CORRESPONDENCE

Correspondents are asked to be brief

Control of Rabies H. M. Davies, D.P.H.	302	Fenfluramine and Dreaming A. C. B. Hooper, M.B.	305	Heparin in Acid Solutions S. L. Stock, B.Sc., and N. Warner, B.Sc.	307
Smallpox Vaccination G. W. J. Bousfield, M.D.; Flight Lieutenant C. D. E. Morris, M.B.	302	Working of the Abortion Act Elizabeth Allan and others	305	Infectiousness of Glandular Fever M. A. Casson, D.C.H.; D. H. Judson, M.B.	307
Freedom from Amphetamines C. Berry, D.P.M.; J. R. James, B.M.	302	Obstetric Appointments and the Abortion Act C. J. Carr, M.R.C.O.G.; J. M. Gate, F.R.C.O.G.	305	Hong Kong 68 Variant of Influenza A2 P. W. Gill, M.B.	308
Halothane Hepatitis T. H. S. Burns, F.F.A.R.C.S.; Margaret E. Dodson, M.D.; M. W. Johnstone, F.F.A.R.C.S.	303	Haemorrhage Mimicking Intravascular Haemolysis P. J. Black, M.B., and others	306	Organization and Staffing of Operating Theatres C. A. Foster, F.F.A.R.C.S.	308
Penicillin Prophylaxis G. Gover, M.B.; M. G. Wright, M.B.; J. D. Langdon, L.D.S. R.C.S.	303	Familial Hyperparathyroidism G. D. Kerr, M.R.C.P.	306	Psychogeriatric Services T. B. Dunn, F.R.C.P.	308
Laparoscopic Sterilization through Cusco's Speculum J. O. Greenhalf, F.R.C.S.ED., and H. R. M. Robert, F.R.C.S.	304	Complications of B.C.G. Vaccination I. Machtay, M.D.	306	Royal College of Psychiatrists P. A. Barker, M.R.C.P.ED., D.P.M.	309
The Ward Sister I. Christine Brown, S.R.N.; J. W. Paulley, F.R.C.P.; P. H. Powley, F.R.C.S.	304	Acute Complete Inversion of the Bladder S. El-Hammady, D.S., D.G.U.S., and M. Ghoneim, M.CH.	306	Hazard of Self-inflating Resuscitation Bag D. R. Garbe	309
Fenfluramine Dependence T. W. Harding, D.P.M.	305	Air Embolism during Haemodialysis J. Grainger, S.R.N., and A. G. M. F. Eisinger, M.R.C.P.	307	Alcohol and Glibenclamide E. N. Wardle, M.R.C.P., and G. O. Richard- son, F.R.C.P.	309
		Sterilization of Young Wives D. B. Brown, F.R.C.O.G.	307	Visits Outside Practice Area J. P. Lester, M.B.	309

Control of Rabies

SIR,—I am pleased to hear that the Committee of Inquiry on Rabies (10 July, p. 63) has once again expressed its concern at the possibility of this disease again becoming endemic in the United Kingdom. The real problem, as the committee says, is the importation of dogs and cats, and they confirm the necessity that dogs and cats imported into this country should undergo a six months' quarantine on entering Britain. They also recommend that points of entry should be restricted to a limited number of airports and seaports. With this once again I agree, but speaking personally as the Port Medical Officer for the Port of Teignmouth, which most certainly would not qualify as one of these "points of entry," one cannot guarantee that the large number of coastwise and foreign ships which visit Teignmouth, in 1970 some 651 of them, could not contra-

vene this regulation, as at least one-third of them carry dogs and cats as pets.

The masters of these ships are warned on entry that it is illegal to bring pets ashore, but the only effective supervision is that which can be given by the customs officers and the police. Although these officials do all that they reasonably can, I would be the last person to guarantee that no animal could get ashore from one of these coasters.

I feel very strongly that illegal importation of domestic animals is a strong possibility, and would very much like to see an international regulation prohibiting domestic animals from being carried on these small ships.—I am, etc.,

H. DAVIES

Devon County Council,
Newton Abbot

Smallpox Vaccination

SIR,—Professor George Dick (17 July, p. 163) has put forward a very strong case for the abolition of routine smallpox vaccination. His admirable summary of the conditions prevailing today will convince many thinking people that the time is ripe to abolish the procedure.

As one who has had much to do with various forms of immunization for many years I feel obliged to support his contention heartily, with one proviso. In the case of a sudden scare, there must be neither Ministerial nor press campaigns to induce masses of people to seek sudden protection, as was the case some years ago relating to both smallpox and diphtheria. This crash procedure leads to treatment of many subjects who should not have been inoculated, as there is no time to get proper histories. Doubtless a number of severe reactions and

deaths described by Professor Dick can be traced to failure to ask adequate questions, and sometimes by the utilization of extra staff who did not realize the nature of essential inquiries.—I am, etc.,

GUY BOUSFIELD

Broadbridge Heath,
Sussex

SIR,—In Professor George Dick's article on smallpox vaccination (17 July, p. 163) and the leading article provoked by it (p. 129) the complication and death rates for vaccination are quoted with no indication of the method employed. To make the procedure safer the multiple pressure technique is recommended and becoming employed by an increasing number of doctors, particularly

those newly graduated from medical school.

I am responsible for vaccinating about 150 adult males every week, and by employing the multiple pressure technique have considerably reduced the morbidity. The "good scratch" given previously often produced considerable systemic and local reaction.

If the multiple pressure technique was universally employed, would it produce a trend towards reduction in complication and death rates sufficient, perhaps, to render vaccination a lesser hazard than the risk of smallpox itself?—I am, etc.,

C. D. E. MORRIS

R.A.F. Station Medical Centre,
Swinderby, Lincoln

Freedom from Amphetamines

SIR,—In general I would join in congratulating the group of doctors, led by Dr. F. O. Wells of Ipswich (17 July, p. 176), who have entered into a voluntary ban on the prescription of amphetamines. However, attention should be drawn to a group of patients who suffer by this ban, and who do not appear to have been mentioned in discussions so far. I refer to those chronic neurotics who have been maintained on a small dose of amphetamine for many years, who suddenly find their supply terminated. This usually happens when circumstances oblige them to change their practitioners.

Such a patient suffers from withdrawal effects, including lethargy and depression, and seeks relief from these in other prescriptions such as tricyclic antidepressants, which in his case are ineffective and have unpleasant side effects. This measure having failed, the unfortunate patient may be referred for prolonged psychotherapy, if available, for which he has neither the time nor the motivation. The patient is thus converted from a well-

compensated neurotic taking a small dose of amphetamine to a highly distressed human being making excessive demands on an already busy service.

In my view there is a strong case to be made for excluding patients who have been on amphetamines for several years from the current witch hunt, although I agree that no neurotics should be started on the drug at this point in time.—I am, etc.,

COLIN BERRY

Central Hospital,
near Warwick

SIR,—Sir George Godber is reported as saying (17 July, p. 176) that "there was almost nothing that amphetamines could do which was not done better by other drugs," but he does not spell out what are the exceptions that he has in mind.

Before anti-amphetamine enthusiasm reaches the climax of a total ban, may I mention one type of case in which dexamphetamine sulphate is, so far as I am aware, superior to any other drug? It is nocturnal enuresis in those patients whose sleep is exceptionally deep. Admittedly such cases are not very common. As a general practitioner I see about two a year; but some of these are adults on whom other treatments—tricyclic antidepressants, for example—have been tried and failed.

Dexamphetamine may be presumed to be effective in such cases not only because it lightens sleep, but also because of its action in facilitating conditioning and habit formation.¹ The dose has to be exact, just below that dose which will prevent sleep. But once the dose is found by experiment, the response is usually gratifyingly rapid. It would be a great pity if, because of widespread abuse of this drug, we were to be left without any effective treatment for a very distressing condition.—I am, etc.,

J. R. JAMES

Southsea,
Hants

¹ Eysenck, H. J., *The Dynamics of Anxiety and Hysteria*. London, Routledge and Kegan Paul, 1957.

Halothane Hepatitis

SIR,—The article by Professor William W. Mushin and his colleagues (3 July, p. 18) illustrates one of the problems inherent in attempting to keep comprehensive anaesthetic records.

By the time a problem needs investigation, it is too late to obtain all the relevant information from the best of such records. To give but two examples—it appears to be impossible to be sure that the breathing apparatus used to administer the halothane was free from infection, and the method of preparation and degree of purity of the halothane is not stated.—I am, etc.,

T. H. S. BURNS

Department of Anaesthetics,
St. Thomas's Hospital,
London S.E.1

SIR,—Postal problems have prevented me from commenting earlier on the article "Halothane Hepatitis—A Preventable Disease?" (20 February, p. 448).

The narrow concentration of interest in halothane as the main cause of postoperative

jaundice is blinding doctors to the wider problem of liver function changes and even jaundice which occurs in patients who have never had halothane. In the Liverpool area the reporting of cases of postoperative jaundice was certainly biased in favour of patients who had received halothane, but 4 out of 11 patients were known to have had a non-halothane anaesthetic.

Anaesthetists are aware of the fact that anaesthesia disturbs liver function, sometimes fatally. They are also aware that almost every drug used has at some time been accused of causing jaundice. However, anaesthesia does not involve only the administration of drugs, but it also causes alterations in physiology. Some of these physiological changes are known to disturb liver function or blood flow,^{1,2} and some of these factors must operate in the patient who does not have halothane and becomes jaundiced. Why should they not also operate in the patient who is given halothane?

Let us be sure of the extent to which halothane, and halothane alone in anaesthetic doses in man, causes liver damage before condemning a most useful drug.—I am, etc.,

M. E. DODSON

Department of Anaesthesia,
New Mulago Hospital,
Kampala

- ¹ Johnstone, M., *British Journal of Anaesthesia*, 1964, 36, 718.
- ² Little, D. M., and Wetstone, H. J., *Anesthesiology*, 1964, 25, 815.
- ³ Galindo, A., *Canadian Anaesthetists Society Journal*, 1965, 12, 262 and 337.

SIR,—I can assure Dr. R. Williams (10 July, p. 110) that the immunosuppressive effect of anaesthetic agents is neither a clinical impression nor a figment of the imagination. It is an established fact¹ which he must accept whether or not it disheartens him. He will be glad to know that steps have been taken to see what can be done about it. An electron microscopic study has shown that halothane has no adverse hepatic effects in species not susceptible to viral hepatitis.² The electron microscopic and other features of allergic liver necrosis have been described.³ It is interesting to note that mitochondrial swelling is one of them, as in viral hepatitis.⁴

Hepatologists eminent or otherwise are adept at selecting references to suit their purpose. They regard the report from Denver⁵ as the first to draw attention to the occurrence of liver necrosis in one patient after halothane anaesthesia. They ignore a subsequent publication from the same source⁶ describing similar hepatic necroses after other forms of anaesthesia.

As a physician, Dr. Williams may be forgiven for his unfamiliarity with the problems of anaesthetic practice. The publication of his advice to anaesthetists is difficult to understand. It is a pity he was unable to suggest a non-immunosuppressive anaesthetic technique for patients who require multiple anaesthetics and who show signs of viral infection after the first.—I am, etc.,

M. W. JOHNSTONE

Department of Anaesthetics,
The Royal Infirmary,
Manchester

- ¹ Bruce, D. L., and Wingard, D. W., *Anesthesiology*, 1971, 34, 271.
- ² Scholler, K. L., *Acta Anaesthesiologica Scandinavica*, 1968, Supplementum 32.

- ³ Sabesin, G. M., *The American Journal of Pathology*, 1953, 42, 743.
- ⁴ Sherlock, S., *Gut*, 1971, 12, 324.
- ⁵ Virtue, R. W., and Payne, K. W., *Anesthesiology*, 1958, 19, 562.
- ⁶ Gingerich, T. F., and Virtue, R. W., *Surgery*, 1965, 57, 241.

Penicillin Prophylaxis

SIR,—In "Therapeutic Conferences" on upper respiratory tract infections (10 July, p. 101) your experts recommend that all upper respiratory infections should be treated conservatively except in "special risk" cases. By their own admission it is impossible to distinguish between viral and bacterial tonsillitis and it is impractical to swab all cases.

There are various reasons for the reduction in the number of cases of rheumatic fever and nephritis, and one of these must be a result of the treatment of tonsillitis with penicillin. It has been my own practice to treat all cases of tonsillitis with penicillin, realizing that many of these are viral (I obviously select an alternative antibiotic for those who are allergic to penicillin). I swab all cases that I do not treat.

I would agree that too many antibiotics are too freely prescribed, but surely this is the one condition that should not be treated conservatively if we do not want an increase in the number of "at risk" cases?—I am, etc.,

GEOFFREY GOVER

Horsham, Sussex

SIR,—I feel that one point from your Therapeutic Conference (10 July, p. 101) requires further clarification.

It is stated that patients who have had rheumatic fever should have treatment with penicillin to cover such operations as dental extractions. If these patients are already taking chemoprophylaxis with penicillin, it is obviously the last antibiotic one would choose to cover the operation as resident mouth flora would already be resistant to penicillin.—I am, etc.,

M. G. WRIGHT

Gordon Hospital,
London S.W.1

SIR,—I was dismayed to read in "Therapeutic Conferences" (10 July, p. 101) that penicillin prophylaxis for those patients susceptible to subacute bacterial endocarditis should be administered two hours prior to any proposed dental extractions and also that the intramuscular route was anything less than mandatory.

Subacute bacterial endocarditis is still a serious illness carrying a high mortality (up to 50% in the first 12 months after the first infection). For antibiotic cover penicillin is the drug of choice, for patients who are not allergic to it, and who are not receiving long-term penicillin prophylaxis. It is bactericidal and the oral strains of *Strep. viridans* are very rarely penicillin-resistant. Absorption of penicillin from the gastrointestinal tract is unreliable both in the height and the timing of the peak blood levels of the drug. Intramuscular injection results in predictable blood levels with a peak occurring 20-30 minutes after the injection. To administer penicillin two hours before an extraction means that the bacteraemia following the extraction does not co-