dramatic fall in the parasitaemia to 0.5%. Forty eight hours after admission her temperature was normal and no parasites were detectable in further films. The quinine was then continued orally for 10 days at a dose of 600 mg every 12 hours.

Her subsequent antenatal course was uncomplicated. Films remained negative for malarial parasites. Four weeks after her admission she was readmitted in spontaneous labour that resulted in a vaginal delivery of a healthy girl weighing 2680 g. The puerperium was uneventful.

Comment

We believe this to be the first report of successful exchange transfusion for severe infection with *P falciparum* in pregnancy. Mothers in the second trimester of their first pregnancy are particularly at risk of the complications of malaria.^{2,3} Exchange transfusion is thought to act by reducing the number of red cells infected with the parasites and may also remove deleterious humoral factors such as tumour necrosis factor, which has been implicated in the pathogenesis of organ failure.^{4,5}

P falciparum does not have an exoerythrocytic liver phase, and thus clinical malaria that occurs more than a year after the patient has lived in a malarious zone is rare. This patient did not live close to an airport and there was no reason to disbelieve her history. Perhaps the most likely explanation is that a chronic, asymptomatic parasitaemia developed into fulminating disease as a result of the immunosuppression associated with pregnancy.

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Five year outcome in patients withdrawn from long term treatment with diazepam

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Only in the past 10 years has dependence on benzodiazepines in therapeutic doses been recognised as a major problem,^{1,2} and information on long term outcome is limited. Ashton found that 92% of patients had not resumed benzodiazepine treatment 10 months to 3½ years after stopping long term treatment, but her population was a specialised group referred to a clinical pharmacologist.³ We report here the five year follow up of 41 psychiatric outpatients referred by their general practitioners who took part in a controlled withdrawal programme from long term treatment with diazepam in 1980-2.⁴

Patients, methods, and results

The 41 patients (15 men, 26 women, mean age 43.6 years) had been diagnosed as having generalised anxiety (30), agoraphobia (7), depressive neurosis (2), social phobia (1), or obsessive compulsive neurosis (1) and had taken diazepam (mean 11.3 mg/day) for a mean of 37.5 months before gradual reduction with placebo substitution. In the original study 36 had completed withdrawal and five failed to stop their drugs completely. Follow up was carried out by AH without knowledge of their original state. Whenever possible patients were interviewed exactly five years after attempted withdrawal and their drug history checked by examining general practice, medical, and psychiatric records (when relevant).

Two of the 41 patients had died in the follow up period. Thirty eight of the remaining 39 patients were seen by AH and full prescribing details were obtained on all patients (table). Thirty one of the 41 patients had taken benzodiazepines at some time in the five years, although only 14 were still taking them at follow up. Four other patients took other drugs (dothiepin,

propranolol, trifluoperazine, and dichloralphenazone) for anxiety symptoms at some time without taking benzodiazepines. There were 73 episodes of new prescribing of benzodiazepines, 69 from general practitioners, comprising diazepam (34), lorazepam (11), chlorthalidoxepoxide (8), temazepam (8), clobazam (5), nitrazepam (3), oxazepam (2), and medazepam (2), all in doses at or below 15 mg of diazepam equivalents per day. In 13 of these episodes the drug was taken for insomnia only, in the remainder for anxiety and stress symptoms.

Psychotropic drug treatment of 41 patients in five year follow up period

Outcome	No of patients
No psychotropic drugs at any time	6
Other psychotropic drugs but no benzodiazepines	4
Initial failure to stop diazepam but stopped during follow up	4
Took benzodiazepines for some time (2 weeks-1 year)* but stopped before end of five years	13
Restarted benzodiazepines and was taking them at follow up	14

* Distributed between year 1 (3 patients), year 2 (7), year 3 (3), year 4 (1), and year 5 (2).

Comment

It is disturbing that, despite the widespread publicity about benzodiazepine dependence during the period of follow up, most of the patients received a prescription for a benzodiazepine. None the less, the practice of short term prescription was successful in many cases and not followed by a second period of dependence, and no patients required specialist help in coming off their drugs after their participation in the initial study. The continued use of benzodiazepines may also reflect the absence of satisfactory alternatives; once patients have derived benefit from, or been dependent on, benzodiazepines other drug and psychological treatments are rarely deemed a satisfactory substitute at times of subsequent stress. Although the patients' opinions were not sought formally at interview, none regarded the represcription of a benzodiazepine as wrong, although several were not aware of the nature of the drugs they had received.

The results suggest that benzodiazepines may still have a place in treating patients who have been taking long term treatment in the past. Although their use in

this group is not without risk and needs careful monitoring, many patients can take these drugs judiciously for short periods only.

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Exclude eclampsia early

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We report on a woman whose eclampsia was misdiagnosed.

Case report

A 35 year old West Indian woman was seen in the casualty department after having four seizures. She was an unmarried mother of one child and was on holiday in the United Kingdom. She was conscious and lucid and on direct questioning denied being pregnant. She was endorphic (weight 96 kg, height 163 cm), with a blood pressure of 135/65 mm Hg and 3+ proteinuria; she was considered to have generalised oedema. Findings on neurological examination were unremarkable.

Four hours after admission she had a seizure, characterised by tonic-clonic movements of her arms and legs, and was incontinent of urine. Her blood pressure was 200/130 mm Hg and her proteinuria persisted. She was given an intravenous bolus of diazepam, paracetamol, nifedipine, and frusemide. Investigations showed raised aspartate transaminase (53 U/l) and alkaline phosphatase (630 U/l) activities and a low serum albumin concentration (17 g/l). Results of haematological tests and urea and electrolyte concentrations were normal.

Because of her proteinuria, hypoalbuminaemia, and oedema she was given a high protein diet and her fluid balance was strictly controlled. Her weight fell from 96 kg to 89 kg. She was considered clinically to have ascites, and so on day 6 a drain was sited in her right flank; one litre of fluid was drained over 24 hours. A brain scan on day 7 showed a localised 2 cm lesion in the right parietal lobe with associated bilateral cerebral oedema, and a primary or secondary tumour was diagnosed provisionally. The fluid obtained by paracentesis was reported as containing chorionic or mesothelial cells. A pelvic mass was now palpable, and an ultrasound scan showed a fetus with no signs of life. She was referred to obstetricians.

A further scan showed a fetus with no signs of life and oligohydramnios. The patient's serum urate concentration was 728 μ mol/l, she had 3+ proteinuria, and her diastolic blood pressure was 128 mm Hg. Labour was induced with extra-amniotic prostaglandin, and her blood pressure was controlled with an

infusion of hydralazine. A fetus weighing 1100 g was delivered; the patient refused permission for a post-mortem examination. The postpartum period was uneventful, and she was subsequently discharged.

A repeat brain scan 21 days after the first did not show any lesion, and so a revised diagnosis of an intracerebral haemorrhage secondary to her hypertensive episode (eclampsia) was postulated.

Comment

Eclampsia is rare in the United Kingdom,¹ with an estimated incidence of less than 1 in 1000 deliveries. In black people it is more common and progresses more rapidly.² Most maternal deaths in England and Wales have been due to eclampsia or pre-eclampsia (though pulmonary embolism is now an equally common cause), with cerebral haemorrhage usually being the lethal event.³ In most cases (72%) of death due to eclampsia or pre-eclampsia the care (diagnosis and management) was considered to have been sub-standard,³ with half of the patients who died of eclampsia having had fits while in obstetric consultant units.

It is understandable that the diagnosis of eclampsia was delayed in our patient, especially as she denied being pregnant and was referred to a medical ward. The clinical diagnosis of ascites was remarkable as, although ascites is not uncommon in severe pre-eclampsia, it is generally diagnosed retrospectively at caesarean section or necropsy⁴ or prospectively by ultrasonography. The initial brain scan did not help in the diagnosis, probably because findings in eclampsia are non-specific.⁵ The revised diagnosis after repeat scanning, however, correlates with necropsy findings in most of the maternal deaths from hypertensive disease.³

This case serves to remind all doctors of the importance of considering and excluding all clinical conditions early when faced with a complex case. A regular review of reports of clinical audit, such as the Confidential Enquiry into Maternal Deaths, in leading journals might well improve matters.

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ONE HUNDRED YEARS AGO

The attention of the General Medical Council may with advantage be called during its present session to the communication from Mr J R Williams, LRCP, MRCS, which we publish in another column, concerning practice in British Columbia, from which it appears that registered British practitioners are now not entitled as such to practise in British Columbia,

but are compelled to pass an examination there in preliminary as well as final subjects. Not only are British diplomas thus disqualified from taking effect in a British colony, but it appears that a plain intimation is given that the intention is not only to set up an independent standard to judge of the fitness of medical men possessing a double British diploma to practise, but in effect to employ, also, such legislation with the view of prohibiting practice where it is considered that local interests require such prohibition. (*British Medical Journal* 1890;ii:1263.)