of oncoming traffic, worry about smells, the compulsion to make sexual innuendos, and the awkward behaviour of the very guilty, pointing to this boy's having been assaulted sexually by an older person probably in authority. Subtle examination—and I have examined children and delinquents since 1941—revealed that no actual assault had taken place, only what this deep-feeling child had interpreted as an assault. He had been submitted, along with his classmates, to a course of instruction from his well-intentioned headmaster on body mechanics, including copulation, "fully illustrated in colour."

This child has always been quick to see the reality behind the symbol and the meaning underlying everything. So now, alerted to the magnitude of the sex act, he found, as it were, that he was armed with a seemingly automatic weapon the control of which was beyond him but for which he would be held responsible. Intercourse with his one permanent and reliable authority (his mother; he has no father) he found impossible, for that act and word had now a sexual connotation. And he found himself party to a sexual experience that was illicit because it was without the knowledge and sanction of his authority. He had therefore three reasons for developing this anxiety state.

This child's very ill condition was recognized and duly treated because of his social connexion with me, a child psychiatrist. Other children's psychiatric states can be passed off as "a phase" which will heal sooner or later with defect, leaving a lasting personal scar. I therefore feel bound to call the attention of my colleagues, especially those concerned with mental health and the health of schoolchildren, to this fresh cause of psychiatric states in the young, the giving of "sex education" (the internal details of the male and female animal, the mechanisms of mating, foetal development, and delivery) to persons in a defenceless position in a class situation before they are sufficiently mature to face these stark, staring realities.—I am, etc.,

LOUISE F. W. EICKHOFF,

Selly Oak Hospital,
Birmingham.

Occupation, Chemicals, and Cancer

SIR,—In a leading article commenting on an excellent article by Dr. Georgiana Bonser (10 June, pp. 649 and 655) you attribute to me a statement which I never made and do not support. You state that I "advocated that evidence of carcinogenic hazard should be clear-cut, and a solution should be available before pressure is put on manufacturers to reduce the exposure of their employees." What in fact I did say was, "Until the data are clear-cut and a solution has been found—i.e., either control of the material or its elimination—*publicity* through newspapers, congressional committees, or other types of *non-scientific* releases can hope to accomplish no useful objective." (My italics.)

Where an adequate occupational health team exists, and this includes both a knowledgeable physician and industrial hygienist, measures can be taken to minimize or eliminate exposures even before a situation is fully understood. In fact in my experience an outmoded plant was once dismantled by a

company even before the cause of an occupational cancer was fully understood—obviously eliminating exposure. This was on the recommendation of such an occupational health team. Where such a team does not exist within an industry it can be made available to the industry through Government or consultants. Obviously if an industry, through financial greed, fear of litigation, inertia, or plain laziness, fails to obtain or heed the advice of such consultants, or the Government, additional pressures may have to be brought to bear upon the management, but this can be done through established mechanisms, not through publicity.

Even Dr. Bonser quotes Leitch¹ as follows: "The solution of the problem [of dyeworkers' bladder cancer] would be welcome, for until the particular noxious substance or group of substances is known no real measures can be taken to prevent dyeworkers' cancer." Such a solution is arrived at through careful, quiet, competent research, such as has been described by Dr. Bonser, not through raucous publicity in non-scientific channels. I personally have found industrial management easy to convince once the facts are known, but extremely difficult to convince when the facts are unclear or unknown. I personally do not consider this a shortcoming.—I am, etc.,

Linden,
New Jersey, U.S.A.

R. E. ECKARDT.

REFERENCE

- ¹ Leitch, A., A.R. *Brit. Emp. Cancer Campgn*, 1929, 6, 32.

Second British Academic Conference in Otolaryngology

SIR,—May I be permitted, please, to correct the misunderstanding likely to have arisen from what you printed of your special correspondent's account of the Second British Academic Conference in Otolaryngology under the heading Otolaryngology Conference (26 August, p. 555)? It is true that two half-days of this important four-day meeting were given over to the Sections of Laryngology and Otology of the Royal Society of Medicine for their combined summer meeting and that the presidents of these sections, Mr. T. G. Wilson and Mr. Maxwell Ellis respectively, took the chair at the plenary sessions on the Friday and Thursday mornings, but I cannot believe that Mr. Wilson would wish to pose as "the president of the meeting," which was in fact presided over with characteristic proficiency by the Master, Sir Terence Cawthorne.

I am aware also that your special correspondent was asked to report particularly on the symposia entitled Facial Paralysis, the Catarrhal Child, and the Present Position of Chemotherapy in Head and Neck Cancer. Nevertheless, anyone not there would never guess from the report that these were only three of the forty topics that constituted this part of the scientific programme. There were also an almost continuous display of scientific films, a large area given over to exhibitions, and a very full and varied social programme. The editor of the *Journal of Laryngology and Otology* has generously agreed to make available one-half of the November issue of the journal for an account of this landmark in the history of British

otology, and those of your readers who wish to obtain a correct impression of what took place in Oxford from 30 July to 4 August may care to look out for it.—I am, etc.,

L. F. W. SALMON,
Hon. General Secretary,
The Second British Academic Conference
in Otolaryngology.

Guy's Hospital,
London S.E.1.

Delayed Death in Imipramine Poisoning

SIR,—Dr. C. M. Steel and his colleagues (9 September, p. 663) in their article on imipramine and amitriptyline poisoning in children refer to two noteworthy cases where sudden collapse and death occurred after periods of progressive clinical improvement. The following case, where death occurred after apparent recovery from an overdose of imipramine, may be of interest.

A woman aged 49 was admitted to hospital on 17 March 1967 at 12.10 p.m. She had been taking imipramine intermittently for recurrent depression, and had apparently taken an overdose the night before—two empty bottles were found near the bed after the husband had been unable to rouse her. On admission she was deeply unconscious and unresponsive to painful stimuli. The stomach was washed out and 10 mg. of bemegride given intravenously. During the first hour after admission to the ward the patient had two major epileptic fits, and the level of unconsciousness became deeper. Temperature, pulse, respiratory rate, and blood pressure were within normal limits at this time. Frusemide 40 mg. was given intravenously and 500 ml. of mannitol was transfused during the next two hours. This was followed by 1,000 ml. of normal saline. The patient had five more epileptic fits in the next six hours, and at 8.30 p.m. she started to recover consciousness. At 9.30 p.m. she was reported to be very restless and trying to get out of bed. The intravenous drip was kept running and a further 1,000 ml. of normal saline was transfused.

Throughout the next 96 hours she remained fully conscious, but was confused, restless, and uncooperative most of the time. There were, however, brief periods when the patient was quiet, co-operative, and completely rational. Paraldehyde and chlorpromazine hydrochloride by intramuscular injection seemed to be producing adequate sedation, but on 21 March she became increasingly confused, agitated, and unmanageable. Her speech showed flight of ideas and her mood was somewhat elated, the picture being typical of a state of mania. At 9 p.m. she became semicomatose and her axillary temperature went up to 105° F. At 11 p.m. the level of consciousness deteriorated, the temperature remained elevated, and generalized muscular twitchings were observed. Three hours later the patient had a sudden cardiac arrest.

On post-mortem examination the leptomeninges on the cerebral surfaces were intensely congested and contained haemorrhages. There were numerous petechial haemorrhages on the subpleural surfaces of both lungs, with massive haemorrhages on the subpleural surfaces of the left lower lobe and right middle lobe. On section both lungs showed typical acute bronchopneumonia. The heart was congested, with haemorrhages in the muscle substance and in the visceral and parietal pericardium. The stomach mucosa was congested and contained semi-solid yellowish material but no evidence of tablets or capsules. The pancreas, spleen, and adrenal glands were congested. The kidneys were red and intensely haemorrhagic, and the bladder showed acute cystitis. Imipramine was detected in the following quantities—stomach contents 3.0 mg./100 ml., liver 4.7 mg./100 g., kidneys 2.8 mg./100 g., and blood a trace.

Previously an uninterrupted recovery could confidently have been expected in this type of poisoning once the patient had regained consciousness. This case would suggest that relapse and sudden death may occur in poisoning by tricyclic antidepressant compounds after apparent recovery. The forced diuresis may have kept the patient alive initially and there could be an argument for continuing this treatment in order to wash out the possible second wave of metabolites, which would otherwise contribute to an unexpected relapse.

I should like to thank H.M. Coroner and Dr. A. A. Miller for permission to describe the post-mortem findings, and Dr. C. Maxwell, of Geigy Pharmaceutical Limited, for helpful advice.

—I am, etc.,

Whittingham Hospital,
Preston, Lancs.

A. B. MASTERS.

Oculogyric Crises after Phenothiazines

SIR,—In view of the reports of bizarre neurological disturbances following treatment with perphenazine (Fentazin) from Drs. D. A. Heath and J. M. McGarry (11 February, p. 363) and Dr. J. R. Harries (22 July, p. 241) we should like to summarize briefly our experience with eight similar cases which have been seen in the last year. The patients have mainly been young adults, their ages ranging from 14 to 50 years with an average of 23 years. In four cases reactions have followed a single 5-mg. intramuscular injection given as premedication or postoperatively for vomiting. Symptoms have begun abruptly from 18 to 36 hours after the onset of treatment, and in none of our patients has this type of reaction been seen as a complication of long-term therapy.

Spasms of the head and neck occurred, most commonly with twitching, neck retraction, risus sardonicus, and oculogyric crises. These spasms were associated with curious subjective feelings of stiffness and immobility of the tongue with difficulties in chewing and swallowing, which occasionally preceded the more dramatic spasms by a few hours. Opisthotonos, flexion, and extension spasms of the limbs with a *main d'accoucheur* deformity were seen in the more severely affected. All patients remained completely alert mentally but were unable to modify their movements in any way. The attacks subsided spontaneously or in a few hours, with or without mild sedation. We have not used benzotropine (Cogentin), which Ayd¹ has found to give rapid relief.

We feel that, although these neurological complications are not uncommon, they are as yet poorly recognized, and our cases have presented with a wide range of provisional diagnoses, including tetanus, tetany, epilepsy, and hysteria. Our experience confirms the finding of Kinross-Wright² that young people are unduly susceptible to these dystonic and dyskinetic reactions and we would advise caution in the use of this drug parenterally in this age group.—We are, etc.,

E. C. B. KEAT.

Royal Sussex County Hospital,
Brighton, Sussex.

P. J. TOGHILL.

King's College Hospital,
London S.E.5.

REFERENCES

- 1 Ayd, F. J., jun., *J. Amer. med. Ass.*, 1961, **175**, 1054.
- 2 Kinross-Wright, V. J., *S. Afr. med. J.*, 1957, **31**, 1167.

Case of Diarrhoea and Goitre

SIR,—I was fascinated by the report in the Clinicopathological Conference of the above case (29 July, p. 293), but, as a surgeon, I would like to have seen some remark to the effect that the patient had been offered an operation to remove the thyroid nodule discovered in 1960.

I have recently seen a young woman with a small lump in the neck which I thought might be a carotid body tumour. Three years before she was told by two practitioners in England that the lump was nothing to worry about. I referred her to South Africa, where the lump was found to be a metastasis from a thyroid carcinoma. At subsequent hemithyroidectomy and block dissection involved nodes were found to extend into the superior mediastinum.

We are used to rural Africans refusing operations until their tumours become inoperable, but it is alarming to find doctors not pressing for the histological diagnosis of "innocent" lumps which their patients bring to their notice.—I am, etc.,

Princess Marina Hospital,
Gaborone,
Botswana, Africa.

IAN KENNEDY.

Mercury Perchloride in Surgery

SIR,—In a letter (9 September, p. 679) Mr. H. B. Devlin discussed the use of 1:500 mercuric perchloride solution in large-bowel surgery. He concluded that it was a safe anticancer agent when used as described by Goligher *et al.*¹ There have been no reported cases of mercury poisoning following the use of this solution in this manner. Keynes² has suggested that the solution may be too toxic to leave in the peritoneal cavity to prevent intraperitoneal seedlings of tumour, although he used a 1:500 solution for this purpose on one occasion without ill effect. We wish to report the following case to emphasize that mercuric perchloride is too dangerous to use in the peritoneal cavity.

A woman of 68 years with no pre-existing evidence of renal disease underwent an ovarian cystectomy on 2 May 1967 for what was subsequently shown to be a mucous cystadenoma. During the course of the operation, which was otherwise uneventful, the peritoneal cavity was irrigated with 250 ml. of a 1:500 solution of mercuric perchloride. It was not known whether the peritoneal cavity was mopped dry prior to closure. Immediately postoperatively the patient became severely oliguric, and was transferred to the Hammersmith Hospital on 8 May for treatment of an acute renal failure. On admission peritoneal dialysis was commenced, but, as this was unsatisfactory, a Scribner A-V fistula was inserted into the right forearm to facilitate haemodialysis with a Kolff twin-coil artificial kidney machine.

Ureteric obstruction was excluded by cystoscopy and bilateral retrograde pyelography. Intermittent haemodialysis was necessary on 19 occasions during the next two and a half months. After the first month her urine output gradually increased, and since her discharge on a 20-g. protein diet with moderate fluid restriction the blood urea has remained at 90 mg./100 ml. Her daily urine volume is approximately 800 ml., containing 6.5 g. of urea. On this regimen she is now leading an active life at home.

A specimen of urine taken one month after exposure to mercuric perchloride revealed a mercury content of 150 µg./litre. This figure is much lower than that sometimes observed in chronic mercurial poisoning, but it is

known that there is no correlation between the urine mercury level and the degree of renal damage sustained. Indeed, the urine mercury concentration falls with the onset of renal tubular damage.

In view of our experience with this case, we advise that mercuric perchloride should not be used as an irrigating agent in the peritoneal cavity.

We are grateful to Mr. H. T. Delves, A.R.I.C., Institute of Child Health, London, for performing the urine assay for mercury.

—We are, etc.,

J. C. GINGELL.
JOHN CLEGG.
M. WALLACE.

Hammersmith Hospital and
Royal Postgraduate Medical School,
London W.12.

REFERENCES

- 1 Goligher, J. C., Dukes, C. B., and Bussey, H. J. R., *Brit. J. Surg.*, 1951, **39**, 199.
- 2 Keynes, W. M., *Ann. Surg.*, 1961, **153**, 357.

Diagnostic Paracentesis

SIR,—I have been glad to note the growing interest in diagnostic abdominal paracentesis as evidenced by the articles of Morris¹ and Baker *et al.*² I now use it routinely in all abdominal diagnostic problems, including the patient with ascites of uncertain aetiology.³ A film, cell count, and protein estimation are all simple procedures for a small laboratory and allow treatment or prognosis on a sure basis.

I am surprised that only "80% positive paracentesis can be expected in intraperitoneal haemorrhage." I have found that a No. 1 needle on a 10-ml. or 20-ml. glass syringe, usually only into either lower quadrant, is quite adequate if the patient has been made to lie on the appropriate side, either before or after insertion of the needle. The needle is withdrawn slowly, the plunger under tension. It is often only as it seems the tap has been negative one obtained a small amount of fluid coming from a thin film on the peritoneum.

A negative paracentesis thus performed is now accepted as a contraindication to surgery for suspected ectopic pregnancy, especially when there is an associated sudden fall in Hb level. Two recent cases in this hospital were explored in spite of negative taps. They were found to be normal intrauterine pregnancies but associated with acute haemolytic crisis.—I am, etc.,

Wesley Guild Hospital,
Ilesha, Nigeria.

REFERENCES

- 1 Morris, P. J., *Brit. J. Surg.*, 1966, **53**, 707.
- 2 Baker, W. N. W., Mackie, D. B., and Newcombe, J. F., *Brit. med. J.*, 1967, **3**, 146.
- 3 Nwokolo, C., *ibid.*, 1967, **1**, 33.

Headlight Glare

SIR,—Dazzling headlight glare we know is the cause of some of our road accidents at night. Dipped headlights are not 100% effective even if properly adjusted. The following solution is therefore offered for your consideration and comment.

Let us suppose that it was made compulsory to polarize headlights at 45° from the vertical, then if windscreens or sun visors or goggles or glasses were similarly polarized to 45° in the same plane one would not interfere with one's own headlight field, but light from