depress respiration further but this is readily managed in hospital and the dramatic effects of its appropriate administration make therapeutic trial very worthwhile.

I am grateful to Professor R. Kilpatrick for permission to report these cases.

—I am, etc.,

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- ¹ Jaffe, J. H., in *The Pharmacological Basis of Therapeutics*, ed. L. S. Goodman, and A. Gilman. New York, Macmillan, 1970.
- ² Wright, N., and Syme, C. W., *British Medical Journal*, 1969, 3, 596.

Expenses for Study Leave

SIR,—There are many young consultants like Mr. N. J. Barwell (27 July, p. 262) who have worked their way up the ladder, often suffering from unfavourable differentials at each stage, only to find that consultant status was not financial Valhalla (defined, I note, as either a palace of bliss or a general burial place for a nation's great men). It is, however, the niggling restriction on expenses that is often the most irksome thing, and nowhere is this more evident than in attitudes to study leave.

The South-east Thames Regional Health Authority recently sent round a circular on this subject, and I would like to quote from the part relating to senior staff. "No financial help will be given for annual meetings of associations held in the United Kingdom. . . . No preferential consideration can be given to those reading papers. . . . The normal contributions will be up to half expenses with a maximum contribution of £100 (£200 for visits to U.S.A., Australia, New Zealand, the Far East, India or Pakistan) for whole-time consultants and on a pro rata basis for sessions less than nine per week." How much, I wonder, for cloud cuckoo land?

Surely our employers must be made to realize that study leave with full expenses is a necessary part of postgraduate education and an essential means of communicating medical advances in Britain to the rest of the world. This penny-pinching attitude, furthermore, discriminates against the whole-time consultant, for the tax authorities rightly recognize that attendance at medical meetings, particularly to present a paper, is a legitimate professional expense.

I would also like to point out that the whole system of expenses for study leave is at the whim of the individual regional health authority. It is well known, and I have personal experience of this, that some old regional hospital boards were more generous (or, I should say, fair and enlightened) than others. I am convinced that there should be a national rather than a regional policy on this matter.—I am, etc.,

PETER BANKS

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Reporting Deaths to the Coroner

SIR,—Dr. R. N. Palmer (10 August, p. 410) regrets that there is no authoritative definition of the "archaic" phrase "persons about the deceased" who, the Brodrick Committee alleges,¹ incur an obligation at common law to give immediate notice to the coroner of circumstances requiring the holding of an

inquest. The phrase "persons about the deceased" is not archaic. It first appeared in the edition of "Jervis on Coroners" which followed the Coroners Act 1887. Shortly after that the council of the Coroners' Society resolved "that in cases of death from violence or from any unnatural cause, it is a common law duty imposed on the medical practitioner in attendance, among others, to report to the coroner." This provoked a strong leading article in the *B.M.J.* It observed that "no coroner has yet been found rash enough to try the experiment of indicting anyone for not giving him information of a suspicious death," and it concluded that "no medical practitioner need feel seriously disturbed by the announcement of this new addition to his multifarious activities."² This view was later reinforced by Sir Roland Burrows when the Medical Protection Society sought his opinion in 1943. He stated: "There is no power in a coroner to require medical practitioners as such to notify any death to him; there is no legal duty on the practitioner to report them; and there is no common law or statutory provision giving any such power or imposing such duty and consequently no penalty."³ The most recent editions of Jervis admit that the duty is unenforceable at law.⁴

It was largely for these reasons that the B.M.A. report of 1964⁵ recommended that medical practitioners should be required to notify the coroner or his officer immediately they become aware that a death has occurred which ought to be investigated by the coroner. It is interesting to note that the Brodrick report says of the B.M.A. report, "our own inquiries have left us firmly convinced that the attitude adopted in this report was unduly alarmist." It did, however, have the advantage of providing references to the evidence on which its recommendations were based.—I am, etc.,

J. D. J. HAVARD

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- ¹ Home Office, *Report of the Committee on Death Certification and Coroners*, Cmd. 4810. London, H.M.S.O., 1971.
- ² *British Medical Journal*, 1899, 2, 1750.
- ³ Havard, J. D. J., *Detection of Secret Homicide*, Cambridge Studies in Criminology, Vol. xi, p. 85. London, Macmillan.
- ⁴ Jervis on the Office and Duties of Coroners, ed. W. B. Purchase and H. W. Wollaston, 9th edn., p. 56. London, Sweet and Maxwell.
- ⁵ *Deaths in the Community*. London, British Medical Association, 1964.

Fenfluramine and Psychosis

SIR,—Your leading article (2 February, p. 168) suggested that fenfluramine might be of use in some obese patients while on psychotropic drugs. Over the past three months we have admitted three patients in whom this drug appears to have played a part in precipitating their psychotic decompensation.

The first, a 38-year-old married woman who was admitted in a manic state, had a history of fluctuating mood states but her only previous contact with psychiatric services had been two outpatient attendances for depression. This had quickly resolved without drugs. Eight weeks before admission she had been prescribed fenfluramine 40 mg twice daily. She had taken this fairly regularly. Her husband described how 30 to 60 minutes after taking the medication she would become increasingly active and remain so for several hours. This became more and more obvious until her behaviour brought her to the notice of the police and thus to hospital.

The second, a 23-year-old single woman with no previous psychiatric treatment, had become emo-

tionally disturbed after the breakup of a close relationship with a man two years previously. She had continued to harbour paranoid feelings toward him. At the time, however, she had received only a minor tranquillizer and remained at home for two weeks. She was admitted in a schizophreniform state with mild clouding of the consciousness. After the clouding cleared she displayed features of paranoid schizophrenia. On admission she was in the fifth week of a course of fenfluramine 60 mg/day for obesity.

The third was a 43-year-old married woman who had had a schizophrenic illness when aged 20. Two years before admission she had had a relapse and had remained on medication since. She had been increasingly troubled with depression. She had been maintained on fluphenazine decanoate 50 mg four weekly, chlorpromazine 200 mg nightly, and imipramine 100 mg twice daily. Increasing homicidal thoughts towards her children, suicidal feelings, and auditory hallucinations necessitated her admission. She was in the third week of a course of fenfluramine and taking 40 mg twice daily on admission.

Psychiatric complications of fenfluramine have already been noted. Dr. A. Levin reported¹ euphoria, derealization, and perceptual changes and also depressive illness of various degrees. Dr. J. D. F. Lockhart (2 March, p. 394) emphasized the danger of combining antidepressant medication with fenfluramine. In addition, from these cases, the precipitation of a psychotic illness in predisposed persons seems a real possibility.—We are, etc.,

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- ¹ Levin, A., *British Medical Journal*, 1973, 2, 49.

Aspirin and What Else?

SIR,—Your leading article (6 July, p. 5) stated that alcohol does not affect haemostasis unless it causes cirrhosis. I would point out that alcohol appears to act as a direct megakaryocyte or platelet toxin, or both, with resultant thrombocytopenia.^{1,2} This thrombocytopenia, which is not due to hypersplenism or folate deficiency, is rapidly reversible on withdrawal of the alcohol, and there may even be a compensatory thrombocytosis. Cowan³ has demonstrated decreased platelet survival and Haut and Cowan,⁴ studying the effects of ethanol on the haemostatic properties of platelets, concluded that, apart from the thrombocytopenia, ethanol impaired platelet function due to both extracorporeal factors and platelet injury.—I am, etc.,

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Cape Town,
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- ¹ Lindenbaum, J., and Hargrove, R. L., *Annals of Internal Medicine*, 1968, 68, 526.
- ² Post, R. M., and Desforages, J. F., *Annals of Internal Medicine*, 1968, 68, 1230.
- ³ Cowan, D. H., *Journal of Laboratory and Clinical Medicine*, 1973, 81, 64.
- ⁴ Haut, M. J., and Cowan, D. H., *American Journal of Medicine*, 1974, 56, 22.

Chemotherapy before Bowel Resection

SIR,—Talking to medical representatives recently I learnt to my surprise that a lot of surgeons give preoperative chemotherapy to patients who are going to have bowel resections, and also that patients are being brought in four to five days before operation to be put on special diet to help lessen the