for any published account of these misfortunes, which are presumably theoretical.

I have used the gingival sulcus route of administration of oxytocin with complete success, and, may I dare to suggest, much greater comfort, satisfaction, and safety to the patients.¹ Ritchie and Brudenell have also published papers describing the satisfactory use of oxytocin administered by absorption through the buccal mucous membrane.^{2,3}

It would be interesting to know why absorption of a drug through the buccal mucosa is more dangerous than giving the same drug intravenously.—I am, etc.,

Croydon,
Surrey.

T. G. E. WHITE.

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Porton Jet Injector

SIR,—We were somewhat perturbed by the implication of Dr. W. G. White (23 August, p. 472). From the earliest design and development work done at Porton it was never intended that the instrument should be used for intramuscular injection, and we have always stressed the difficulties and, indeed, the undesirability of attempting to give intramuscular injections with this type of instrument.

There are many obvious reasons for this, which I do not wish to expand upon in a short letter, but for the present I wish to stress my opinion that neither this nor any similar instrument that I have handled can be relied upon to deliver an accurate or accurately emplaced dose below the deep fascia.—I am, etc.,

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Thrombocytopenia with Multiple Autoantibodies

SIR,—The cyclical aspect of the thrombocytopenia in the interesting case described by Dr. O. Brey and his colleagues (16 August, p. 397) need not be stressed. The patient had established and dangerous platelet deficiency; the physiological variation in the low platelet count was not important.

I have recently investigated two similar patients, both of whom were cured by splenectomy. One patient relapsed after four years, however, and despite continuous steroid cover she died 18 months later of uncontrolled intestinal bleeding. Not unexpectedly, splenuli were found post mortem. The patient of Dr. Brey and his colleagues had a high serum globulin and the added interest of hyperthyroidism. The overaction of the thyroid appeared to be only temporary. Was the goitre perhaps painful at first and the lesion therefore de Quervain's thyroiditis? My colleagues and I have submitted for publication elsewhere an example of this syndrome associated with sarcoidosis. Did their patient have evidence of sarcoid changes?

The discovery of mitochondrial antibodies may be particularly relevant. Primary biliary

cirrhosis is possibly chronic sarcoidosis. Reversion of the Kveim test by time is usual. Thus the autoimmunity is a result and not the cause of the disease. Differences in severity of the primary inflammation rather than differential absorption of antibodies, I suspect, accounts for the inconstant immune titres.—I am, etc.,

G. A. MACGREGOR.

Chilworth, Surrey.

Do Cervical Smears Save Lives?

SIR,—Your leading article (7 June, p. 585) stated that the answer to the question why 10 years' mass population screening programme for cervical cancer in British Columbia has not significantly reduced mortality from the disease is simply because the deaths were mostly occurring in the 25% of the population that did not come forward for routine cytological screening. This explanation is overoptimistic if not misleading.

The initial experience of cytological cancer screening in Singapore and Malaysia has shown a disappointingly low pick-up rate of 2-4 early cervical cancers out of 1,000 gynaecological and obstetrical patients screened. This despite the fact that cancer of the uterine cervix is the commonest malignant tumour among women here.

The incidence of cervical cancer among Singapore women is one of the highest in the world, computed at 52.5 per 100,000 women aged 35-64 years.¹ Ashley² put forward the idea that there may be two types of cervical cancer, and supported this with epidemiological data on carcinoma-in-situ and invasive carcinoma of the cervix from the United States and the United Kingdom. One, the slowly progressive carcinoma-in-situ or early invasive carcinoma among women in the fourth decade of life is usually detected by vaginal cytology and amenable to treatment with good prognosis. The other, the more rapidly growing invasive carcinoma among women in the fifth decade of life, is diagnosed in the late stages of the disease, is difficult to treat, and has a poor prognosis. This proposition may well prove to be true.

Thus cervical smears should continue to be used, but we should realize the limitation so far as saving lives is concerned.—I am, etc.,

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Kuala Lumpur,
Malaysia.

LAWRENCE CHAN.

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Nalorphine in Opiate Poisoning

SIR,—In the treatment of opiate drug poisoning the total dose of nalorphine is stated to be 60 mg./hr.¹ or 40 mg.² The reason advanced for this restriction in dosage is that nalorphine itself may cause respiratory depression.³ We believe, however, that the total dose and rate at which nalorphine is given should be dictated not by arbitrary figures of total dosage over standard intervals of time but rather by the condition of the patient. The following report illustrates this point.

A 40-year-old woman was admitted to the Regional Poisoning Treatment Centre with a history of having taken 20 tablets of Diconal (that is, 200 mg. of dipipanone, equivalent to 100 mg. of morphine), together with 10 Mandrax tablets (methaqualone and diphenhydramine), five hours before admission. She was deeply unconscious; unresponsive to any painful stimulus; shocked and apnoeic; her pupils were fixed and dilated. Endotracheal intubation and hand ventilation served to correct the anoxia, and the pupils became pinpoint in size. There was no improvement in her level of consciousness or shock despite correction of her anoxia. Nalorphine 20 mg. was given intravenously, and her spontaneous minute volume improved from apnoea to 4½ litres. Over the next hour her minute volume could only be satisfactorily maintained by an infusion of nalorphine, and a total dose of 105 mg. was given intravenously in that period. The pupils became normal in size and her level of consciousness improved so that she responded to minimal painful stimulus. Full reversal of her conscious level was, no doubt, prevented by the Mandrax. (Serum methaqualone 1.5 mg./100 ml.) A total dose of 170 mg. nalorphine was given over a period of four hours, 105 mg. of which was given during the first hour. This succeeded in reversing the dipipanone-induced respiratory depression without itself producing any respiratory complications.

It may be concluded that in gross opiate overdosage it may be both safe and therapeutically necessary to give nalorphine in incremented doses in excess of that previously considered safe. The indication for further medication should be the clinical state of the patient. Care should be taken on the one hand not to undertreat, with resulting continuing respiratory depression, and, on the other, not to overtreat, with resulting nalorphine-induced respiratory depression.—We are, etc.,

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Psychosis and Antithyroid Drug Therapy

SIR,—We were interested to read the report by Drs. C. F. Herridge and I. Abey-Wickrama (19 July, p. 154) of acute psychosis in a patient treated with antithyroid drugs. Our recent experience with a similar patient provides an interesting comparison, since it suggests that the psychotic illness is not necessarily related to the onset of hypothyroidism.

A 27-year-old married woman was admitted to a general medical ward with suspected thyrotoxicosis. The diagnosis was confirmed by radioiodine tracer studies and a serum protein bound iodine (P.B.I.) level of 15.6 µg./100 ml. There was no personal or family history of psychiatric illness. Treatment was started with carbimazole 60 mg. daily in divided doses, and at the time of discharge three weeks later she was still clinically hyperthyroid; the serum P.B.I. was 6.1 µg./100 ml. She was advised to continue carbimazole 60 mg. daily for a further