

lapping of sigmoid and other bowel loops often made interpretation difficult. This patient was remarkable for the relatively small size of his colon.

Dr Calder indicates that the rural Kenyan is less likely to undergo barium enema investigation. One need not conclude that the elderly countryfolk suffer from undiagnosed diverticular disease. It may be that the urban Kenyan's diet and way of life are more Western than is apparent, and that the diverticular disease observed is consequential on a changed life-style.

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Amyl nitrite as a sexual stimulant

SIR,—I was interested in your expert's reply to the question about amyl nitrite as a sexual stimulant (14 July, p 117). As a venereologist practising in London from 1969 to 1975 I saw many male homosexuals who admitted to the use of amyl nitrite ("poppers") in sex play. It tended to be used by the more sophisticated members of that group, especially those into the "leather scene." Some stated that orgasm was not so good if amyl nitrite was not used. It was also inhaled by the recipient in the practice of inserting the clenched fist into the recipient's rectum (fist fucking)—presumably the sphincter relaxing at the time of inhalation.

Several pharmacies in London sold amyl nitrite vitellae BPC freely to members of the public without prescription at the time. I understand that since about 1976 this has no longer been allowed. Certainly, practising in Yorkshire one hears very little of this use of a volatile nitrite being used as a social drug. However, as Cohen mentioned,¹ the practice of some "adult bookshops" aimed at homosexuals in the London area persists, where "street" varieties of amyl nitrite are sold very profitably to clients.

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¹ Cohen, S, *Journal of the American Medical Association*, 1979, 242, 2077.

Tuberculosis

SIR,—I read Dr Neville Oswald's article on tuberculosis ("In My Own Time," 21 July, p 188) with much nostalgia.

Although never attaining his eminence or indeed ever being on the staff of the Brompton I did also work with all forms of tuberculosis in outlying sanatoria and clinics for 30 years from 1930 onwards. How well one recalls the struggle of those early days—the persuading of patients to accept months of complete bed rest, including the children with bone and joint disease, who had to bear with various forms of plaster or, even worse, the total immobility of being strapped to a Robert Jones frame. Despite this came the problem of infected sinuses, followed all too often by the invariably fatal amyloid disease. Then back to the pulmonary cases with the induction of artificial pneumothorax or pneumoperitoneum and the difficulties of torn adhesions, plural effusions, and empyemas. I well remember, as does Dr Oswald, the large refill clinics with the weekly or fortnightly x-ray screening of patients before the refill.

How much radiation, I wonder, did those patients (and ourselves) absorb?

And so on to 1950 and the excitement of the arrival of streptomycin, to be allayed all too soon by the bitter disappointment of finding that by itself it rapidly produced bacillary resistance—this excitement to be renewed about a year later by the discovery of two further drugs, para-aminosalicylic acid, and isoniazid and the almost miraculous coincidence of the fact that when given separately resistance occurred, but when given together or with streptomycin this did not occur. And so the happy 10 years from 1950 onwards when we learnt how to use these new drugs and so cure many early cases or to render many of the older, chronic cases fit for curative surgery—for example, limited thoracoplasty or localised excisions which had not previously been possible.

It is surely not too much to call this the conquest of tuberculosis and it is surprising that the public at large and even the profession itself does not seem to have realised the vast importance of the change that occurred—I feel privileged to have been able to play even a small part in it.

Finally, the one important lesson to come from this story, which was never more true than in the management of tuberculosis, is that in medicine one is never simply treating a disease—one is treating a person suffering from that disease and this is by no means the same thing.

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The "Radcliffe" hospitals, Oxford

SIR,—Mr Malcolm H Gough is to be congratulated for his historical review of the Radcliffe Hospitals (7 July, p 33). His assertion that few would leave the old Radcliffe Infirmary without a sense of regret is not echoed by myself and other junior doctors, who leave with an immense sense of relief. It is sad that such a famous institution should have become the most inefficient and uncaring, with appalling facilities for staff and patients, severely deficient pathological services, and understaffing of the telephone exchange (GPs regularly took over an hour to get the switchboard to answer). Staff accommodation, which in my case probably contravened both public health and fire regulations at the old hospital, is excellent in the new one, and urgent blood tests are possible too.

It is most heartening to hear a senior consultant such as Mr Gough concerned about the absence of a residents' mess in the new John Radcliffe Hospital. Although it is easy to blame the incompetence and ignorance of administrators (which are rife), doctors themselves must take their share of responsibility for the decline in standards to a disgraceful level at old hospitals, such as the Radcliffe Infirmary, and the inadequate provision in new ones. It is a question not just of financial resources but of priorities, which all grades of medical staff must reiterate incessantly to preserve the standards of patient care and staff provision which are essential. Every hospital doctor in this country should read Jurg Schifferli's Personal View (16 June, p 1623), in which he comments about the strike of porters and catering staff: "What amazes me is how people react. They think it is a pity but no one protests, no one ex-

postulates or demonstrates his or her annoyance."

Sir James Cameron was reported (30 June, p 1803) as saying that the BMA's reputation "rested largely on the respect built up in the public's mind by the thousands of doctors who quietly practised their profession irrespective of the problems of the day." Sir, there comes a point when to practise quietly serves the interests of patients and profession less than to protest loudly. Some of us consider that that point has been passed, and deplore the apathy and disinterest which our colleagues show in the working of our health services.

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Motor neurone disease associated with bronchial carcinoma?

SIR,—In their case report of a syndrome indistinguishable from motor neurone disease (21 July, p 176) Drs D M Mitchell and S A Olczak base much of their case on the pattern of electrophysiological abnormality. However, this was far from typical of motor neurone disease.

Firstly, motor conduction velocity was normal in their case but it is usually possible to demonstrate a differential slowing of motor as opposed to sensory conduction. Secondly, in motor neurone disease it is usual to find fasciculation potentials and discrete motor unit activity on voluntary contraction. Thirdly, although prolonged polyphasic potentials can be an indication of reinnervation,¹ polyphasic potentials are more common in myopathies. In motor neurone disease giant motor units of 10-15 mV can occur. None were seen in the case reported.

One must consider their case as not proved on electromyographic grounds. They may have witnessed the reversal of another carcinomatous neuromyopathy.

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¹ Buchthal, F, *Acta Neurologica Scandinavica*, 1970, 43, suppl p 129.

SIR,—The association of motor neurone disease with carcinoma remains the subject of considerable controversy. The short report by Drs D M Mitchell and S A Olczak (21 July, p 176), suggesting a causal relationship between carcinoma of the bronchus and a neurological syndrome indistinguishable from motor neurone disease in one of their patients, prompts us to raise some of the problems of making such an association and to describe one of our own cases in which, we believe, that association exists.

The first difficulty is to verify the diagnosis of motor neurone disease. The clinical picture should be complemented by neurophysiological and neuropathological evidence to make the diagnosis as certain as possible. Thus a picture of progressive onset of combined upper and lower motor neurone weakness without sensory loss should be confirmed by the following objective findings. (1) An electromyographical demonstration of lower motor neurone denervation, the surviving motor units being of long duration and very large in amplitude. "Malignant fasciculation" may be

present. There should be some evidence of upper motor neurone damage such as large amplitude stable "F-responses," or the presence of "H-reflexes" in muscle groups where these are not usually seen. (2) Normal sensory action potentials. (3) Muscle biopsy demonstrating the features of denervation. (4) Biopsy of a sensory nerve (for example, sural nerve) which shows no abnormalities. (5) Normal biochemical and haematological findings—for example, normal B_{12} , folate, and creatinine phosphokinase values.

The second difficulty, as Mitchell and Olczak point out, is to show a definite association between treatment of the carcinoma and improvement in the neurological illness. In only three other cases in the literature was such improvement demonstrated.¹⁻³

Our patient is a 64-year-old man (we and V Gallai described this case to the May 1979 meeting of the Italian Society of Neuropathology). He presented in October 1978 with a history of cough, dyspnoea, and progressive shoulder girdle weakness. He was found to have weakness, wasting, fasciculation, and pathologically brisk reflexes in the upper limbs, with weakness and brisk reflexes in the lower limbs. Electromyographic studies of the affected muscles demonstrated lower motor neurone denervation, the surviving motor units being of long duration with amplitudes up to 8000 μ V. There were unusually prominent F-responses in the hand muscles and an H-reflex was recorded in (R) abductor hallucis. Both the sensory nerve fibre action potentials and the motor conduction velocities were normal. Biopsy of an affected muscle (right deltoid) showed only the changes of denervation. Biopsy of the right sural nerve gave normal results. Chest x-ray showed a mass in the lingula of the left lung, which on biopsy proved to be a squamous cell carcinoma of the bronchus. Subsequent treatment of the carcinoma with radiotherapy resulted in simultaneous shrinkage of the tumour and improvement in the neurological illness—an improvement which has so far been maintained.

The association of motor neurone disease with carcinoma is an important one to make, but we feel that the documentation must be very careful in order to exclude other conditions such as polymyositis, peripheral neuropathy, and myelopathy, which are already well documented as occasional complications of carcinoma.⁴

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¹ Lord Brain, Croft, P B, and Wilkinson, M, *Brain*, 1965, **88**, 479.

² Stephens, T W, Rousgas, A, and Ghose, M K, *British Journal of Diseases of the Chest*, 1966, **60**, 107.

³ Croft, P B, and Wilkinson, M, *Brain*, 1969, **92**, 1.

⁴ Anderson, G, *Paramalignant Syndromes in Lung Cancer*. London, Heinemann Medical Books, 1973.

Psychiatric symptoms and hallucinogenic compounds

SIR,—I would like to reply to matters raised by Dr P Petch (9 June, p 1568) and Dr D Jacobs (7 July, p 49) following my report on persistent psychiatric symptoms after eating psilocybin mushrooms (19 May, p 1319).

Only a dozen or so of the numerous species of fungi native to the British Isles are hallucinogenic. The commonest of these are *Psilocybe semilanceata* and *Amanita muscaria*.¹ Hallucinogenic fungi can be divided into two groups according to the psychoactive drugs present in them. Fungi in the first group contain psilocin and psilocybin. Examples

include *Psilocybe semilanceata*, *P montana*, and *P coprophila*. Three other genera are included in this group—namely, *Panaeolus*, *Stropharia*, and *Hyphaloma (cyanescens)*.

The distinguishing characteristics of *P semilanceata* are its cap, which has a diameter of between about 5 and 25 mm and is one and a half times as tall. It is of conical or hemispherical shape and it has a prominent nipple, and the margin of the cap is curved inwards. The stem is 2.5 mm thick, up to 76 mm tall, and cream coloured, paler than the cap. The edges of the gills are white, and are attached in an adnate-to-adnexed fashion with little spacing between them.

P semilanceata contains from 0.1 to 0.4% psilocybin by weight of the dried mushroom.¹ Hence 30-40 g of fresh or 5 g of dried mushroom contain from 3 to 12 mg of psilocybin. The dose of psilocybin required to produce hallucinations in humans is from 3 to 6 mg or 0.1 mg per kg body weight. In practical terms this is achieved by eating about 30 small mushrooms. I am satisfied that my patient described to me the features of *P semilanceata*, and that he ate a sufficient quantity to suffer ill effects. The effect of the mushroom is augmented by drinking alcohol. An electroencephalogram was done on this patient, but it proved to be normal. I am unable to add any comments to the hypothesis of Dr D Jacobs (7 July, p 49) that these symptoms represent temporal lobe dysrhythmic abnormality.

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¹ Cooper, R, *A Guide to British Psilocybin Mushrooms*, ed C Render, 2nd edn. London, Hassle Free Press, 1978.

Tuberculous paraplegia

SIR,—The old adage quoted in your leading article on tuberculous paraplegia (2 June, p 1442) might be rewritten to read "The treatment of tuberculosis changes with time and place." Certainly the treatment of Pott's paraplegia is changing now as many surgeons become disenchanted with the difficulties, complications, results, and expense of radical surgical procedures. Our experience is no exception.¹

Between 1965 and 1975, in the orthopaedic centre at Tunis, we treated 63 patients with Pott's paraplegia, 37 by bed rest and chemotherapy (streptomycin for three months, isoniazid and ethionamide or rifampicin or aminosalicylic acid for 18 months) and 26 by anterior decompression as well, the selection of treatment being arbitrary. We drew the following conclusions. The more proximal the vertebrae affected and the more marked the kyphosis, the greater was the incidence of paraplegia. Chemotherapy alone was more effective than combined medical and surgical treatment. Sixty-eight per cent of the medical group had complete neurological recovery but only 35% of the surgical group. Medical treatment was safer than surgery, having a mortality rate of 6% compared to 23%.

Even when paraplegia was complete, or had been present for more than a year before starting treatment, recovery was still possible. Complete neurological recovery was unlikely, however, if the patient had total paraplegia and anaesthesia with urinary retention. Patients in either group who had no neuro-

logical improvement within six months of the beginning of treatment were unlikely to recover.

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¹ Sliman, N, *et al*, Les Paraplégies Pottiques. Congrès France-Italien des Groupes d'Étude de la Scoliose. Rome, 1977.

Indications for Keflex

SIR,—Once more out of my *BMJ* fell an advertising slip asking the question "How can you free the family from throat infections?" The answer to this apparently is supposed to be with Keflex, 500 mg twice daily. The text inside indicates that this is an inexpensive routine treatment for acute throat infections, by which it means streptococcal pharyngitis.

Treatment with penicillin is considerably cheaper and surely at least as effective. The only reason for not using penicillin for the treatment of streptococcal pharyngitis would be if the patient were known to be allergic to penicillin; and in this situation the cephalosporins would also be contraindicated because of the possible cross-sensitivity, and erythromycin would be the better choice. I think that the *BMJ* should not allow the inclusion of this advertising handout.

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* * * We sent a copy of this letter to the manufacturers, whose reply is printed below.—Ed, *BMJ*.

SIR,—Thank you for the opportunity to comment on the letter from Dr K A Harden, who raises some important and interesting issues.

I do not accept that cephalosporins are contraindicated in patients who are allergic to penicillin. Probably no more than 10% of patients who are allergic to penicillin will be allergic to cephalosporins, and this may make them a very suitable choice in this particular group. With the much better blood levels achieved they are probably a better choice than erythromycin.

One of the main areas for concern in therapeutics is that of compliance, and it is likely that patients will be more compliant if they have fewer daily doses to remember. It could well be that Keflex would be particularly suitable if this were a major concern in an individual situation, as it can be used in a twice-daily dosage for throat infections.

Finally, on the question of cost, it is true that Keflex is considerably more expensive than the cheapest generic penicillin. However, most physicians prefer the medicines they prescribe to come from companies who have a consistent record of high quality products. In this situation Keflex is not a particularly expensive product.

BRIAN GENNERY

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Gutter treatment for ingrowing toenails

SIR,—The authors of the article "Gutter treatment for ingrowing toenails" (21 July, p 168) are to be congratulated in achieving a 56% cure rate with a non-surgical method of