can be more convincing to a patient than the more callous approach of a seasoned practitioner who has seen it all before.

(2) The doctor should stress to the patient that the presence of a student may actually improve the care he is getting. The patient can be told that the melding of seasoned experience and up-to-date scientific knowledge that his physician and student when acting in concert bring to a clinical situation can work only to his advantage. This calls for an admission of humility on the part of the physician, but this too is a welcome thing to many patients.

(3) The patient should be informed that students have to learn and that medical education is only part book learning. The practice of medicine, and general medicine in particular, is something that must be learned in the field. A certain altruism on the part of the patient can and must be cultivated.

Finally, at the end of the interview a few minutes can be spent with the patient in a tactful way to determine if he held back on any information because of reluctance to be candid in the presence of a third party. Occasionally important facts come to light and the patient has been served.

Obviously what I am talking about cannot be done in an office which has a rapid turnover; but then perhaps those offices are not ideal for the training of medical students. If encouraged and made to feel a part of the health care team our students will grow into more sensitive and caring physicians.—I am, etc.,

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Isolation System for General Hospitals

SIR,—I suggest that some of the recommendations of the Control of Infection Group at Northwick Park Hospital (6 April, p. 41) seem to be examples of the first of Todd's¹ list of the main errors of medicine—basing treatment on theory. Or, as Chapin² might have put it, that the group do not always distinguish clearly between how diseases might be spread and how they are in fact spread.

As cubicle isolation is expensive in resources, it is important to record observations which indicate when it is not necessary. I therefore report that in the infectious disease unit at this hospital during the past 27 years patients with hepatitis (in its icteric stage), meningitis (of all forms), encephalitis, erysipelas, herpes zoster (in adults), leptospirosis, psittacosis, brucellosis, glandular fever, malaria, pneumonia, and non-infective disease have commonly been nursed together in open wards without evident ill effects. Though the Northwick Park group do not recommend isolation in the five last-mentioned conditions, I include them in the record because when treated in infectious disease units elsewhere the patients are commonly nursed in cubicles—for lack of any other accommodation.

These observations suggest the possibility of great saving in gowns, gloves, time, and other expenditure.—I am, etc.,

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¹ Todd, J. W., *Lancet*, 1970, 1, 665.

² Chapin, C. V., *The Sources and Modes of Infection*. New York, Wiley, 1910, cited by Taylor, I., and Knowleden, J., in *Principles of Epidemiology*, 2nd edn., p. 117. London, Churchill, 1964.

SIR,—Those of us who have been concerned with the control of infectious diseases will have been impressed by the article on isolation in general hospitals (6 April, p. 41). The Control of Infection Group at Northwick Park Hospital are to be congratulated.

However, the implication that cases of suspected smallpox should ever be confined in such a unit is a cause for concern. Whenever smallpox is suspected direct admission to a special smallpox hospital should be the rule. Any attempt to contain the patient locally while the diagnosis is confirmed is to be deprecated since it can result in needlessly contaminating part or all of the general hospital, with grave disruption of general medical services during the subsequent inevitable closure.—I am, etc.,

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Accidental Poisoning in Children

SIR,—In the debate on the adjournment in the House of Commons on 18 March Dr. David Owen, Under Secretary of State for Health, said that medicines were chiefly responsible for hospital admissions in cases of poisoning in children under 5 and that aspirin was the largest single cause (30 March, p. 652). It seems likely that of the 16,000 children admitted to hospital for accidental poisoning each year about 5,000 are due to the specially flavoured "junior" aspirins.

A personal study of over 300 such cases has shown that these children practically invariably finish the opened packet which usually contains 50 tablets (total of 4 g). Dr. Owen says that he is prepared to examine anything which could reduce the risk of accidental poisoning. One of the simplest and most practical measures would be to forbid the sale of "junior" aspirin in packages of more than a dozen (1 g). This amount is very unlikely to give rise to toxic effects and would make the admission of the child to hospital unnecessary.—I am, etc.,

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Rebound Migraine

SIR,—I would like to draw attention to a syndrome which can develop in patients taking ergotamine preparations for the relief of migraine and which can easily go unrecognized. Four patients were encountered personally over a six-month period in whom migraine or migrainous neuralgia had initially responded to ergotamine but who had then developed daily headaches while taking the drug every day. The headaches were similar to those for which they had first sought treatment, but there were often slight differences in their character, situation, or timing. They were improved for an hour or more by a dose of ergotamine, but as its effects wore

off they invariably recurred and were relieved again only by another dose. When all ergotamine preparations were stopped the headaches subsided within a few days.

Infrequent accounts of this situation have appeared before.¹⁻⁴ The terms "ergotamine tolerance," "ergotamine withdrawal headaches," and "ergotamine-induced headaches" have been used to describe it, but these are not satisfactory descriptions. Ergotamine tolerance has never been proved⁵ and it is misleading to call these "withdrawal" headaches since they are at their worst while the drug is being taken and disappear, sometimes immediately, when it is stopped. Though they are undoubtedly induced by ergotamine the situation is more complex than this, for they continue to be relieved by it as well. I suggest that the syndrome should be called "rebound migraine," which evokes the continuous fluctuation of symptoms in relation to ergotamine intake. The probable underlying mechanism is a recurring cycle of vasoconstriction → vasodilatation with headache → vasoconstriction,¹ based on a primary followed by a rebound response to each dose of ergotamine.

This syndrome may be much commoner than is generally realized. The diagnosis should be considered in any migrainous patient who has intractable headaches while taking substantial amounts of ergotamine every day; such headaches may be occurring because of rather than in spite of the drug. Withdrawing the ergotamine can lead to complete relief, but the patient must be given to understand that this may take several days and that the trial period of abstinence has therefore to last at least a fortnight.

A fuller account of this condition will be published elsewhere.—I am, etc.,

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¹ Peters, G. A., and Horton, B. T., *Proceedings of the Staff Meetings of the Mayo Clinic*, 1951, 26, 153.

² Friedman, A. P., Brazil, P., and von Storch, T. J. C., *Journal of the American Medical Association*, 1955, 157, 881.

³ Lucas, R. N., and Falkowski, W., *British Journal of Psychiatry*, 1973, 122, 199.

⁴ Rowsell, A. R., Neylan, C., and Wilkinson, M., *Headache*, 1973, 13, 65.

⁵ Brazeeau, P., in *The Pharmacological Basis of Therapeutics*, ed. L. S. Goodman and A. Gilman, 4th edn., p. 893. London, Collier-Macmillan, 1970.

Polyarteritis after Influenza Vaccination

SIR,—We would like to draw attention to a patient who developed acute polyarteritis of a fulminating type following administration of a dose of inactivated influenza vaccine.

The patient, an Englishman aged 46 with a family history of diabetes mellitus but no family history of allergy or asthma had suffered from mild bronchitis for most of his life. In 1968 bronchial asthma was diagnosed and this required intermittent courses of steroids. In 1972 he was investigated and found to be sensitive to house dust and house dust mites. There was no history of any other allergy and in particular no intolerance to eggs. Respiratory function tests showed moderately severe airways obstruction with a reversible component. He was started on long-term steroids and was well controlled with disodium cromoglycate and 2.5 mg of