Sex	Age	Previous Systemic Therapy	Response*	Toxicity
F	31	—	+++	—
F	57	Methotrexate	+	leucopenia
F	57	—	+	—
F	63	Methotrexate	+	raised bilirubin
F	39	—	+	—
F	73	Methotrexate	+++	anaemia, leucopenia
M	61	Methotrexate	+	—
M	52	Triamcinolone	+	—
F	38	Methotrexate	+	—
F	72	Methotrexate	+	—

*Grading of response:
○ = 0–25% reduction in area of involvement
+ = 25–50%
++ = 50–75%
+++ = 75–100%

extent 25% or more. Improvement occurred at two weeks in two patients. In the remaining three improvement was not observed till four to six weeks. In three of the patients who had shown improvement azathioprine treatment was discontinued at the end of the six-week period. One month later relapse had occurred in two of these. In three of the 10 patients toxic effects were noted (leucopenia in two, raised serum bilirubin in one), but these reverted to normal on ceasing azathioprine.

Methotrexate given in daily oral dosage is effective in 70–100% of cases of chronic psoriasis,^{6,7} whereas in the present study only one-half of the patients showed significant clearing with azathioprine. Since, however, three of the remaining patients had failed to respond to methotrexate and one to systemic triamcinolone the comparison is probably misleading, and we feel our results are sufficiently encouraging to justify a more detailed study of azathioprine in psoriasis.—We are, etc.,

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REFERENCES

1 O'Rourke, R. A., and Eckert, G. E., *Archives of Internal Medicine*, 1964, **113**, 191.
2 Coe, R. O., and Bull, F. E., *Journal of the American Medical Association*, 1968, **206**, 1515.
3 Ryan, T. J., and Vickers, H. R., *British Journal of Dermatology*, 1966, **78**, 612.
4 Muller, S. A., Farrow, G. M., and Martalock, D. L., *Archives of Dermatology*, 1969, **100**, 523.
5 Kravetz, R. E., and Balsam, T., *Archives of Dermatology*, 1961, **84**, 597.
6 Ryan, T. J., Vickers, H. R., Salem, S. N., Callender, S. T., and Badenoch, J., *British Journal of Dermatology*, 1964, **76**, 555.
7 Rees, R. B., Bennett, J. H., Maibach, H. I., and Arnold, H. L., *Archives of Dermatology*, 1967 **95**, 2.

One-eye Viewing

SIR,—It has long been recognized that monocular clues such as perspective and the change in apparent colour of objects as they recede into the distance are of considerable importance in depth perception.¹ For several years I have illustrated this point in my teaching by asking students to view colour photographs or reproductions of representational paintings.

When viewed with both eyes open the pictures appear flat. Presumably this is because binocular clues provide the accurate information that all points in the picture are in the same plane. This predominates over any illusion of depth created by the monocular clues. When one eye is covered most subjects report a greatly increased impression of depth. This illusion is enhanced by

detailed inspection of the picture at close range. The phenomenon is quite striking and I am surprised that it is not better known. I presume it has been described before and I would appreciate information concerning previous reports in the literature.

The significance of this phenomenon is by no means trivial. I have spent many happy hours wandering through art galleries with the catalogue lightly covering one eye. I have been amazed at the extra life that this injects into most paintings. The impressionists especially respond to this

method of viewing. Also I wonder if even the most expensive stereoscopic apparatus can create a more realistic impression of depth than does a good quality colour photograph viewed with one eye?—I am, etc.,

R. B. CROSS.

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REFERENCE

¹ *Starling and Lovatt Evans Principles of Human Physiology*, eds. H. Davson and G. Eggleton. 14th edn. London, Churchill, 1968.

Children in Intensive Care Units

SIR,—The interesting article by Drs. J. R. Harper and G. Varakis (28 March, p. 810) points the way to the logical utilization of the complicated and expensive facilities and specialized staff involved in intensive therapy units. In Peterborough we have gone one step further in that we admit all children requiring intensive therapy, including neonates, to the adult unit.

Peterborough District Hospital (opened August, 1968) has a seven-bedded intensive therapy unit with all the usual facilities, including a hyperbaric oxygen chamber. In the year preceding January, 1970, out of 462 admissions to the unit 50 were children under the age of 12 years with a simple statistical breakdown as follows:

	Total	Ventilated	Nasal Endotracheal Tube Only	Died	Average Length of Stay
Medical—Neonates	20	16	2	6	7.2 days
Others	15	7	2	4	4.2 days
Surgical—Head injuries	6	—	—	—	4 days
Postoperative	9	—	—	—	

Like our colleagues at Northampton we have found that the children were adaptable, and those old enough to comment gave no indication that they thought of the unit as being any more frightening than the other parts of the hospital. On the other hand we find that the children, especially the neonates, demand a great deal of attention, and this is occasionally disturbing to the adult patients on the unit, particularly at night. We are fortunate in that as part of the intensive therapy unit there is a separate environment-controlled room which is proving invaluable for nursing the smaller babies. We feel that, though still an intrinsic part of the adult unit, the paediatric portion should have a definite area where the relevant equipment can be concentrated, and not exist as an adaptation of whatever space is vacant at the time. Obviously, however, the unit must remain flexible to meet the occasional heavy demands of either paediatric or adult patients.

by the senior members has smoothed the initial difficulties and now children are welcomed as providing a more complete range of work. The children's ward staff have noticed the understandable "I.T.U.-itis" on transfer back from the unit, but state that the patients soon re-adapt to the ward atmosphere and that no real problems have been encountered.

In conclusion we agree, as already stated, that the duplication of these expensive facilities in separate areas for adults and children is not feasible in the district general hospitals, and hope our results help to prove that the alternative of treating all patients together can work.—We are, etc.,

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Allergy to Iprindole (Prondol) with Hepatotoxicity

SIR,—Dr. P. J. W. Young (7 February, p. 367) reported an allergic reaction to iprindole with hepatotoxicity. We would like to draw attention to two cases which have occurred in the last year in this practice where hepatotoxicity without obvious allergic phenomena was demonstrated.

The first was in a 30-year-old house-

wife who had had a long-standing history of depression and who had been on tranylcypromine until a fortnight before iprindole was prescribed on 24 December 1968. A week later she felt unwell and by 3 January 1969 she was jaundiced, had discomfort in the right hypochondrium, and had dark urine in which bilirubin and urobilinogen were

demonstrated in small amounts. Liver function tests on that day were as follows:

Total bilirubin 1.1 mg./100 ml.; conjugated bilirubin 0.6 mg./100 ml.; alanine transaminase 60 I.U.; alkaline phosphatase 10 K.A. units; thymol turbidity 1; thymol flocculation 0; colloidal gold 0.

Iprindole was withdrawn, and the patient made a complete recovery within a few days and remains well physically. The liver function tests, when repeated on 16 January showed:

Total bilirubin 0.5 mg./100 ml.; conjugated bilirubin 0.3 mg./100 ml.; alanine transaminase 4; alkaline phosphatase, thymol turbidity, thymol flocculation, and colloidal gold were all within normal limits.

The second case was a 49-year-old man who was seen on 1 October 1969 with a moderately severe endogenous depression and iprindole 2 tablets t.d.s. were prescribed, together with nitrazepam 10 mg. at night. This was his first surgery attendance for five months. By 10 October his depression had improved and the iprindole was repeated. He was next seen at home on 14 October, having taken to bed on 11 October with fever and malaise. Minimal icterus was apparent when he was seen, but the urine gave a negative response to Ictotest. Iprindole was discontinued and when he was seen on 17 October no jaundice was apparent. However liver function tests done on 19 October were as follows:

Total bilirubin 1.8 mg./100 ml.; conjugated bilirubin 1.2 mg./100.; alanine transaminase 17 I.U.; alkaline phosphatase 19 K.A. units; thymol turbidity 1; thymol flocculation 0; colloidal gold 0.

At this stage he was prescribed amitriptyline and he continued to recover.

These cases show that hepatotoxic reactions can occur in response to this drug which rapidly resolve when it is withdrawn. Perhaps it is significant that in both cases the drug had been administered for one week before the reactions appeared.

We should like to thank Dr. G. A. Faux of the medical department of John Wyeth and Bro. Ltd. for his help with the presentation of these cases.

—We are, etc.,

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J. A. COLLINGS-WELLS.

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Hants.

Value of Culdocentesis

SIR,—I would endorse the findings of Drs. Cynthia Lucas and A. M. Hassim (24 January, p. 200) as reported in their paper on culdocentesis and ectopic pregnancies.

In the years 1968-9, 14 cases of ectopic pregnancy were admitted in this hospital (30 surgical beds). This represents 12% of all major surgical emergencies during this period. Culdocentesis was performed in 10 of these patients and in every case confirmed the diagnosis. There was no doubt in the diagnosis of the remaining four cases, and laparotomy was carried out immediately. There was one false-positive result which at laparotomy turned out to be a rupture of the uterus due to chorioncarcinoma (biopsy). In another patient, despite a negative result from culdocentesis, laparotomy was performed only to reveal a pyosalpinx. There have been no maternal deaths in this small series.—I am, etc.,

ALAN ROBSON.

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Cost of Anaesthetic Agents

SIR,—I am sorry that Mr. G. Teeling-Smith (4 April, p. 52) finds it "distressing" to have to spell out that the cost of delivering domiciliary oxygen is bound to be high, particularly when I had granted this point in my original letter. It was not the fact but the size of the price differential that I was querying.

However, there is another price differential whose very existence I find puzzling. The total cost to the N.H.S. of a 48 cu.ft. (1.4 cu.m.) cylinder, excluding the chemist's delivery charge, is 37s. 6d., of which the Drug Tariff component is 27s. The same cylinder if delivered to my dentist, who uses considerably less oxygen than at least one of my patients, costs 13s. 9d. Why?

My own experience suggests that the use of domiciliary oxygen is on the increase. If so, distribution costs should fall and we can hope for a price reduction.—I am, etc.,

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Unexpected Danger of Diazepam

SIR,—The report by Drs. S. A. Feldman and B. E. Crawley (14 March, p. 691) on the apparent potentiation of non-depolarizing muscle relaxants by diazepam (Valium), prompts me to suggest a possible synergism between it and methaqualone-diphenhydramine (Mandrax).

A patient during recovery from an overdose of the latter became difficult to manage on account of hyperpnoea, restlessness, muscular hypertonia, intermittent tremor, and trismus. An intravenous injection of diazepam 10 mg. was followed by apnoea and muscular relaxation. Tracheal intubation was easily performed, and he was mechanically ventilated without attempts at spontaneous respiration for two hours. After recovery of spontaneous respiration no further difficulty in his management was experienced.—I am, etc.,

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Fibrinolytic Activity in Pregnancy

SIR,—Recently I had an opportunity of studying the blood fibrinolytic activity in a 24-year-old woman who was taking a combined oestrogen-progestogen contraceptive pill (Ovulen). The woman stopped taking the pill in order to be able to conceive. A close check was kept on her fibrinolytic activity during the whole of the pregnancy as well as the post-partum period (Graph). The blood fibrinolytic activity was estimated by the euglobulin lysis time (E.L.T.) method described by von Kaulla modified and using an E.L.T. recorder,¹ and expressed in units by multiplying the reciprocal of the lysis times in minutes by 10,000.

There was no difference in the blood fibrinolytic activity during the period when the pill was taken and the period immediately after withdrawal of the drug.

However, within four weeks of conception the blood fibrinolytic activity had decreased and this fall persisted during the whole of the pregnancy. It must be pointed out that the decrease observed four weeks after conception was proved to be due to pregnancy only retrospectively. A further reduction in blood fibrinolytic activity was

noted during the last trimester of the pregnancy.

On examination one week after delivery the blood fibrinolytic activity had returned to normal levels, which is in agreement with the findings reported by other workers.²⁻⁴ Though decreased blood fibrinolytic activity during pregnancy has been observed^{3,5,6} a survey of the literature has failed to reveal any studies where this has been estimated immediately before and soon after a pregnancy in the same woman.—I am, etc.,

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REFERENCES

- 1 Menon, I. S., Martin, A., and Weightman, D., *Laboratory Practice*, 1969, 18, 1186.
- 2 Hodgkinson, C. P., Margulis, R. R., and Luzadre, J. H., *Journal of Clinical Investigation*, 1954, 33, 1553.
- 3 Biezenski, J. J., and Moore, H. C., *Journal of Clinical Pathology*, 1958, 11, 306.
- 4 Shaper, A. G., Macintosh, D. M., and Kyobe, J., *Lancet*, 1966, 2, 874.
- 5 Menon, I. S., *Clinician*, 1970, 34, 9.
- 6 Wardle, E. N., and Menon, I. S., *British Medical Journal*, 1969, 2, 625.