Spread of Cholera

SIR,—Professor L. J. Bruce-Chwatt (28 August, p. 532) draws attention to the spread of cholera in tropical Africa and to the need for travellers to Africa and Asia to be vaccinated against the disease.

I regret that in mentioning the minimum period of one week between injections of the vaccine he has said nothing about the necessity or desirability of a much longer interval.

Many travellers who have had adequate time to prepare for the journey seek vaccination at the last moment because they have been told by their doctors or by travel agents that cholera vaccination takes only one week to complete. The minimum period of seven days has become the desirable (and almost the maximum) period in the public mind. Parish and Cannon¹ write that an interval of one week is too short and should be avoided except in emergency. The leaflet which accompanies Wellcome cholera vaccine states: "Primary vaccination consists of two doses of vaccine preferably separated by a period of over a month, but this interval may be reduced even to seven days when rapid immunization is necessary, though the longer the interval the better the response." I am aware that there is some evidence that so far as adults are concerned two injections at an interval of seven to ten days are as effective as two injections at an interval of 28 days, but there is also much evidence to support the longer interval, and in my opinion it should be observed, especially for children.—I am, etc.,

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¹ Parish, H. J., and Cannon, D. A., *Antisera, Toxoids, Vaccines and Tuberculin in Prophylaxis and Treatment*, 6th edn., p. 148. Edinburgh, Livingstone, 1962.

The New F.F.R.

SIR,—Dr. F. Pygott (28 August, p. 533) makes a valuable contribution and reflects the serious disquiet that many Members and Fellows feel about the proposed change in the regulations and syllabus for the Fellowship.

The new proposals ignore the essential historical clinical background of the Faculty and its Fellowship by the introduction of physics and photography into the Part I of the diagnostic diploma, much of which is relevant, but not to a clinical fellowship in radiodiagnosis. Such studies are part of the D.M.R.D. (and D.M.R.T.), while the Fellowship has always been concerned with clinical radiology—as the name of its journal implies.

In addition, the examination structure of Part I and Part II reveals not one essay type paper—surely a denigration of scholarship—and yet we are told that the intention is to "main'tain the same standard in the F.F.R. as at present." Even if we accept this intention, the present pass rate is on average about 33%, so that Dr. Pygott's point of the lack of value of the failing candidate's training outside of radiology is well taken.

Sir, it took years for the Fellowship to be recognized as a higher diploma equivalent to the M.R.C.P. and F.R.C.S. Before that time candidates with the latter diplomas

were considered superior and given priority over those with the F.F.R. The present proposals will put the clock back, to the detriment of the Fellowship and its position in Britain today. I am not against change—some of the suggestions put forward, such as the new viva examination, are excellent. I am concerned that change is for the better—from the position of the Fellowship.—I am, etc.,

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Pupillary Paralysis after Tranquillizer

SIR,—Dr. R. J. M. Crawford (28 August, p. 530) suggests that pimozide was responsible for the cycloplegia and mydriasis occurring in his patient. Had he forgotten that he was treating her iatrogenic Parkinsonian condition with benzotropine? Although her benzotropine was changed to orphenadrine, he appears to attribute her recovery solely to the reduction in dosage of her pimozide. Do we need to look beyond benzotropine as the likely cause of both the mydriasis and the cycloplegia, since the principle side effects of benzotropine are anticholinergic in nature, including paralysis of the sphincter muscle of the iris and the ciliary muscle of the lens? The slow recovery of her visual acuity over a period of two weeks is compatible with the cumulative effect of benzotropine. These complications are less likely to occur with orphenadrine, whose anticholinergic effects are relatively weak.¹

This case serves to illustrate the care that we must take in looking out for the side effects of our drugs. Interpretation is made especially difficult in instances involving multiple therapy.—I am, etc.,

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¹ Goodman, L. S., and Gilman, A., *The Pharmacological Basis of Therapeutics*, 4th ed. London, Macmillan, 1970.

Circulatory Arrest and Bone Cement

SIR,—We wish to report our experience of two recent cases of patients who survived circulatory arrest during the insertion of a Thompson's femoral head prosthesis. Both patients were female and fit on admission with no previous history of serious illness. The first patient was 75 years old and the second 78 years old. Both had displaced subcapital fractures of the neck of the right femur.

The operations were carried out some 24 hours after admission, and a Thompson's prosthesis was inserted via the posterior approach. In both cases the subsequent events were similar. Some three minutes after the insertion of the cement the blood pressure dropped dramatically, and the patients became pulseless. The first patient recovered within three minutes of a rapid saline infusion and tilting to the head-down position. The wound was closed in the normal fashion. In the case of the second patient, after the precipitous fall in blood pressure, E.C.G. revealed the presence of asystole. The operation was immediately stopped, the wound covered with sterile towels, and the patient placed in the supine position, with head-down tilt, and external

cardiac massage initiated. Three minutes later 10 ml of 10% calcium chloride were administered by the intracardiac route and a central venous line via the subclavian vein was established. Re-establishment of sinus rhythm was rapid and the wound was closed 15 minutes later with the patient still supine and a sandbag beneath the lumbar region to facilitate access.

Both patients were able to sit up on the next day and developed no further complications. Subsequent investigation revealed no evidence of fat embolism or pulmonary embolism having occurred during the operation.

The first patient was discharged two weeks after the operation and the second four weeks after operation, the longer stay of the second patient being due to social reasons.—We are, etc.,

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Blood Pressure, Anaesthesia, and Bone Cement

SIR,—May I criticize the lack of controls in the article about bone cement by Mr. H. Phillips and others (21 August, p. 460). They state that "hypotension occurred between 12 and 90 seconds after introducing the cement. . . ." Presumably, they have recorded the lowest pressure occurring during that 90-second period. There is no mention of the highest pressure.

Blood pressure varies quite markedly under anaesthesia. Two recordings a minute apart may be quite different. Had the measurements in the experiment been made at introduction of cement and 60 seconds afterwards, one could compare this change with a pair of measurements 60 seconds apart at some other part of the operation. A *t* test would then be valid.—I am, etc.,

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Diagnosis of Cystic Fibrosis

SIR,—It was with interest that I read your leading article on the diagnosis of cystic fibrosis (28 August, p. 489), especially the passing reference to the screening of meconium for the presence of albumin. This screening method has been in use in two Newcastle hospitals for well over a year, and several thousand neonates have been screened for cystic fibrosis. I have recently started screening all newborn babies born at the local maternity hospital in Penrith.

The test is extremely simple and cheap, merely involving the dipping of an Albustix or Labstix (Ames) strip into a mixture of meconium and water on a glass slide. A positive result is indicated by the presence of two or more + of albumin on the strip.

So far one new case of cystic fibrosis has been detected at birth. However, it is not known yet how many cases, if any, have been missed, though none have been reported so far.

The test would seem to fulfil the criteria in your article in that it is universally