dition due to either a learned reaction or a continuing abnormality of the sort found often in LSD patients."

The above report is produced to demonstrate the unhappy state of affairs which supervened in a patient who had received ketamine for a routine minor surgical undertaking. It is fully conceded that a patient might well be made of the "psychotic stuff" which would breed a long-term disability from an experience which others might throw off in a matter of hours, but this patient's psychometric testing would show her to be relatively normal and, therefore, whatever mechanism produced the long lasting symptoms, attribution to the drug could not easily be denied.

I am grateful to Dr. John Slorach, consultant psychiatrist to Carlton Hayes Hospital for his help, and also to Mr. Derek Burton, psychologist.

—I am, etc.,

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An Antidysrhythmic Agent

SIR,—Dr. S. Oram and others' report (9 October, p. 113) on the use of verapamil (Cordilox) as an antidysrhythmic agent prompts us to report its use in a further patient with paroxysmal supraventricular tachycardia resistant to other treatment.

A 58-year-old man had been seen by us for 2½ years with paroxysmal supraventricular tachycardia after myocarditis of possible viral aetiology. The arrhythmia had failed to respond to various combinations of digoxin, lanatoside C, propranolol, practolol, quinidine, and atropine compounds. Over the last six months attacks lasting two minutes to 24 hours had become increasingly frequent with great reduction in the patient's exercise tolerance. Heart rate had varied from about 140 to 220 per minute. The electrocardiogram showed a short PR interval of 0.10 seconds, but the QRS width was not increased and there was no slurring of the R wave. A pre-excitation syndrome of the Wolff-Parkinson-White type was therefore not definitely confirmed.

A series of attacks precipitated admission and a moderately raised α -ketobutyric dehydrogenase in the next two days suggested some secondary myocardial damage. The patient was taking practolol 200 mg q.d.s. orally, but a further dose of 40 mg intravenously over 30 minutes failed to control the arrhythmia. Lignocaine 80 mg intravenously caused immediate reversion to sinus rhythm on two occasions, but a lignocaine infusion at 2 mg per minute did not prevent further supraventricular tachycardia.

Verapamil 5 mg in five minutes intravenously immediately produced atrial fibrillation at 110 per minute, and three minutes later sinus rhythm at 76 per minute. Verapamil 80 mg q.d.s. orally failed to maintain this, but with further verapamil 5 mg intravenously and 160 mg q.d.s. orally sinus rhythm has been maintained.

We would like to concur with Dr. Oram and colleagues that verapamil may be of use as an antidysrhythmic agent in arrhythmias, such as resistant paroxysmal supraventricular tachycardia.—We are, etc.,

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Visual Field Defect in Glaucoma

SIR,—A neuromechanical lesion is suggested as an aetiological factor in the visual field defect which occurs in glaucoma. The existing theory of arteriolar and capillary ischaemia, giving rise to both the central and peripheral scotomata, is questioned, since vitreous pressure transmitted to the retinal vessels is unlikely to have a particular predilection for the affected nerve fibres. The affected capillaries surrounding the optic cup are contiguous with those which are not affected until a considerably later stage. This implies that the vitreous would be exerting differing pressures at points separated by only fractions of a millimetre, which would seem to be improbable.

One common factor which the central and peripheral scotomata share is that the fibres from both take an almost elliptical course, the major axes of the two being at right angles. It is considered that with an increase in intraocular pressure some stretching of the sclera occurs. This is favoured by consideration of the following two items of evidence. Firstly, as the disease becomes advanced, refractive errors occur and are progressive with the increase in intraocular pressure. Secondly, in buphthalmos, where the young sclera is capable of far greater expansion, in view of the softer tissue in the child, a large degree of stretching occurs. Stretching of the sclera is accompanied by a corresponding increase in length of the adjacent nerve fibres. It is considered that those fibres which undergo the greatest increase in length per unit increase in surface area of the retina are those whose course most resembles an ellipse with its minor axis equal to half its major axis.

These are the fibres which are first damaged, and as the condition progresses recruitment occurs of the fibres on either side of these, with development of the characteristic horseshoe scotoma. That maximal damage occurs as the fibres run over the edge of the optic cup, in accordance with the observations of Siedel, is tenable from the physical consideration of distortion being maximal at that point. Pure mathematical proof of such a hypothesis is difficult to obtain because of the presence of so many independent physiological variables—e.g., inconstant thickness of the sclera. Also as there is a three-dimensional aspect to the course taken by the fibres they cannot exactly be co-ordinated with the mathematical theorems which prompted the above hypothesis. However, preliminary experimentation with elastic models has shown a remarkable degree of correlation with the above theory.—I am, etc.,

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Cremation Regulations

SIR,—Dr. T. O. P. D. LAWSON (23 October, p. 230) quite correctly ascertained that the force of Form E is to the effect that the issuing coroner is irrevocably satisfied that no further investigation, medical or otherwise, is required before actual cremation. As a crematorium medical referee he also relates his experience of several coroners who, appearing to doubt the practical wisdom of this, have been ready to afford him an opportunity to add his medical expertise to

the final decision to proceed with cremation.

I agree with both Dr. Lawson and Dr. H. C. Maingay (25 September, p. 770) that this practice is in accordance with common sense even if it is entirely contrary to the official view that a coroner with no medical knowledge or experience is completely competent to reach a final decision without it. With respect to them both I am equally of the opinion that if they on their side have only the pathologist's "Cause of Death" copied from the postmortem report upon which to make their final judgement they are not necessarily a great deal better off than a legal coroner.

As Dr. Lawson says, "Let us hope that the Brodrick Committee will recommend a satisfactory solution to this problem," and it is to be hoped that it will bear in mind that it includes cases where disposal is by burial. At present, unless a coroner happens to be medically qualified, all death certificates he issues are final and inevitably lack the sort of medical validity a general practitioner like Dr. Maingay feels desirable. This situation has itself arisen out of the great preponderance of purely legal coroners, and even though some of them are evidently beginning to take account of its weakness I expect it to be perpetuated by the Brodrick Committee. Indeed it is said that the committee even considered a suggestion that coroners should never be medical men.—I am, etc.,

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Cot Deaths

SIR,—I must disagree with the opinion expressed in your leading article on cot deaths (30 October, p. 250). The recommendation that babies be placed on their sides or backs is just what must be avoided. It is in this position that the airway is most liable to obstruction by the tongue, and aspiration of regurgitated material is bound to occur. Laryngeal spasm may be caused by regurgitated material or food debris in the oropharynx touching the true or false vocal cords.

Babies should be put in their cots lying prone. They will reflexly turn their heads to the side, the airway will not be obstructed, and aspiration cannot occur. Surely this is how postoperative and comatose patients have been nursed for years.

There is no evidence that the work of breathing is increased in the prone position, as your article suggests, neither is there any reason to suppose that the respiratory difficulty of babies who succumb is due to inadequate power of the respiratory muscles.

I repeat, babies should sleep prone.—I am, etc.,

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Mental Deficiency Nursing

SIR,—I have read with great interest the letter by Dr. D. A. Spencer (30 October, p. 301). I would like to take this opportunity of reiterating this view in everything he has said, particularly in respect of his statement that in planning for the mentally handicapped, doctors, nurses, and parents are least consulted. I am glad to say that in Wales, at least, there is beginning to appear