risk of cardiac arrest. There is an added advantage since cement extruding through these holes acts as a key preventing rotational strains from loosening the cement in the shaft.

I had hoped to study the long-term results by x-ray films using radio-opaque cement but, unfortunately, there was some reluctance to use this substance in case of toxic effects.—I am, etc.,

ERIC S. GLEN.

Victoria Infirmary,
Glasgow.

SIR,—I was interested to read the medical memorandum on two cases of cardiac arrest associated with bone cement, by Dr. J. N. Powell and others (8 August, p. 326). They state that "A fall in blood pressure in association with the use of bone cement is known to occur, but is rare in the elective operation of total hip replacement, where patients are often younger and fitter." In view of this comment I have reviewed the blood pressure charts of 50 patients undergoing the operation of total hip replacement in this unit and the findings may be of interest.

The majority of patients were aged between 60 and 70 years (22 cases) but there were 13 patients aged between 70 and 80, two aged over 80, nine aged between 50 and 60, and one patient of 46. Of the charts inspected 26 showed no obvious blood pressure response to insertion of the cement. In 15 cases a definite transient fall occurred, varying from 10 to 30 mm. Hg, but the remaining nine cases are of particular interest.

In these cases the insertion of the cement into the femoral component was followed after approximately one minute by a precipitous fall in blood pressure to 70 mm. Hg. In all cases recovery was rapid, unassisted by transfusion or vasopressors, and normal levels of blood pressure were regained in five to six minutes. The patients' ages ranged from 59 to 84 years and there was no obvious correlation between age, preoperative condition, or steroid therapy of those who showed this response, and in all cases there had been adequate replacement of weighed blood loss. The fall and recovery of blood pressure in these cases was so rapid that the original method of recording blood pressure every five minutes missed this fall, and in all cases blood pressure is now measured at minute intervals immediately following insertion of the cement before introduction of the prosthesis.

In vitro experiments reconstituting the C. M. W. Laboratories' cement at room temperature of 23.3° C. have shown that the maximum temperature of the cement occurs some six minutes after mixing the monomer and the powder—a temperature as high as 96° C. was recorded. While the cause of this extreme fall in blood pressure in some patients remains obscure it is of interest that the timing of the fall corresponds with the gaining of a very high temperature by the inserted cement, and the recovery of blood pressure with the commencement of the slowing of the chemical process.—I am, etc.,

PHILLIDA M. FROST.

Orthopaedic Unit,
Abergele Hospital,
Denbigh.

Epilepsy and Driving

SIR,—The new regulations relating to the eligibility of certain epileptics to drive would appear to be far from clear (15 August, p. 407). No guidance is given in the regulations as to whether the control of fits should be with or without anticonvulsants. If applicants have their episodes controlled by such medication, how does one overcome the current restriction relating to driving under the influence of drugs, especially as anticonvulsants are soporific in their action?

I should be interested to know what "evidence" the authorities expect to receive in order to confirm that three-year requirement? For almost 20 years I have been actively concerned in the placing of disabled persons (unregistered as well as registered) in suitable employment. It has been my experience that, as a group, epileptics are more prone to withhold detrimental information than other groups. Why then, Sir, as mentioned in your leading article (15 August, p. 362) should "informed medical opinion" feel that this human failing is less likely to be evident when applying for a longed-for driving licence? After all, the applicant's general practitioner has no satisfactory practical way of confirming his patient's statement when requested for a report by the medical officer of health.

A history of epilepsy, whether controlled or not, still bars the issue of a Heavy Grade Vehicle or Public Service Vehicle licence. Such drivers are no less likely to run into a bus queue than those of private cars—and there are far more of the latter. On the other hand, consider the epileptic driving a private car who could (due either to drug effects or an actual fit) veer across the road and be involved in a collision with a fully-laden motor coach coming in the opposite direction.

There is already more than enough avoidable carnage on our roads; surely some further thinking is required before it is too late?—I am, etc.,

F. J. ROBERTSON.

Newcastle upon Tyne.

English Language Problems

SIR,—In reply to Dr. H. Joshi's letter (18 August, p. 348) regarding the English language problems of Commonwealth doctors it is surely an understatement to say that the pronunciation of people in different parts of the country is their only problem. I have taught English to doctors from overseas for eight years and know that the main difficulties are understanding colloquial English in rapid speech, understanding dialectal variations in speech, writing good English, and making themselves understood in their own variation of English. We don't blame them for speaking differently, but many of them must face the fact that they do.

To help my own work¹ I should be grateful if English doctors would send me a note of any unusual regional expressions heard in the patient-doctor relationship.—I am, etc.,

JOY E. PARKINSON.

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London N.6.

REFERENCE

- 1 Parkinson, J. E., *A Manual of English for the Overseas Doctor*, Edinburgh, Livingstone, 1969.

Leucocytes in Semen

SIR,—In the report of the session on subfertility at the Annual Scientific Meeting (18 July, p. 157) it was said that the significance of leucocytes in the semen was not known.

While this is true in many cases, particularly when the numbers are small, it is important to remember that polymorphs in the semen may be the first sign of genitourinary tuberculosis in a man who is being investigated for subfertility. The leucocytes are best seen in slides stained by Papanicolaou's method. In these cases, specimens of urine should be examined and cultured. In addition, at least three specimens of the whole of the early morning urine should be cultured for *Mycobacterium tuberculosis*.—I am, etc.,

H. C. M. WALTON.

Beck Laboratory,
Swansea Hospital,
Swansea.

Malabsorption and Intestinal Flora

SIR,—A report¹ last year of a number of cases of tropical sprue patients displaying abnormal flora of the small bowel, coupled in some cases with malabsorption of fat and vitamin B₁₂, and B.M.J. articles (9 May, p. 340 and 16 May, p. 380) prompt me to report a case of longstanding diarrhoea and malabsorption. This patient's history supports the premise that an abnormal flora of the small bowel may be involved.

A male aged 49 has always resided in England. For 10 years he suffered attacks of diarrhoea and abdominal pain. After six years of palliative treatment he complained of extreme lassitude and darkening of the skin. His weight had fallen to under 8 st. (52 kg.). As many as 10 frothy fatty offensive stools were passed each day. The blood picture showed a megaloblastic anaemia. Marrow biopsy confirmed iron, B₁₂ and folic acid deficiencies. Electrolytes were normal: haemoglobin 85%, M.C.H.C. 31%, serum iron 8 µg./%, serum B₁₂ 75 µg./ml., serum folate 1.5 mg./ml. A xylose excretion test showed that 10% only of xylose was excreted in the urine in 5 hours. The day faecal fat estimation was 21.8 g./day. The appearance of the small bowel suggested steatorrhoea and a biopsy of the jejunum showed a flat mucosa. A diagnosis of coeliac syndrome was made.

The anaemia responded to and continues to be controlled by injections of vitamin B₁₂ in conjunction with iron, folic acid, and an oral multiple vitamin preparation. At first a gluten-free diet produced some response with his weight rising to 9 st. 2 lb. (58 kg.). The diarrhoea persisted and gradually his weight dropped to 8½ st. (55 kg.). Two years later a haemophilus-like organism was cultured from the jejunal juice. Immediate response to tetracycline therapy was good, but after some months was not maintained. His condition deteriorated with sometimes as many as 15 bowel motions a day with abdominal pain and tenderness. Sedatives, alkalis, spasmolytics, and antibiotic therapy were all tried without lasting benefit.

A little over a year ago he was put on Sedacol, a mixture of clioquinol and phanquone, in an attempt to normalize his intestinal flora. Two tablets t.d.s. for two

months resulted in early and continued overall improvement. The stools became firmer and the frequency reduced to two or three a day. There was relief of the abdominal pain and discomfort. His weight has remained constant at 8½ st. (55 kg.). He has been maintained for 11 months on one tablet t.d.s. with no evidence of tolerance developing, and now has returned to his normal work as a garage mechanic.

My thanks to Dr. B. Cream and his unit at St. Thomas's Hospital for their investigation of this case.—I am, etc.,

J. A. B. WESTON.

Chertsey, Surrey.

REFERENCE

- Gorbach, S. L., et al., *Lancet*, 1969, 1, 74.

Action on Amphetamines

SIR,—The Ilkeston Hospitals' Medical Staff Advisory Committee, including in its membership all the general practitioners in the town of Ilkeston, at a recent meeting recommended that there should be a total ban on the prescription of amphetamine and its analogues.

The committee took this action in the light of the many break-ins of chemists' premises in the town in recent months, where amphetamine has been one of the main targets of the raids. Its members are aware that lack of prescription will result in the chemists ceasing to stock the drugs, with the end result that the uncontrolled use of the drug will be diminished, if not eliminated.

While this action has been taken because of the local situation the committee recommend a similar voluntary action by doctors elsewhere to combat the problems created by the use of this particular drug, especially among young persons [see also *B.M.J.* 8 May, p. 361].—I am, etc.,

T. H. GILLISON,

Chairman,
Medical Staff Committee.

Ilkeston General Hospital,
Ilkeston, Derbyshire.

Fluphenazine Enanthate in Schizophrenia

SIR,—The use of fluphenazine enanthate¹⁻³ and more recently decanoate in schizophrenia has been shown to be a considerable therapeutic advance.⁴ This, coupled with advances in community care, has had a very beneficial effect on the management and prevention of relapse of rehabilitated schizophrenics living outside the hospital.

The drug is also useful in initiating the treatment of some acutely disturbed patients when they refuse regular medication. On a number of occasions patients who refused all forms of treatment were persuaded to receive a test dose of 12.5 mg. of fluphenazine decanoate and subsequently were willing to continue with a full dose of 25 mg. five days later because of the improvement in their mental state due to the initial dose. Two cases are described because they are illustrative, although in no way exceptional.

A 72-year-old paranoid schizophrenic woman had been in hospital for nine years. Over six months she showed a steady deterioration in her contact with reality, in her co-operation with other people, and in her habits. She was spending all day in a side room with the curtains drawn holding loud conversations with her voices. She refused to attend meals, co-operate in ward activities, or keep her room or her person clean and tidy. She was abusive towards the nursing staff claiming they were stealing her property. She was prescribed chlorpromazine, which she refused to take. She was then prescribed fluphenazine and eventually persuaded to receive this after having seen its beneficial effect on another patient whom she knew well. Within two days she claimed to feel better. She started taking more interest in other people and co-operated better. She gradually stopped sitting and talking in her room. She accepted further injections. Within two weeks she was working at occupational therapy mixing well on the ward, and even taking an interest in the health of the ward staff.

A ward sister, aged 37, was transferred from another hospital in a manic episode of manic-depressive psychosis. She showed extreme irritability, motor restlessness, pressure of talk, and flight of ideas with lack of insight—conforming closely to Jung's "manic ill humour"⁵. She refused chlorpromazine denying that she was ill. However, when it was explained that treatment was obligatory, she permitted an injection of fluphenazine to be given. Her extreme irritability responded within a week, and there was a decrease in restlessness and speed of thought. She was willing to accept her second and subsequent injections. It was possible to transfer her to haloperidol orally, on which she was maintained. It was thought inadvisable to discharge a patient with her diagnosis on fluphenazine because of the theoretical possibility of depression⁶ and the difficulty of reversing depression with a long acting drug.

It is suggested that disturbed patients who refuse treatment may sometimes successfully start treatment with fluphenazine decanoate, a long acting phenothiazine drug. In several instances improvement was sufficient after initiating treatment for second and subsequent injections to be accepted by the patients without demur.—I am, etc.,

A. C. P. SIMS.

All Saints Hospital,
Birmingham 18.

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- Jung, C. G., *The Collected Works of C. G. Jung*, Vol. I, London: Routledge and Kegan Paul, 1957.
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Traveller's Diarrhoea

SIR,—Having recently returned from Mexico, where I was medical officer to the 1,500 or so England supporters, I would like to present the following observations gathered from an admittedly small but probably significant study appertaining to the present controversial use of prophylactic therapy for "traveller's diarrhoea."

I was consulted by 108 people suffering from diarrhoea with or without vomiting/abdominal pain and, of this number, 65% were already taking Entero-Vioform. Most had taken it prophylactically since their holiday started and had increased the

dose as recommended when symptoms started.

Only four patients had generalized upset manifested by raised pulse and pyrexia, etc., and they were all taking Entero-Vioform as above.

Ninety-five per cent. of all patients were symptom free within 72 hours of dietary restraint and kaolin compound for the more severe cases. The 40 with toxic symptoms responded well to Streptotriad (sulphadiazine, sulphadimidine, sulphathiazole, and streptomycin) in addition. The remaining 5% had intermittent diarrhoea for a further 7-10 days but were not seriously incommoded by it.

The conclusions from this are easily drawn I think.—I am, etc.,

R. CRUTHERS.

Croydon,
Surrey.

Body Contour for Radiotherapy

SIR,—I was interested to read Dr. D. E. Meredith Brown's letter on the determination of body contour for radiotherapy (8 August, p. 345). This system has been in use for many years, of course, but it is welcome news that a commercial instrument is available. It is to be hoped that the use of flexible metal strips will soon be relegated to history.

One point, however, is worthy of consideration. If a set of parallel needles is used, skin surfaces which are perpendicular to the direction of the needles are recorded accurately, but those lying almost parallel to the needles are recorded very inaccurately. This difficulty can be overcome either by using two sets of needles positioned on a right angled frame, or by using a device with needles arranged radially around the arc of a circle.—I am, etc.,

L. ARTHUR FIRTH.

Leamington Spa,
Warwick.

Propranolol and Serum Calcium in Thyrotoxicosis

SIR,—We were interested to read the paper by Drs. R. G. Twycross and V. Marks (20 June, p. 701) on the control of symptomatic hypercalcaemia in hyperthyroid patients by means of conventional antithyroid therapy. We would like to record our unusual experience of the effect of propranolol in two hyperthyroid patients.

An Indian male, aged 41 years, was first admitted to hospital on 5 January with a history of loss of weight (33 lb., 15 kg.) over two months, weakness, and marked sweating. Clinically he was found to have diffuse thyroid enlargement with a systolic bruit, exophthalmos, lid lag, fine tremor of the hands, pulse rate 140/min., sweaty palms, and a proximal myopathy. His protein bound iodine (P.B.I.) was 13.3 µg./100 ml., 24-hour ¹³¹I uptake 82.2% (normal 15-50%), and latex particulate triiodothyronine ¹³¹I 47.5% (normal 18-28%). He was discharged on propranolol 20 mg. t.d.s. and carbimazole 10 mg. t.d.s.

We saw him for the first time 6 weeks later with new complaints of anorexia, constipation, polyuria, and polydipsia, and he stated that he had stopped his antithyroid drug therapy. Hypercalcaemia was suspected and his serum calcium