initially treated in an identical fashion. It makes me wonder whether in fact Chinese treatment is really St. Peter's treatment and whether, perhaps, Chairman Mao paid us a surreptitious visit before the cultural revolution (or vice versa?).—I am, etc.,

J. M. JONES

Woking, Surrey

Medical Prisoners in Chile

SIR,—There has been some expression of concern recently in the press for the political prisoners held by the new military régime in Chile. However, little has been heard of the fate of the many members of the medical profession arrested by the military junta after they came to power in September 1973.

According to the testimony of escaped colleagues, these doctors, nurses, and others were rounded up shortly after the new régime came to power simply for being supporters of the medical policies of the Allende government. In this way they are being held without trial for their medical beliefs and in no way can they be considered political prisoners. President Allende was trying to pursue medical policies designed to take the emphasis away from the urban élite and redistribute health facilities to the bulk of the Chilean population in the rural areas.

I believe that it should be a matter of concern to all members of the medical profession, all over the world, that these doctors should be persecuted for the practice of medicine to the best of their ability. I feel sure that if the new junta believed that the eyes of the medical profession were watching their treatment of these doctors, then they would moderate their actions. I would therefore like to ask all those doctors who are indeed concerned at the treatment of their colleagues in Chile to write to those in power expressing this concern. I have a list of addresses to which they should write and can also arrange translation facilities where necessary.—I am, etc.,

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Response to Propranolol and Diazepam in Somatic and Psychic Anxiety

SIR,—The recent paper by Drs P. J. Tyrer and M. H. Lader (6 April, p. 14) clearly differentiates two entirely different kinds of anxiety. Both kinds of anxiety are met with in student health practice, particularly in the period approaching a major examination. Drs. Tyrer and Lader called their anxieties "somatic" and "psychic" and this goes some way to clarifying a situation in which nomenclature has fogged our thinking since the nineteenth century. Writing about the connexion between lactate metabolism and anxiety, Pitts and McClure¹ wrote: "Anxiety reaction is not symptomatically distinguishable from anxiety neurosis or from the disorders represented by the terms neurocirculatory asthenia, vasoregulatory asthenia, nervous tachycardia, effort syndrome, neurasthenia, Da Costa's syndrome, vasomotor neurosis, nervous exhaustion, irritable heart,² soldier's heart and others. . . .

This semantic confusion has probably impeded and almost certainly not facilitated the study of lactate metabolism in anxiety neurosis." They went on to define an anxiety attack and were able to reproduce it in susceptible cases (which closely resemble Drs. Tyrer and Lader's "somatic" group) by lactate infusion.

In the student age group it is clear that the adrenaline-lactic-acid autonomically mediated anxiety in the examination period is much more a fear reaction, and the observation of a tense, white-faced patient with sweating hands and feet complaining of a multiplicity of anxiety-oriented symptoms should not automatically lead to "tranquillization." If we accept the differentiation of Drs. Tyrer and Lader, then it becomes apparent that the somatic group (with a rapid pulse) is likely to be helped by propranolol and the psychic group is not. Psychic anxiety as they define it seems to come much more into the "depressive" range of illness. The use of propranolol is contraindicated in this group of patients, firstly because of its ineffectiveness in symptom relief and secondly because it produces side effects of its own which it does not seem to produce in autonomically mediated anxiety attacks. The clinical touchstone to differentiate these two groups of patients is a labile pulse rate which under the "stress" of a surgery consultation may rise to 110-140 per minute.

Students in the somatic group are very rewarding to treat as their behaviour is exclusively examination-oriented and has been conditioned in the Pavlovian sense. The interruption of the autonomic pathway removes the effect of conditioning and a couple of successful examinations may serve to recondition the patient without the need for any complex medical or psychotherapeutic regimen. The first 20 patients in whom propranolol was used specifically in a somatic group collected in 1970-72³ were each matched by age, sex, year, and faculty with the next student alphabetically (whether they had been seen in the health centre or not). The examination results were compared and in each of the two groups three got distinguished degrees, 15 got moderate results, and two failed or had to resit an examination. Looked at from the outside this is not impressive. However, my own assessment of the patients was that in many cases the examination would have been missed or, if attendance had been achieved, the backlash would have ensured failure. It is difficult if not impossible to perform controlled experiments on this group before examinations because, where the diagnosis is established, in my opinion no other treatment is effective so that we are in the position of doing experiments for academic curiosity in a situation where a patient's whole life will be altered by our inactivity. The ineffectiveness of adequate daytime tranquillization has been mentioned previously³ and the clinical picture of "slow motion panic" is a familiar one to student health doctors.—I am, etc.,

MICHAEL CONWAY

University Health Service,
University of Salford

¹ Pitts, F. N., and McClure, J. M. jun., *New England Journal of Medicine*, 1967, 277, 1329.

² Da Costa, J. M., *American Journal of Medical Services*, 1871, 61, 17.

³ Conway, M., *Practitioner*, 1971, 206, 795.

Reversing the Brain Drain

SIR,—In recent times much attention has been given to the exodus of young doctors for the financially more rewarding positions open to them in the U.S. and Canada. It has occurred to me that it would be possible to reverse the brain drain or at least to compensate for it. To my knowledge there are not a few qualified U.S. physicians who would be glad to serve abroad if the opportunity were offered to them. Because of the large income many of them command they are in a financial position to retire at the age of 50 if they so desire. In ordinary circumstances they would not dream of doing so because medicine is their life and they would be bored and frustrated without practising their skills. Therefore many of them give an increasingly large proportion of their time to voluntary services, research, and teaching.

It is these doctors that I believe it would be possible to attract to these shores if an organized framework were set up within which they could be received. They would not be in competition with local doctors since they would not be in private practice but would be directed to institutions where their services are needed. This would make available, with no cost to the Health Service, a sizeable reservoir of well-trained physicians. Some easily organized amenities, such as housing and facilities to widen their social horizons, would probably be sufficient, especially if the official nature of the enterprise enabled them to claim U.S. tax deductions for their out-of-pocket expenses. These doctors, unlike their British colleagues in the large cities, would probably welcome being posted to the provinces since the opportunity to mix with the local communities is usually easier in the smaller towns.

I myself am a U.S. physician who retired from a busy private practice in order to take up a new career in teaching and writing. Currently I am lecturing in an honorary capacity at one of the teaching hospitals of London University.—I am, etc.,

A. D. JONAS

London S.W.1

Skull Transillumination

SIR,—Transillumination of the skull of infants and young children is a simple procedure which takes about two minutes to perform, requires inexpensive equipment, and may yield valuable information. Intracranial collections of fluid such as subdural effusions, hydrancephaly, or porencephalic cysts may be readily identified. The technique involves taking the child into a completely dark room or cupboard and applying a light to different parts of the skull. The light should be shielded from the observer's eye, and this demands a flexible lamp shade which will mould to any irregularities on the infant's skull.

There is no torch designed for this purpose on the market in this country. After several attempts with sticking plaster and rubber pessaries a simple solution was evolved using an infant oxygen funnel (McKilroy's Inhaler, Medical and Industrial Equipment, Manchester). The bell is trimmed to a diameter of 2-3 cm and the

stem cut back to the point where it opened out into the bell of the funnel. This end will now slip over the illuminating tip of most pen torches (see fig.).

Transilluminating Torch with trimmed McKilroy's Inhaler fitted over light source, and intact inhaler (oxygen funnel) for comparison.

I feel prompted to describe this simply because none of the six paediatric units in which I have worked have had a comparable alternative and because many of my colleagues are still gummed up with sticking plaster.—I am, etc.,

D. M. LEWIS

Stepping Hill and Wythenshawe Hospital,
Manchester

Beta-blockade in the Presence of Renal Disease and Hypertension

SIR,—We read with interest the paper by Dr. D. J. Warren and others (27 April, p. 193), reporting three cases of deterioration of renal function in patients with chronic renal failure following beta-blockade. We would like to report a further case, in which the sequence of events was attributable to two therapeutic agents.

A 49-year-old housewife developed chronic renal failure following analgesic abuse, having taken approximately 50 A.P.C. (aspirin, phenacetin, and codeine) tablets per day for five years. At the end of this period her serum urea level was 60 mg/100 ml and her serum creatinine 2.1 mg/100 ml. She was hypertensive with casual readings at 190/110 mm Hg. Seven days before admission she was started on prindolol 10 mg twice a day in an effort to control her hypertension. This was followed by the development of acute left ventricular failure and pulmonary oedema, with a rapid deterioration in her renal function, and when referred to our unit her serum urea was 440 mg/100 ml and her serum creatinine 16.8 mg/100 ml. The patient was treated with haemodialysis, but to date her renal function has not returned to normal (serum creatinine 9.8 mg/100 ml), though her pulmonary oedema rapidly resolved. She is being managed at present without maintenance haemodialysis. Renal biopsy showed periglomerular fibrosis, interstitial medullary fibrosis with round cell infiltration, and patchy flattening of the tubular epithelium consistent with acute tubular necrosis and chronic interstitial nephritis secondary to analgesic abuse.

As we were unable to demonstrate any other precipitating cause for her acute tubular necrosis and acute renal failure, we were left to conclude that the deterioration was caused by beta-blockade and its subsequent effects. The initial chronic renal failure was consistent with analgesic nephropathy.

We would not agree that beta-blocking drugs should not be used in severe renal failure but would rather state that their effects should be closely monitored and

dosages adjusted accordingly. We have found beta-blocking drugs extremely useful in gaining effective control of hypertension in patients with moderate to severe renal failure without previously seeing this reaction.—We are, etc.,

A. SNELL
M. WALLACE

Renal Unit, Waikato Hospital,
Hamilton, New Zealand

Who is the Dental Anaesthetist of the Future?

SIR,—Dr. D. Hogg (18 May, p. 386) implies that there is an inexhaustible supply of medical anaesthetists. In the best of all possible worlds every general anaesthetic would be administered by a consultant anaesthetist. Regrettably we live in a world in which demand almost invariably exceeds the resources available to meet it. This is certainly so in the field of general anaesthesia.

Since it is inevitable that in the foreseeable future a large number of anaesthetics will be administered by dental practitioners, surely Dr. Hogg will agree that they should be adequately trained.—I am, etc.,

J. F. REEVES

Leicester

Beclomethasone Aerosol in Treatment of Non-specific Pulmonary Fibrosis

SIR,—A fat and apparently fit woman of 65 was found on routine chest x-ray to have multiple patches of evenly distributed, diffuse opacity in both lung fields. On direct questioning she admitted to breathlessness and some loss of weight over the previous six months. A diagnosis of interstitial non-specific pulmonary fibrosis was eventually confirmed at the Broomfield Chest Hospital after lung biopsy. By the time that the diagnosis was established she had become frankly dyspnoeic, and treatment was begun with 30 mg of oral prednisolone daily.

She began to feel better, but some 10 weeks later she was gaining excessive weight. There were purple striae and bruising on her arms and legs, florid facies and other signs characteristic of the Cushingoid state. Lung stiffness was still such that it would not have been advisable to reduce her steroid dosage, but a trained member of my ancillary nursing staff suggested at a practice discussion that beclomethasone dipropionate aerosol might conceivably be used instead.

Knowing more about the pathology, we were dubious. We felt that the aerosol would either be deposited on the alveolar epithelium or that, if some was absorbed, it would probably be carried into the blood stream. There was nothing to be lost in the attempt, however, and the patient was given a metered inhaler and instructed to continue with the oral prednisolone at the original rate for a further week while taking three puffs of the aerosol four times each day.

A week later she stated that she was feeling less breathless and her oral prednisolone was therefore reduced. Improvement has continued and we have been able to reduce oral prednisolone to 2.5 mg daily while the aerosol is now being taken at the rate of two puffs four times a day. The patient has now lost her Cushingoid appearance.

It is therefore clear that local diffusion occurs from the alveoli not only slightly into the blood stream but also, at a therapeutic level, into the interstitial fibrous tissue. This is an effective means of reversing fibrous degeneration. On reviewing sections of lung it does seem that a rather greater surface of interstitial tissue is in contact with the alveolar linings than with the capillary beds.

I should be interested to hear if any of your other readers have had similar experience of treating interstitial pulmonary fibrosis by means of metered beclomethasone dipropionate aerosol.—I am, etc.,

J. P. T. LINKLATER

Fingringhoe, Essex

Endocrine Disorders in the Elderly

SIR,—Dr. M. F. Green's statement (9 February, p. 232) that in treating elderly patients with thyrotoxicosis antithyroid drugs can be discontinued "when the disease remits, which is usually between one and two years after the onset" might be taken to imply that eventual remission is invariable. It would be more appropriate to say "if the disease remits," for, while it is well recognized that about 50% of patients with Graves's disease go into remission, as might be expected with what is probably an autoimmune disease, we know of no evidence that this ever occurs in toxic autonomous goitre ("toxic nodular goitre").

It is our experience¹ that with advancing age autonomous goitre becomes an increasingly common cause of hyperthyroidism and Graves's disease relatively less common. The actual proportion of elderly patients who are thyrotoxic because of autonomous goitre rather than Graves's disease may vary from area to area depending on factors such as iodine nutrition and pre-existing goitre. It is apparent, however, that the likelihood of remission after antithyroid drugs in the elderly is probably substantially less than 50%.—We are, etc.,

J. C. STEWART
G. J. VIDOR

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¹ Vidor, G. I., et al., *Journal of Clinical Endocrinology and Metabolism*, 1973, 37, 901.

Foreign Doctors in London

SIR,—It is with regret that I read (*Supplement*, 1 June, p. 83) the statement reported to have been made by Drs. D. R. Cook and A. Elliott at the meeting of the General Medical Services Committee on 16 May.

It may appear regrettable to them that central London is getting depleted of British doctors because of the high cost of housing. But Dr. Cook's inference that foreign doctors who are coming in are able to do so only because they are used to a lower standard of housing appears unwarranted.

One can have views about foreigners but to express such views publicly at such a meeting might offend a large number of their colleagues throughout the country and is both divisive and a disservice to the profession. We expect moral leadership.—I am, etc.,

S. K. ROY

Dagenham, Essex