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

- ¹ Keatinge, W. R., *Brit. med. J.*, 1965, 2, 1537.
- ² Keatinge, W. R., *Trans. Soc. Occup. Med.*, 1968, 18, 73.
- ³ Keatinge, W. R., *Brit. med. J.*, 1966, 1, 423.

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

- ¹ 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.,

G. J. WILKINS,

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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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Harlow, Essex.

REFERENCES

- ¹ B.A.P.M. Multicentre Trial, *Brit. med. J.*, 1966, 1, 253.
- ² 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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REFERENCES

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- ² Feldberg, W., *Proc. roy. soc. Med.*, 1965, 58, 395.
- ³ Maclean, R., Nicholson, W. J., Pare, C. M. B., and Stacey, R. S., *Lancet*, 1965, 2, 205.

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

attribute to an "abstinence syndrome." In all of the literature which I have been able to survey, and in personal clinical experience, hallucinations have not been seen as a symptom of psychostimulant withdrawal. The most generally described symptoms are lethargy, depression, and suicide attempt. I would suspect that these symptoms in the case presented represent the psychologic response of a schizophrenic woman to the withdrawal of a drug on which she is psychically dependent, or a psychic response to hospitalization.

Studies have demonstrated the considerable correspondence between very large doses of stimulants over a period of a few days and the development of a paranoid psychosis.¹ The aetiology of a psychosis which has existed for one and a half years at first observation, developing four and a half years after beginning to take excessive quantities of phenmetrazine, is problematic. This is so especially when that dosage, while excessive, is less than that which may be necessary to cause the acute, drug-induced psychosis. If we may roughly equate 25 mg. phenmetrazine with 5 mg. dexamphetamine, then their patient took the equivalent of 30–40 mg. dexamphetamine, daily. This is, in my experience, insufficient to cause an acute drug (or sleep deprivation) psychosis. That chronic, moderately high doses of amphetamines can cause a psychosis independent of personality variables has been suggested,² but not established.—I am, etc.,

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REFERENCES

- ¹ Griffith, J., *Amer. J. Psychiat.*, 1966, **123**, 560.
- ² Lemere, F., *Amer. J. Psychiat.*, 1966, **123**, 569.

Subdural Haematoma and Effusion in Infancy

SIR,—Mr. Murray A. Falconer (7 September, p. 614) is indeed correct when he writes that the treatment of subdural haematoma and effusion is *sub judice*. I believe it will remain so for a long time. He states that the groups which I described, treated by one of the two distinct methods, do not allow "valid statistical comparisons." A re-reading of my paper will show that I did not attempt such comparisons, and was well aware of the pitfalls. I stated that treatment by subdural-pleural shunt "may be superior to craniotomy," and that in the group treated by this method the follow-up period was shorter so that "assessment of impaired intelligence is more difficult and less accurate."

My statement that operation for insertion of a subdural-pleural shunt is simpler and less traumatic than craniotomy is correct. Such features are of importance in the surgery of infancy.

Dr. J. G. Henderson's remarks and questions are very pertinent (14 September, p. 678). My short paper (17 August, p. 400) attempted to deal only with the presentation of the disease and two methods of treatment. It will be recognized by all who have had dealings with these infants that surgical treatment is often only an early incident in

the long and difficult management of a family situation. I deliberately avoided such complex matters in my article, but of course cannot do so in clinical practice.

The psychosocial history about which Dr. Henderson inquires became available in most of my cases. One important discovery was that no less than 14% of the infants came from foster homes. In six cases the parents were eventually taken to court accused of injuring the child. In 27 other cases I considered there was reason to suspect that injury had been inflicted intentionally. I much regret the way in which the phrase "battered baby" is so frequently used without definition. I am reasonably sure that some of the babies in my series were injured intentionally by adults on one occasion only and never again. It is unwise and harmful, in my opinion, to call this a "battered baby syndrome"; to do so may induce an attitude in the doctors, nurses, children's officer etc., which impedes our ability to help the parents and the child. I do not think that we have, in Britain, sufficient data to allow profitable discussion in medical journals. Rather should we organize group surveys and studies of the family situations in which these babies are found. Minimum requirements at present include a radiological survey of the whole skeleton and discussions with parents, medical social workers, and local medical officers of health. The possibility that retinal or subhyaloid haemorrhage may be due to injury elsewhere in the body, referred to by Dr. Henderson, is important, but should not be allowed to reduce our vigilance in seeking a cause within the skull.

In the follow-up period only a small proportion of children appear to have been injured again. Such findings will depend upon our care in looking for evidence of injury and (more importantly) upon the measures taken to help the family in avoiding a repetition of the original abuse. To protect the child from further injury (which is sometimes fatal) and yet to avoid removing him unnecessarily from the parents is a difficult task of those who are increasingly concerned with these matters.—I am, etc.,

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Spout Cervical Oesophagostomy

SIR,—I was horrified to read the letter by Mr. L. F. Tinkler (17 August, p. 433) on the use of spout cervical oesophagostomy in terminal malignant obstruction of the oesophagus. The author says "one of the distressing terminal features . . . is the patient's inability to swallow his saliva."

Surely the author does not seriously suggest that this method is preferable to the many other well-tried and acceptable procedures, ranging from Souttar's tubes, the various makes of plastic tubes, and the Mousseau-Barbin tube, to palliative bypass procedures using tubes of stomach or other bowel, all of which have as their objective the ability of the patient to swallow his own saliva as well as food and drink. As to collecting his discharges and homogenizing them for gastrostomy feeding, the mind boggles. These poor unfortunate people occasionally have a year or two or even longer left of life, but in the majority of cases it is only a matter of months.

In my opinion gastrostomy is never indicated as a palliative treatment (although a case can occasionally be made out for a temporary one in conjunction with other surgery). No doubt other more informed thoracic surgeons than myself will reply to this letter, but I must enter a protest against this operation and suggest that there can be no possible indication for its use.—I am, etc.,

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Queensland, Australia.

Orf in Man

SIR,—The last sentence in your leading article (17 August, p. 392) on orf conveyed the impression that orf in man is a rare disease. Orf, or ovine contagious pustular dermatitis, has been known and recognized as a clinical entity for a long time. It occurs in most of the sheep-rearing countries of the world, and the curious name has regional variants. The Australians call it "scabby mouth," and the hill farmers of West Wales call it simply "crach." Its seasonal incidence is fairly constant, and it seems to occur mainly in the spring and early summer. Older lambs and young sheep are most commonly affected. Loss of condition and development of the lambs is said to be due to the orf infection itself, but feeding difficulties often arise from the lesions in the mouths of the lambs and on the teats of the ewes. A mild case with multiple small vesicles and little crust formation can easily be missed in a flock.

In man there are some interesting clinical features. Human orf is recognized more frequently and its significance better understood by shepherds and veterinary surgeons than by doctors. It tends to affect children rather than adults, the farmer's wife perhaps more often than the farmer, and the veterinary student almost as often as the veterinary practitioner. There is seldom any constitutional disturbance with orf in man. This can, however, occur, and in one case biopsy of a lesion appeared to precipitate a viraemia with a generalized maculopapular rash. The bacteriological service in the area has found virological studies of crusts disappointing. Fortunately, clinical diagnoses are usually straightforward, particularly with a history of animal contact. Nevertheless, a physician colleague was once confronted with a case of human orf during a smallpox epidemic. This case was fully investigated virologically before being accepted as orf.

The Figure shows a lesion on the vulva of a child aged 9 which was diagnosed clinically as orf. I was asked to see the patient in May this year. The child's mother had assigned the lesion to the child's habit of riding bareback on her favourite pony. There was orf in the sheep on the farm, and outbreaks had recurred over recent years. The child also fed and played with a pet lamb which had mild orf infection. The vulval lesion presented a typical clinical appearance of human orf. The whole area was reddened and there were nummular lesions on each labia majus, all with raised margins and most with purulent semi-necrotic centres. There were seven in all. There was no bacteriological evidence of secondary infection. The