Intal-Compound

SIR,—How does Intal (plain) become Intal Co. (Dr. P. Hugh-Jones and others, 7 November, p. 366)? All but a dozen or so of three to four hundred patients who have started treatment on Intal plain (disodium cromoglycate) in this department have returned within a few months taking Intal Co. Also, we have yet to see a patient who has started treatment elsewhere who is taking Intal plain. We understand that unless the word "plain" is included in the prescription Intal Co. is usually dispensed; neither do the manufacturers advertise Intal plain as being generally available.

We would agree that many patients are taking Intal Co. at great cost solely for the relief they get from the small amount of isoprenaline it contains. In those patients who do benefit from inhaling disodium cromoglycate there is no doubt that in many the effect is greatly improved by the prior inhalation of a bronchodilator. We have found that the long-acting salbutamol or oriprenaline is particularly effective in enhancing and prolonging the action and thereby reducing the frequency of the dose.—We are, etc.,

CHARLES J. STEWART.
DAVID VAN ZWANENBERG.
MICHAEL BARRY.
D. P. F. EMBLETON.

St. Helen's Hospital,
Ipswich, Suffolk.

Information Service on Occupational Health

SIR,—Just over two years ago an information and advisory service was established at this Institute. Its objectives were to provide doctors, trades unionists, managers, and others with factual information, informed advice, or field studies on problems in occupational medicine and hygiene.¹

Analysis of the 196 requests for information so far received shows that while industry in the form of management, unions, and medical officers provided 85 and universities and other research bodies a further 24, no less than 46 have come from National Health Service doctors. Most of these questions have come from general practitioners, but some from hospitals and local health authorities. Fifteen have been referred via the Poisons Reference Service at Guy's Hospital. Classification of the requests by their nature has shown that two-thirds have concerned a very wide range of chemicals including proprietary substances, while the remainder have screening examinations, the effects of noise included topics such as working conditions, or glare, employment problems of disabled individuals, and selected bibliographies.

The advisory service, to which queries are referred when they cannot be answered by factual information alone, has received 61 requests, 36 from industry and nine from the N.H.S., but in contrast to the information queries, most of these nine have come from medical officers of health. The problems have included an investigation of respiratory symptoms arising from the manufacture of an enzyme detergent powder,² a study of headaches and migraine in printing workers,³ surveys of organizations to assess

their needs for occupational health services, and a number of environmental dust, solvent, vapour, and other measurements.

The policy of the Institute is that these services should attempt to become financially self-supporting. A charge is therefore made whenever possible to organizations other than trades unions, who already support the Institute through the T.U.C. grant to the London School of Hygiene and Tropical Medicine. In practice however—for various reasons—146 of the information queries, amongst them those from N.H.S. doctors, have been answered without charge, and the income from this source has been £330. This compares sadly with the £1,000 spent on reference material alone. The advisory service has been rather more successful, having earned nearly £7,000 from 30 sources.

In addition to expanding the existing services, future plans include educational activities directed at the large number of non-professional people who deal with problems of occupational health in their daily life. The main problem however will be financial.

The provision of this type of service may not be generally accepted as a proper function of a university department, but it is already being done by others. Our experience indicates that it widens the scope of our teaching, produces new problems for research, and helps industry and doctors in the National Health Service to deal with problems related to the health of people at work.—I am, etc.,

PETER TAYLOR.

T.U.C. Centenary Institute of
Occupational Health,
London School of Hygiene and
Tropical Medicine,
London W.C.1.

REFERENCES

- 1 London School of Hygiene and Tropical Medicine, *First Annual Report of the T.U.C. Centenary Institute of Occupational Health*, London, 1970.
- 2 Newhouse, M. L., Tagg, B., Pocock, S. J., and McEwan, A. C., *Lancet*, 1970, 1, 689.
- 3 Taylor, P. J., Pocock, S. J., Hall, S. A., and Waters, W. E., *British Journal of Industrial Medicine*, 1970, 27, 364.

Depression and Oral Contraception

SIR,—Dr. J. T. Hart (7 November, p. 367) suggests that women who use a diaphragm as a contraceptive method are temperamentally more stable than women taking the pill. His criticism draws attention to the great difficulties of finding a suitable control population when investigating the side effects of the pill, but I do not think that it invalidates our findings (17 October, p. 142). Our results showed that 6.6% of women taking the pill were more severely depressed than the control group, and whether this was the result of a more unstable experimental group or the converse is surely less relevant than the conclusion that the pill-taking population is more likely to develop severe depression.

The need for careful supervision of women on the pill is emphasized, and doctors should look for mental changes as part of a regular examination.—I am, etc.,

BRENDA HERZBERG.

West Park Hospital,
Epsom, Surrey.

Postpartum Renal Failure

SIR,—Dr. I. Timor-Tritsch and his colleagues (24 October, p. 221) describe a patient with pregnancy toxæmia who showed evidence of intravascular coagulation and recovered normal renal function after treatment with heparin and repeated haemodialysis. On the basis of a statement that postpartum renal failure causes irreversible renal insufficiency in most, if not all, cases, and that there have been no reports of successful treatment, they suggest that treatment with heparin probably prevented permanent renal damage.

Acute renal failure is an important problem in obstetrics, and because of the current interest in intravascular coagulation as a possible aetiological factor, and consequently in heparin as a method of treatment, it seems important to question the authors' interpretation of this case. It has been our experience that acute renal failure associated with severe toxæmia, which is not complicated by abruptio placentae, nearly always recovers, provided of course the patient is not permitted to die from electrolyte imbalance in the acute phase. The following is a summary of a recent case very similar to the one described.

A 29-year-old primigravida was admitted in labour at term. The blood pressure was 140/90 mm.Hg, but she could not provide urine for examination. She had a spontaneous delivery of a healthy infant two hours later. One eclamptic fit occurred 12 hours after delivery when the blood pressure was 150/110 and the urine (300 ml.) obtained by catheter contained massive amounts of protein. Anuria persisted for eight days, during which haemodialysis was performed on four occasions. The patient was discharged from hospital 17 days after delivery, and renal function was normal at three months: serum creatinine 0.8 mg./100 ml., urea 29 mg., and electrolytes within normal limits. Mid-stream urine and intravenous pyelogram were normal.

When assessing the likely outcome of a case of acute renal failure in obstetrics it is of vital importance to advert to the clinical circumstances in which it occurred. It is essential not to evaluate treatment in cases which have a very high rate of natural cure.—We are, etc.,

KIERAN O'DRISCOLL.
FRANCIS GEOGHEGAN.

National Maternity Hospital,
Dublin 2.

Postoperative Leg Vein Thrombosis

SIR,—Of course I agree with Mr. L. R. J. De Jode, and others (3 October, p. 56) and with Mr. G. F. Moloney and others (24 October, p. 244) that there are more causes of deep vein thrombosis than venous stasis. Broadly speaking venous thrombosis can be explained in terms of Virchow's triad: defects in the wall of the vein, a change in the chemical and cellular properties of the blood, and stagnation of the flow.

The number and anatomical sites of the defects in the walls of the deep veins of a patient's lower limbs cannot be known. We can neither discover whether there are, or are not, mural defects in the lower limb veins, let alone whether they are unilateral or bilateral. A little more can be found out about the chemical factors responsible for the clotting of blood and the increased stickiness of the platelets. The degree of