encouraged to examine more closely the educational task before it"?

We have conducted two surveys on the incidence of breast feeding in Cambridge among mothers attending the ten welfare clinics in the area; the first in 1964 and the second in 1968. In both cases we found that the mothers who had attended grammar school or university were far more likely to breast feed their infants for at least three months, and sometimes for as long as eight or nine months, than less well educated women. They did so because they felt it was the best start for the baby and because they found it so much more convenient than artificial feeding, which entailed additional work in the preparation of the feeds.

On the contrary, the large number of mothers who artificially fed their infants from birth, or who gave up breast feeding before three months (the time we considered breast feeding to have been successful), claimed that bottle feeding was so much easier and convenient in that others could feed the baby for them and thus leave them freer socially. Out of the 500 mothers interviewed only one gave as a reason for not breast feeding an early return to work.

We found that a higher percentage of mothers who were delivered at home breast fed than those delivered in the local maternity hospital. Furthermore, mothers who were delivered in the hospital, whether they were there for only 48 hours or for the full nine days, were far less likely to attempt to breast feed or to continue to do so on their return home. Some mothers felt that the individual attention of the domiciliary midwife at a home confinement gave her advantages over the often harassed pupil midwife who, under pressure of time, finds it easier to administer stilboestrol than help and guide a mother who is not quite certain whether she wants to breast feed or not. In addition, the young primipara is easily swayed by the opinions of a ward full of mothers who tell her that artificial feeding is easier and more convenient.

I feel that the medium of commercial advertising is one of the strongest deterrents to breast feeding. Large posters and colourful and attractive advertisements in magazines advocating the superiority of this or that feed are hardly likely to encourage the less well educated mother to persevere with breast feeding.

Our surveys were devised to cover many factors which might contribute towards the success or failure of breast feeding, and details will be published in the near future.—I am, etc.,

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University of Cambridge
and Medical Research Council,
Cambridge.

Brucellosis Presenting with Arrhythmia

SIR,—We are not aware of any reports of paroxysmal supraventricular tachycardia in brucellosis, and as a presenting symptom of brucellosis it must be rare. Accordingly, we should like to report the following case.

A Lancashire bricklayer aged 44 who had been staying in London for some time presented at casualty one morning complaining of fluttering and discomfort in his chest. It had started twelve hours previously and had passed off while in bed but it had recurred during the morning. Apart from this he had been feeling off-colour for two weeks, but had no other complaints.

On examination his pulse rate was 150 per minute and regular, temperature 99° F. (37.2° C.). No other abnormal physical signs were found. An E.C.G. showed that he was in supraventricular tachycardia, and during the course of the cardiogram his rhythm changed spontaneously to atrial fibrillation with ventricular ectopic beats. It was considered that he might have a mild carditis and he was admitted. On the same day while in hospital, he reverted to sinus rhythm, but later this changed into a supraventricular tachycardia again and he became hypotensive. His blood pressure and tachycardia reverted to normal after two hours, and remained so for the rest of his illness. On

the fifth day of his illness his temperature rose to 101° F., and for six days he had an intermittent fever. Routine investigations for pyrexia of unknown origin were carried out.

On admission a standard agglutination test for brucella antibodies was positive to a titre of 160. This was repeated one week later, when it had risen to 2,560. In the interval between agglutinations and following the rise in titre, blood cultures were taken. *Brucella abortus* was isolated from 11 of the 20 bottles taken, growing equally well in 0.5% glucose broth and liver infusion broth. There was no history of drinking unpasteurized milk, or eating Italian cheese. He is an urban inhabitant who had some contact with cattle 12 months ago while working in a field.

Bassett-Smith¹ first reported a case of atrial fibrillation in brucellosis in 1906, and since then there has been growing literature on heart disease in brucellosis.² Myocarditis is common in fatal brucellosis,³ where it can be demonstrated at necropsy.

We should like to thank Sir John Richardson for permission to publish the clinical findings on this case.

—We are, etc.,

ANTHONY T. R. AXON.
DIANA M. D. RIMMER.

St. Thomas's Hospital,
London S.E.1.

REFERENCES

1. Bassett-Smith, P. W., *British Medical Journal*, 1906, 1, 313.
2. Peery, T. M., and Belter, L. F., *American Journal of Pathology*, 1960, 36, 673.

Unusual Presentation of Diabetes Mellitus

SIR,—I was most interested to read the leading article on oesophageal dysfunction and diabetes (24 May, p. 466). The following case history may be of interest to your readers.

An 81-year-old lady presented to the casualty department at this hospital on 17 March complaining of 5 weeks' severe pain over the top of her head and over both temples. This was constant, unvarying, and not aggravated by coughing. It was unrelieved by analgesics. She had no other symptoms and it was noted that she was a thin elderly lady with a blood pressure of 150/80. She was tender over her temporal and occipital arteries and the diagnosis was thought to be cranial arteritis. Her E.S.R. was 56 mm. in one hour, and her skull x-rays were normal. She was given prednisolone 10 mg. three times a day. Two days later she was no better, and was referred to the neurological department. She was seen on 26 March, when her head was still aching, and it was noted that her temporal arteries seemed normal and were pulsatile, but were slightly tender. It was considered that temporal arteritis might be the diagnosis, but in view of her generally unhealthy appearance that she might have a widespread neoplasm. Routine outpatient urine testing for sugar, ketones, and albumin was negative. Her liver function tests were normal. She was continued on prednisolone 10 mg. twice daily, and 6 days later the top of her head was not so tender. Her E.S.R. was 30 mm. in one hour. The following week she was a lot better and her E.S.R. was 21 mm. in one hour.

A fortnight later she was well, but when next seen on 13 May she complained of difficulty in swallowing for three weeks. She said that liquids gave her a pain in the front and back of her chest, that she vomited if any food did pass down, and that liquids were swallowed much more easily than solids. She had also lost over two stone (12 kg.) in about three months. The patient was an intelligent 81-year-