

Drowning

SIR,—Surgeon Rear-Admiral Stanley Miles (7 September, p. 597) suggests that "the term drowning should be used to denote the process resulting from submersion in water in which there is loss of consciousness and threat to life." Within the common use of "drowning" and the above definition of the term there is an elision—immersion hypothermia.

Keatinge¹ showed in the *Lakonia* disaster that "hypothermia led to the deaths of most, perhaps as many as 113 out of 124 who died." He has also stated that "approximately 1,000 people die from immersion in British coastal and inland waters every year. These deaths are usually ascribed to drowning, but probably include a high proportion of deaths from hypothermia."

The corollaries of the use of "drowning" to include immersion hypothermia are that (1) the prevention of drowning as now taught and practised has to do only with keeping afloat. Much more needs to be said about the need to keep warm in the water, as outlined by Keatinge.¹ And (2) the first-aid treatment of "drowning" may have to be directed towards rapid rewarming as well as towards the establishment of respiration and circulation.

There may also be a need to distinguish clearly—perhaps by suitable neologisms—between the two types of "drowning"—one related to water in the lungs and not breathing, the other to hypothermia—so that existing confusion may be removed. The restriction of "drowning" for the first and the use of "immersion chilling" for the second may be advisable.—I am, etc.,

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REFERENCES

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SIR,—In the article on drowning by Surgeon Rear-Admiral Stanley Miles (7 September, p. 597) reference was made to the importance of positive pressure oxygen ventilation during resuscitation.

Studies performed on anaesthetized sheep by Colebatch and Halmagyi¹ referred to the gross fall in lung compliance following the introduction of fresh or salt water into the lungs. Their findings showed that fluid aspiration produced a reflex response of the parasympathetic nervous system producing closure of lung units. Where inflation of the lungs was ineffective or led to deterioration both atropine and isoprenaline helped to reverse the effects of fresh and salt water, particularly when isoprenaline followed atropine. It would be interesting to know what sort of response these compounds produce in cases of human drowning.—I am, etc.,

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REFERENCE

- Colebatch, H. J. H., and Halmagyi, D. F. J., *J. Appl. Physiol.*, 1962, 17, 787.

"Five-day Courses" and Respiratory Infections

SIR,—Dr. A. F. Foster-Carter's comments on the prescribing of antibiotics for respiratory infections are timely (7 September, p. 614), and we, as authors of the literature which he mentions, would be the last to disagree with his view that antibiotics should not be prescribed in too limited courses or at inadequate dosage levels.

The literature concerned was, however, not designed "to reinforce the widespread and dangerous misconception that antibiotics should be prescribed in limited courses." Our intention was to announce the availability of 100-ml. bottles of our antibiotic syrups in addition to the long-established 60-ml. packs (which is surely a step in the direction advocated by Dr. Foster-Carter). Research into general-practitioner prescribing revealed that the use of 100 ml. antibiotic syrup unit was becoming more frequent, and we and other manufacturers introduced a 100-ml. pack at the same time conforming with the stipulations on metric packaging of the 1968 *British Pharmacopoeia*.

In principle, the pharmaceutical industry tries to correlate packs, where practicable, with the most frequently prescribed quantity of an individual drug. When a new drug is introduced the manufacturer's duty is to recommend the dosage regimen and treatment duration found successful in clinical trials. Our recommendations must perforce be general; the clinician's judgement is individual, and it is always for him to decide when it is appropriate to discontinue therapy.—I am, etc.,

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Brachial Neuralgia and the Carpal Tunnel Syndrome

SIR,—May I comment upon the conclusion reached by Mr. B. Crymble (24 August, p. 470) that some cases of pain in the whole arm, including those in which the pain is maximal in the cervical and shoulder-girdle regions, are due to carpal tunnel syndromes?

In my experience, it is very rare for a patient with a "pure" carpal tunnel syndrome to present with predominantly shoulder or neck pain, particularly if the pain is accompanied by paraesthesia extending above the wrist level. It is probable that both proximal nerve-root and median nerve compression contribute to the pain in most of these cases. Symptoms may be relieved by resolution of either proximal or distal component, or else both components must be treated for complete relief. In the former case it may be that the pressure resulting from each component is additive, each by itself not being sufficient to produce symptoms. Whereas symptoms due to "proximal pressure" are often self-limiting, as has been shown to be in the case of cervical spondylosis,¹ or may be relieved by simple physical treatment (such as neck traction in certain cervical lesion or shoulder-raising exercises in the thoracic outlet syndrome), median nerve compression may require treatment individually by conservative

or surgical means. Pain in the shoulder as a result of the carpal tunnel syndrome alone occurs only in a minority of cases where there is very severe median nerve compression, and where the motor conduction time from wrist to thenar eminence is in the order of 7 msec. or more. In such cases surgical carpal tunnel decompression is nearly always required.²

It would seem that the best practical procedure in brachial neuralgia is to ascertain clinically the levels of compression, and where a "proximal pressure component" is suspected to deal with this initially. Tests of median nerve conduction are carried out then if the symptoms do not resolve, and the carpal tunnels decompressed if indicated.—I am, etc.,

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REFERENCES

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- Goodwill, C. J., *Ann. Phys. Med.*, 1965, 8, 12.

Hyperpyrexia during Anaesthesia

SIR,—The preliminary communication by Dr. G. G. Harrison and others (7 September, p. 594) is of great interest to anaesthetists, who cannot fail to be concerned at the prospect of explosive hyperthermia occurring in a patient having a minor operation.

Halothane, more than any other anaesthetic drug, is widely recognized to be associated with shivering in the postoperative period. The remarkable experiments of Feldberg and Myers^{1,2} may provide the clue to the metabolic storm. If halothane affects the release of amines in the hypothalamus in such a way as to increase the amount of 5-hydroxytryptamine relative to adrenaline and noradrenaline, shivering and a rise in body temperature would be the expected result. Sudden hyperthermia is a rare but well recognized danger to patients taking monoamine oxidase inhibitor drugs, and in them the concentration of 5-hydroxytryptamine in the brain stem rises to about twice its normal value.³

The condition appears to be becoming commoner, and it is conceivable that some apparently innocuous chemical in the food may predispose patients to this catastrophe.—I am, etc.,

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- Feldberg, W., *Proc. roy. soc. Med.*, 1965, 58, 395.
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Phenmetrazine Psychosis

SIR,—The letter of Drs. E. Negulici and D. Christodorescu (3 August, p. 316) sums up well the dangers of chronic phenmetrazine use. In their case report they describe the patient becoming "anxious, restless [and] hallucinated" after "3–4 days." This they