Details of Patients and their Treatment

Patients No.	Age	Sex	B.P. (mm Hg)	Previous Treatment of Hypertension	Dose of Prazosin	Side Effects
1	79	F	200/120 L&S	No Treatment	2 mg (only 1 dose taken)	Collapsed 45 min after first dose, B.P. 80/mm Hg. Severe peripheral vasodilatation with cherry-red skin. Given I.V. Hydrocortisone and oxygen, recovered over 1 hour. No evidence of myocardial infarction.
2	77	M	220/120 L&S	No Treatment	2 mg (only 1 dose taken)	30 min after first tablet, could not stand up without feeling faint. No evidence of myocardial infarction. No further Prazosin given.
3	65	F	210/115 L 180/110 S	Methyldopa	Increasing dose regime—0.5 mg a.m., 1 mg midday, 2 mg evening, then 2 mg t.d.s.	30 min after first 2 mg dose had severe palpitations, which recurred with each subsequent dose. Also lack of energy, headaches and muzziness. After 5 days no change in B.P., tachycardia 124/min regular. Prazosin stopped—all symptoms rapidly disappeared.
4	51	M	180/120 L&S	No Treatment	2 mg t.d.s.	Rapid onset of lassitude, weakness, and diarrhoea. Became bed-ridden. Persisted for nine days until Prazosin discontinued. No recurrence since then.
5	43	F	180/120 L&S	No Treatment	2 mg t.d.s.	2 months after starting B.P. 180/115 mm Hg. lying and standing—dose increased to 5 mg t.d.s.—became sleepy, unable to drive, had palpitations. Dose decreased to 2.5 mg t.d.s. and Nephrol one daily added—still feels tired on this dose.
6	57	F	190/120 L&S	Methyldopa Bethandine Propranolol	2 mg t.d.s. (added to Propranolol 40 mg q.d.s.)	Within few hours of starting drug experienced light-headedness, feelings of unreality and dizziness. She stopped of her own accord. B.P. now controlled with clonidine alone.
7	48	M	190/110 L&S	Methyldopa	2 mg (only 2 doses taken 2 weeks apart).	30 min after first tablet—palpitations, pulse 180/per min. 2 weeks later took 1 more tablet—tachycardia 150/per min B. P. 60/0 mm Hg. Controlled now on clonidine.

L = lying blood pressure. S = standing blood pressure.

dangerous—particularly in elderly patients who may have coexisting cerebral arteriosclerosis. In some patients successive doses of the drug produce the same side effects as the initial dose and tolerance does not develop.

We conclude that the recommended starting dose of 2 mg is too high and that further investigations are needed to establish a safe starting dose and to discover which patients are most likely to suffer side effects.

¹ Prazosin—Evaluation of a New Anti-hypertensive Agent, Proceedings of a symposium held at the Interprofessional Centre, Geneva, 8 March 1974. Amsterdam, Excerpta Medica, 1974.

² Prazosin and Loss of Consciousness—Adverse Reaction, Series No. 12. London, Committee on Safety of Medicines, 1975.

Department of Geriatric Medicine, St. Mary's Hospital, Colchester, Essex

M. J. BENDALL, M.B., M.R.C.P., Consultant Physician

K. H. BALOCH, M.B., B.S., Clinical Assistant

P. R. WILSON, B.M., M.R.C.P., Consultant Physician

Unusual Foreign Body in the Ear

The wearing of a sprung wire collar or "choker" with hooked ends acting as a fastener (see fig.) has become fashionable in adolescents. Three patients have been seen with a hooked end caught in the ear. The three chokers were machine-cut and the ends were sharp with protruding slivers of metal, which increased the liability of the hook to penetrate the meatal skin. The danger could be greatly reduced if these ends were smooth and, preferably, bulbous.

Case Reports

Case 1.—This patient, aged 15, while putting on his choker accidentally let it slip into his left external auditory canal. He failed to remove it because of pain and bleeding. The choker was hanging from his left ear, and after microsuction the end was seen penetrating the skin of the superficial meatus, preventing withdrawal. It was pushed further into the canal and withdrawn by pressing it firmly against the opposite canal wall to prevent reimpaction. The meatal wall was excoriated but the tympanic membrane was intact and the hearing normal.

Case 2.—A 15-year-old boy was on an aircraft when his choker slipped and one end sprang into his right ear. Attempted removal caused pain and bleeding but he stopped trying only when a severe persistent pain developed in the ear. Four hours later he reached a local casualty department, where an x-ray picture showed that the choker was deep in the external canal at the level of the tympanic membrane. Pressure on this had probably caused the persistent pain. The hook was impacted under the skin and was removed under general anaesthesia. The canal was badly excoriated but the tympanic membrane was intact and the hearing normal.

A metal "choker" with hooked ends for fastening.

Case 3.—This patient, a girl aged 12, got the hook of the choker stuck in her external auditory canal when pretending it was a stethoscope. It could not be removed because of pain. Her ear was full of blood and she would not tolerate microsuction. An x-ray picture showed the position of the hook, which was then removed by manipulation. The canal skin was lacerated but hearing and the tympanic membrane were normal.

Conclusion

These patients suffered extreme discomfort due to the presence of the choker in the external auditory canal. Fortunately none incurred damage to the tympanic membrane or ossicles, though these structures are at risk with any foreign body in the ear.

I thank Mr. D. Kilby for permission to report details of his patients.

University Department of Otolaryngology, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP

N. S. LONGRIDGE, F.R.C.S., M.R.C.P., Registrar