I have already drawn attention¹ to the importance of careful monitoring of the patient while he is given propranolol in treatment of digoxin intoxication; I crave the courtesy of your column to repeat this warning. Propranolol for this purpose must always be given under conditions of continuous observation, with atropine either available or given concurrently.

The second statement to which I must take exception lies in the section on β -adrenergic blocking drugs, where the author states categorically that propranolol does not restore sinus rhythm in atrial flutter. In 1967² I reported the successful restoration of sinus rhythm in three patients treated with digoxin and propranolol, and to date I have been able to trace reports of 12 successes out of 20 patients treated in this way. This combination of drugs may well be a satisfactory form of therapy for atrial flutter where D.C. conversion is unsuitable.—I am, etc.,

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Peritoneal Dialysis and Lysol Poisoning

SIR,—A 62-year-old woman was admitted to the Poisoning Treatment Centre, Royal Infirmary, Edinburgh, two hours after ingesting about 150 ml. of Lysol solution (cresol 50% in soap). She had collapsed immediately after ingesting the poison but had not vomited. She was drowsy and confused on admission, but was not shocked. Stomach wash-out produced a return smelling strongly of carbolic and containing flakes of gastric mucosa, but no frank blood.

On admission, serum "total phenols"¹ was 950 μ g./100 ml. with arterial pH 7.33, standard bicarbonate 15.5 mEq/l., and serum potassium 2.9 mEq/l. (Patient had been on long-term diuretics.) Peritoneal dialysis was set up five hours after admission and continued for 23 hours, with 17 exchanges of a standard solution containing no potassium. Serum potassium rose to 4.1 mEq/l. after eight exchanges, and remained in the range 2.7–3.5 mEq/l. thereafter. The dialysate contained a small quantity of free phenol initially (10 mg. in the first exchange), but only "total phenols" were detectable, in insignificant amounts, subsequently. In contrast, 820 ml. of urine was passed while dialysis was in progress, and this contained about 26 times (1,589 mg.) the total dialysis yield of free phenol. The urine continued to contain appreciable amounts of metabolites for a further 72 hours. The patient was given 500 ml. of 5% sodium bicarbonate solution initially, and was also treated with standard doses of hydrocortisone and ampicillin intramuscularly for the first five days. She required potassium supplements for four days after dialysis.

In the presence of adequate renal function, peritoneal dialysis appears to be of no benefit in removing phenol from the body. It is estimated that some 130 mEq K^+ were removed in the course of dialysis, which may then have been incidentally beneficial in preventing a precipitate rise in serum potassium,

possibly an important factor in the early deaths which occur in Lysol poisoning.

This patient recovered slowly and uneventfully, but a serum "total phenols" of 1 mg./100 ml. or more would seem to be of serious prognostic significance.—I am, etc.,

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REFERENCE

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Analgesic Neuropathy

SIR,—“There is nothing like eating hay when you are faint,” the king said to Alice. “I did not say there was nothing better, I just said there is nothing like it.” Perhaps, too, there is nothing like phenacetin, but the paper of Dr. David Bell and others (16 August, p. 378) adds confusion to an already confused picture. The cases reported had all taken multiple drugs, and following admission and diagnosis received general supportive therapy and specific treatment of hypertension, acidosis, etc., as well as withdrawal of analgesics. It would be difficult to attribute their recovery, therefore, to any one of these measures.

The consensus of world opinion would accept that analgesic nephropathy is a real and life-threatening condition, but to ascribe the renal lesion to a particular drug, however, is not only premature but could lull physicians and the public into a false sense of security with regard to the components of commonly prescribed analgesic mixtures.

The Royal Australasian College of Physicians¹ plans to issue a warning against the prolonged use of analgesic mixtures containing aspirin, phenacetin, and codeine, and this action would be in line with most of the evidence presently available.

Dr. Bell quotes Prescott,² and suggests that cases of papillary necrosis associated with aspirin “are rare.” Certainly they are, but reports of abuse of phenacetin alone are rarer still, and I have been able to find only two cases in the world literature.³ We are dealing here with the abuse of a commonly prescribed and freely available analgesic mixture on the one hand and a not uncommon disease which may pass undiagnosed in its earlier stages on the other; this is then a difficult area of research. A critical appraisal of reports referring to “phenacetin nephritis” has led many working in the field to look more closely at the other constituents of analgesics taken in quantity, and recent animal work⁴ has thrown further doubt on the exclusive role of phenacetin. Until the controversy is settled, therefore, the more embracing term “analgesic nephritis” rather than the restrictive concept “phenacetin nephritis” is preferable—I am, etc.,

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Malmström's Vacuum Extractor

SIR,—I have been greatly interested in the modification of the Malmström vacuum extractor described by Dr. G. C. Bird (30 August, p. 526), and I consider that this modification has some advantages over the original Malmström instruments both of 1957 and 1967.

I believe, however, that oblique traction should rarely be applied, and that even Bird's instrument will produce the same forces tending to promote detachment as are shown in his Fig. 1, though in the absence of leverage from a central tube the forces will certainly be less. The preparation of the instrument for application, which will not involve threading of a chain through the tube to the traction handle as in the Malmström instruments, will, however, certainly be an advance and should obviate occasional difficulties met with particularly by the occasional users of the instrument. I have not found the central position of the tube in the original instrument to present any difficulty in insertion and application of the cup, and if episiotomy is carried out there is no difficulty in placing this as far back on the vertex as is required.

I shall look forward, however, to an opportunity of using this modification of the instrument, although I shall still hope to use perpendicular traction only.—I am, etc.,

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Sickness Certification

SIR,—Dr. G. F. Petty (30 August, p. 535) refers to motion 157 at the conference of L.M.C.s. This condemns the present need for general practitioners to issue National Health Insurance certificates. Dr. Petty's letter does not give any argument or evidence against this resolution.

He writes “not all are agreed. . . .” We are unlikely to reach such agreement on anything, but this must not prevent progress. He then goes on to say that it is the doctor's job to advise the patient in relation to his capacity to work. This is surely one thing we might all agree on, but it is quite irrelevant to the issuing of National Insurance certificates. He continues, “It is our moral duty to supply certificates. . . .” Those who feel it their “moral duty” will be free to do so, but why must those of us who feel quite differently be compelled to do so, as we are at present by our terms of service? It is not clear here whether he is referring to National Insurance certificates, which are specified in resolution 157, but the rest of his letter clearly refers to industrial certificates and so has no relevance to the conference resolution.

If industry finds such certificates valuable they should be prepared to pay the economic price and not ride on the back of the N.H.S. I believe they will soon discover their lack of value and give them up.

As general practitioners our job is to advise our patients, but they must be free to accept or ignore our advice. I am not sure whether Dr. Petty agrees with this.—I am, etc.,

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Newport, Mon.