which a loud bruit became audible. Her recovery was complete. The case was reported in greater detail by Enoch and Williams.¹

C E C WELLS

University Hospital of Wales,
Cardiff

¹ Enoch, B A, and Williams, D M, *Postgraduate Medical Journal*, 1968, **44**, 923.

I can see no alternative to the drug and fluid schedule being prescribed on the fluid balance chart and also recorded on a special sheet of the prescription document. If you had said that the fluid balance chart, being a transitory document, should not be the sole record of drugs and fluids given, I would agree.

P J HORSEY

Southampton General Hospital,
Southampton

Additives to intravenous fluids

SIR,—I should be grateful for the opportunity to clarify a potentially confusing recommendation in the report of the DHSS Working Party on the Addition of Drugs to Intravenous Infusion Fluids¹ and one that has been compounded in your leading article on the subject (31 July, p 264). In both the report and your article fusidic acid is said to be too toxic or irritant to be given by intermittent infusion and should therefore be given by continuous intravenous infusion.

In our experience² and that of others³⁻⁵ it is neither desirable nor necessary that the infusion be continuous throughout the period of treatment. The data sheet dosage recommendation for fusidic acid (diethanolamine fusidate)⁶ states that the powder should be dissolved in the buffer provided, diluted to 250-500 ml with the infusion fluid, and infused slowly over a period of not less than two to four hours. This dosage can be given three to four times daily. The intention of this recommendation is that the drug should be administered intermittently over a 24-hour period, albeit in three or four slow infusions. Provided these instructions are followed and the infusion is made into a wide-bore vein the incidence of local irritant effects on the vein is small.

The method of administering intravenous diethanolamine fusidate clearly falls into an area midway between the categories devised by the working party. It is a pity that the working party did not follow the precedent of the editors of the *Prescribers' Journal* and *Drug and Therapeutics Bulletin* in asking for the views of the manufacturers concerned before publishing their report.

B T MARSH
Medical Director,
Leo Laboratories Ltd

Hayes, Middx

¹ DHSS, *Addition of Drugs to Intravenous Fluids*, Health Circular HC (76) 9, London, DHSS, 1976.

² Munday, A P, and Marsh, B T, *Current Medical Research and Opinion*, 1976, **4**, 132.

³ Copperman, I J, *British Journal of Clinical Practice*, 1972, **26**, 83.

⁴ O'Garra, J A, *Lancet*, 1968, **2**, 1037.

⁵ Liddy, N, *Lancet*, 1973, **1**, 621.

⁶ *ABPI Data Sheet Compendium*. London, ABPI, 1976.

SIR,—Your leading article (31 July, p 264) supports the DHSS working party's view that the use of the fluid balance chart for prescribing and recording intravenous therapy is no longer acceptable. I strongly disagree with this, as the fluid balance chart should never leave the bed (or trolley) of the patient as long as IV fluids are given. If a separate prescription sheet is used and drugs have to be entered on it, there will inevitably be times in most hospitals when the sheet is not only not on the bedhead but not in the ward.

Anginal pain in a phantom limb

SIR,—The patient whom Dr C V Deenadayalan records (24 July, p 238) with anginal pain in a phantom left arm recalls two similarly afflicted patients, reported 33 years ago by the late Dr Wallace Jones and myself,¹ in whom anaesthetisation of the brachial plexus to the phantom caused in one patient abolition of the phantom component of the cardiac pain and in the other delay in its appearance and a reversal of its site of onset and spread.

These and other observations led to a hypothesis on the mechanism of visceral pain which I postulated in 1944 in my Lettsomian lectures.² I have seen four additional cases of cardiac pain in a phantom left upper limb in which my earlier observations were repeated, with identical findings.

COHEN OF BIRKENHEAD

Liverpool

¹ Cohen, H, and Jones, W. H., *British Heart Journal*, 1943, **5**, 67.

² Cohen, H, *Transactions of the Medical Society of London*, 1944, **64**, 65.

Toxicity of paracetamol in children

SIR,—Paracetamol (acetaminophen) is no exception to the wide variety of household products and drugs that find their way into the stomachs of young children. In 1975 138 (18%) of the 775 calls about the treatment of paracetamol poisoning received at the London Centre of the National Poisons Information Service concerned children. Follow-up of these cases has failed to reveal any significant toxicity, and this experience is shared by others interested in this subject.¹

This finding is not unexpected, as paracetamol has a wide toxic to therapeutic ratio, and in general the amounts taken were small. Children would appear to find the large tablets of paracetamol difficult to swallow, and the quantities of paracetamol contained in the proprietary paediatric elixirs are too small to cause liver damage. The case reported by Dr S P Glascoe (24 July, p 235) is typical in that despite the child having consumed a "full bottle" the plasma paracetamol levels were well below those associated with liver damage.²

Since paracetamol poisoning in children is usually mild, our experience with antidotes such as cysteamine³ or methionine³ is limited. There is no reason to suppose that the toxic effects of cysteamine seen in adults would not occur in children, and therefore we would recommend its use only in the rare situation where plasma levels indicated risk of liver damage. In cases where the history suggests that significant amounts of paracetamol have

been ingested and a plasma paracetamol estimation is not available we would recommend that oral methionine be used. This treatment is free from significant side effects. For a child of 3 years a suitable dose would be 1 g every four hours for four doses. It should be used only if the first dose can be given within ten hours of ingestion.

Further information may be obtained from us by telephoning the Poisons Unit (24 hour service) on 01-407 7600.

P CROME
J A VALE
G N VOLANS
B WIDDOP

National Poisons
Information Service,
New Cross Hospital
Poisons Unit,
Avonley Road, London SE14 5ER

¹ Symposium on Paracetamol and the Liver, *Journal of International Medical Research*, **4**, Supplement 4, 31.
² Prescott, L F, et al, *Lancet*, 1976, **1**, 109.
³ Crome, P, et al, *Journal of International Medical Research*, **4**, Supplement 4, 105.

Suicide with tricyclic antidepressants

SIR,—Lest Dr C L Brewer's arguments (10 July, p 110) concerning suicide with antidepressants cause the prescribing of the latter to be curbed, may I enter into their defence? It has been shown beyond doubt by controlled trials that the tricyclic antidepressants are effective. It is also one of the greatest causes of pleasure in the clinic setting to experience them acting effectively: to hear a patient after 10 days or two weeks describing a definite lessening of symptoms; and after a further three weeks of a full course of treatment to hear that patient often describe a complete return to his or her normal state.

Many suicides occur in depressed patients. In fact the commonest factor associated with suicide is depressive illness. The two most effective forms of treatment for depressive illness are ECT and tricyclic antidepressants. If in some cases and for good reasons the latter are preferred to ECT, then of course there is a risk of suicide during treatment. The very nature of the condition in which the tablets are being used makes this inevitable.

Dr Brewer's point concerning the apparent small effect on the prevalence rate is misleading. If the tablets are known to be effective, then the static prevalence rate means not that the tablets are ineffective but that without them the prevalence rate would almost certainly be higher.

M G REVILL

Claybury Hospital,
Woodford Green

The geriatric ward and the patient

SIR,—I am disappointed that Dr Kathleen Hurly's impression (7 August, p 371) is that most elderly patients find geriatric wards "grim and dreadful." This might have been true many years ago, but the British Geriatrics Society and the DHSS have been increasingly concerned regarding the type of care provided in the geriatric wards. In fact, many geriatric units up and down the country are already providing a high standard of care, and after adequate treatment (including rehabilitation)