sudden pain in the calf to death from massive pulmonary embolism.

Apprehension still exists as continuing investigations indicate that there are grave discrepancies in the recommended methods of laundering and sterilizing in the hospital service. The non-clinical approach is paramount. Hospital flora are now accepted, apparently calmly (8 August, p. 305). Just how far have we gone backwards in 22 years? Do we need another Lister?—I am, etc.,

GAVIN C. GORDON.

Carlisle.

Acute Malaria in Newborn Infants

SIR,—I read with great interest Dr. N. E. Okeke's observation on malarial parasitaemia in newborn babies (11 July, p. 108).

Chloroquine, however, is absorbed extremely rapidly when given by the intramuscular route as he recommends, and is very liable to give rise to encephalopathy and convulsions in children. The risk is a real one, and I have recently seen a fatal collapse in a 6-month-old infant within 10 minutes of an injection of chloroquine. In most instances the oral route is satisfactory, and a case can also be made out for subcutaneous injection where absorption is sufficiently retarded for toxicity to be uncommon.—I am, etc.,

TERENCE G. GEDDES.

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Wrong Operations

SIR,—Dr. P. H. Addison's letter (22 August, p. 461) deserves careful attention. Various safeguards may be employed to prevent mistakes of identity—for example, the patient wearing a name bracelet, and to prevent operation being performed on the wrong area by marking the site with an indelible pencil. In either case whoever carries out these tasks has to be "fed" the correct information, and carelessness may lead to mistakes.

Surely, Sir, it is the responsibility of the surgeon to examine his patients himself, preferably on the day previously, in order to decide what operation he proposes to carry out and in what order the operations on the list are to be done. If he is wise he will see to it that a note is made on the patient's case records, which he should either write himself, or sign. Identification of the patient and scrutiny of the case notes must also be undertaken by the anaesthetist, who should share in the responsibility of the correct patient being given the correct operation.—I am, etc.,

T. KEITH LYLE.

London W.1.

Sleeping Pills

SIR,—The discussion on the use of hypnotics is most gratifying. I wholeheartedly agree with Dr. A. A. Lewis (22 August, p. 463) that "Dependence on sleeping pills is a condition created and maintained by doctors."

While in charge of a male admission unit for 24 psychiatric patients of all types and ages I discontinued the use of sleeping tablets, except for very occasional doses in states of severe excitement or imminent withdrawal fits. These doses were not given for longer than three nights.

The following observations were made:¹ The majority of patients gave a history of taking hypnotics for years before admission. All patients began to sleep without hypnotics after perhaps a few sleepless nights. It was surprising to see how easily and quickly the normal sleep rhythm re-established itself. All patients confirmed that they had never slept so well in their life.

Night and day nursing staffs, who had been very sceptical at first, confirmed that the ward was quieter and better than in the past when hypnotics were liberally distributed.

Appropriate and adequate psychiatric treatment had of course to be given from the moment of admission. Unfortunately, quite a number of patients relapsed unnecessarily into their previous habit when they returned home.—I am, etc.,

H. FISHER.

Nottingham.

REFERENCE

- 1 Fisher, H., *Die Medizinische Welt*, 1962, 32, 1650.

Transurethral Resection

SIR,—In his lecture on transurethral resection (1 August, p. 241) Mr. J. P. Mitchell omits the discussion of complications related to the absorption of irrigating fluid into the circulation and its effects: overhydration, haemolysis, and hyponatraemia. Perhaps he avoids these contributors to morbidity and the occasional fatality primarily by being swift (the dexterous and experienced surgeon can complete the removal of a 20 g. adenoma in less than 45 minutes), but also by operating under low irrigating fluid pressures and by using isotonic solutions as the irrigating fluid.

Mr. Mitchell refers fleetingly to the use of general anaesthesia for patients undergoing transurethral resections and this, I believe, merits some discussion. Most of the complications, including overloading of the circulation, may be detected early by an alert and knowledgeable anaesthetist, provided the signs and symptoms are not masked by general anaesthesia. These signs and symptoms have been reviewed by several authors during the past number of years.¹⁻³ Subarachnoid spinal analgesia, carried no higher than the 11th dorsal segmental level, will provide the patient with adequate analgesia without compromising the pulmonary or circulatory systems. The occasional slight fall in systemic arterial blood pressure does not require treatment and, in fact, will produce the controllable mild hypotension that Mr. Mitchell finds desirable.

Early restlessness, nausea, and vomiting will warn the surgeon and anaesthetist of circulatory overload. Generalized abdominal pain or lower abdominal pain and rigidity will suggest perforation of the bladder, either intraperitoneal or extraperitoneal perforation.

Although the mortality rate of transurethral resection is in the region of 1%, even lower rates and decreased post-operative morbidity may be expected with the use of subarachnoid analgesia—a technique that is more controllable in the older age group than lumbar or caudal epidural analgesia.—I am, etc.,

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REFERENCES

- 1 Minuck, M., *Canadian Anaesthetists' Society Journal*, 1954, 1, 59.
- 2 Marx, G. F., and Orkin, L. R., *Anesthesiology*, 1962, 23, 802.
- 3 Desmond, J., *Canadian Anaesthetists' Society Journal*, 1970, 17, 25.

Fainting in Mumps

SIR,—We wish to bring to your notice three instances of acute vasovagal collapse triggered by rotation of the neck during the acute stage of mumps.

The first two observations were subjective; they occurred at the height of neck swelling and each was brought on by rotation of the head when searching for a bottle of aspirin. The sensation was unpleasant with faintness, sweating, and bradycardia of 30/min. lasting for about 30 minutes. An electrocardiogram taken shortly after the second episode was normal. The third incident was in a young policeman again in the "bull neck" stage of the illness; when on request he rotated his head he lost consciousness in a typical vasovagal attack.

The cause of this phenomenon would appear to be unusual pressure on the carotid sinus produced by rotation of an acutely swollen neck. It would be interesting to know whether other readers have had similar experiences.—We are, etc.,

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Anaemia and Psychomotor Function

SIR,—I read the paper by Drs. P. C. Elwood and D. Hughes (1 August, p. 254) with interest, but feel they have just missed the boat having such a vast source of clinical material at their finger tips.

In my own practice of family medicine I have seen many women in this Northern Ontario mining community with so-called "depression." In all these cases I have had their haemoglobin level estimated and found it to be 10.5 g./100 ml. or over, whereas the serum iron was either low or below normal. If Drs. Elwood and Hughes had estimated the serum iron levels of their patients under survey, they would have told a different story.

The haemoglobin level alone (or the packed cell volume) does not give any indication of the haematological picture in patients with any disturbance or alteration of psychomotor function.—I am, etc.,

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Canada.