the Jordan Hospital over the course of 11 years, may represent a typical cross-section of more or less sophisticated patients in a Western institutional setting, and their troubles may indeed be unrelated to dapson. This inference, however, does not invalidate the reports that acute psychosis occurred with some frequency when dapson was given in high dosage in the early days, and that it is seen in a small but definite proportion of patients taking 100 mg or less daily.

It would be interesting to ascertain if psychotic episodes, apparently dapson-related, have been noted in patients taking the drug for such conditions as dermatitis herpetiformis, deep mycetoma, etc.—I am, etc.,

S. G. BROWNE

London W.1

¹ Jopling, W. H., *London Clinic Medical Journal*, 1963, 4, No. 2, 47.

Prophylaxis of Supraventricular Tachycardia

SIR,—The recent Therapeutic Conference on supraventricular tachycardia (6 November, p. 354, and 13 November, p. 419) prompted me into writing this personal account of the prophylactic use of oral practolol in paroxysmal atrial tachycardia.

I have suffered from this condition since early childhood. It is typically aggravated by ethanol, smoking, lack of sleep, and mental excitement, and is always precipitated by strenuous physical activity. The paroxysms occurred approximately once a fortnight and usually lasted less than an hour, but occasionally persisted for 12 hours or more. E.C.G.s showed atrial tachycardia without any evidence of Wolff-Parkinsonism-White syndrome. The paroxysms could occasionally be curtailed by physical manoeuvres designed to stimulate the vagal nerve, but usually required oral quinidine, digoxin, or phenytoin to abort an attack. The use of these drugs either as a single dose or in a protracted course had no prophylactic effect. Propranolol in a dose of 10 mg t.d.s. resulted in depression and lassitude and only occasionally prevented paroxysms.

Practolol taken as a single dose of 100–150 mg ground to a powder taken two to three hours before strenuous physical activity, such as a game of football or squash, has been almost completely successful in preventing a paroxysm of tachycardia and has not resulted in any symptoms.

For the young patient with predominantly stress-induced paroxysmal atrial tachycardia a prophylactic regimen of this kind is eminently preferable to continuous drug therapy.—I am, etc.,

A. W. SEGAL

Northwick Park Hospital,
Harrow, Middx

Cot Deaths and Deficiency of Vitamin E and Selenium

SIR,—The young of about 40 mammalian and bird species cannot tolerate vitamin E and selenium deficiency. The pathology of their various fatal diseases is very different, species by species, because of variation in the susceptibility of tissues. However, they are all characterized by effusion, haemorrhage, and necrosis of cells.

Low vitamin E blood levels are usual in bottle fed infants, and Millar and Sheppard¹ of this laboratory have recently measured

differences between the selenium content of human and cow milks. There is evidence of respiratory failure in cot death victims² and if the human pulmonary capillary endothelium is first susceptible to the degeneration characteristic of the veterinary deficiencies, sometimes single, and sometimes dual, I have proposed^{3,4} that changed permeability to gases and liquids could prove fatal before there was visible change, even with the aid of light microscopy. In 1949 Owens and Owens⁵ demonstrated a potent vitamin E activity for infants in the prevention of retrolental fibroplasia after they had observed similarity between its pathology and epidemiology and those of vitamin E deficiency diseases of chickens and rats. Their finding lost importance when the role of oxygen in this disease was appreciated, soon afterwards, and has not been justly referred to in the retrolental fibroplasia literature. More male than female infants are affected, as is the case with the sudden infant death syndrome. For both syndromes the age of victims is similar. Patz⁶ has recorded that one-fourth to one-half per cent of retrolental fibroplasia cases occur without oxygen therapy. This is about the incidence of cot death.

In New Zealand, for the first time on a large scale anywhere, infants are now receiving a vitamin E supplement in Karilac (lactose) and in Glaxo formulae. The Meade Johnson and Wyeth ones have long been supplemented but are not very widely used. Future victims will be classified according to their vitamin E nutrition.—I am, etc.,

D. F. L. MONEY

Superintendent, Animal Health Laboratory

Wallaceville Animal Research Centre,
Wellington, New Zealand

¹ Millar, K. R., and Sheppard, A. D., *New Zealand Medical Journal*, 1970, 72, 417.

² Bergman, A. B., Beckwith, J. B., and Ray, C. G., eds., *Proceedings of the Second International Conference on Causes of Sudden Death in Infants*. Seattle and London, University of Washington Press, 1970.

³ Money, D. F. L., *New Zealand Medical Journal*, 1970, 71, 32.

⁴ Money, D. F. L., *Journal of Pediatrics*, 1970, 77, 165.

⁵ Owens, W. C., and Owens, E. U., *American Journal of Ophthalmology*, 1949, 32, 1631.

⁶ Patz, A., *The Sight Saving Review*, 1966, 36, 67.

Preclinical Salaries

SIR,—We share the concern expressed by Dr. B. F. Martin and his colleagues (23 October, p. 236) and other recent correspondents regarding the number of medical graduates on the permanent staffs of preclinical departments in our medical schools. As your correspondents have indicated, this is a double problem. Recruitment of medical graduates to these departments has declined and continues to do so, and also many medical graduates have left these departments for overseas or clinical appointments.

The only way in which many universities can attract medical graduates to preclinical departments is by making appointments at a starting salary higher than the minimum point of the lecturer scale. This has succeeded in bringing into preclinical departments young medical graduates who are willing to undertake some teaching duties while they study for the primary F.R.C.S. examination or, occasionally, for a higher academic degree. However, these people are very much aware that career prospects in preclinical departments compare unfavourably with those elsewhere in the medical profession, and they seldom stay long. On appointment they

usually have little or no experience in either teaching or research and can make only a limited contribution to the teaching and research activities of these departments. Just as they are gaining in experience they depart for more promising or rewarding careers elsewhere.

Any decline in the number of medical graduates holding permanent appointments on the staffs of preclinical departments, coupled with the expansion of medical schools and the reduction in the time available to teach preclinical subjects, must inevitably lead to a change in the orientation of preclinical courses. We believe such a change will be to the detriment of medical education as a whole. The present emphasis on teaching those aspects of preclinical subjects that are of particular relevance in clinical medicine can be maintained only if a sufficient number of medical graduates take up a career in preclinical departments.

In terms of career prospects the gap between preclinical staffs and other sections of the profession widens with every salary review. This gap can be measured not only in terms of immediate financial reward, but in the prospect of achieving a position of highest seniority, responsibility, and status. If, therefore, the medical profession as a whole shares our concern for the quality of preclinical medical education in this country, then it must use its weight to support an urgent campaign for improvement in the career prospects for medically qualified preclinical staff.—We are, etc.,

G. W. ATHERTON

E. J. CLEGG

D. J. GOLDSTEIN

M. C. HAYES-ALLEN

N. T. JAMES

D. MAYOR

F. C. TRING

C. F. A. WHELAN

Department of Human Biology and Anatomy,
University of Sheffield

Specimens from the Female Genital Tract

SIR,—The purpose of our letter (16 October, p. 170) describing an improved method of specimen collection from the female genital tract seems to have been misunderstood by Dr. W. H. Hughes and Mr. J. M. Davies (13 November, p. 424). We wish to ascertain in the female population the true extent of infection with genital pathogens—including the gonococcus but by no means limited to this organism. At the same time, we certainly have no desire to increase the pressure on our already overworked special clinics. It was for these very reasons that we recommended the use of our convenient new swabbing method in general practice.

Dr. Hughes and Mr. Davies suggest that if a woman's regular male partner has not developed gonorrhoea then she has no reason to fear that she is carrying the infection. This is true as far as it goes, but they do not mention the possibility of a male partner becoming infected, though without symptoms. Even in the male, asymptomatic gonorrhoea is far from rare, and the more carefully it is looked for the more frequently it will be found. One such asymptomatic man was found to be responsible for infecting 22 people.²

In fact, Dr. Hughes and Mr. Davies have indicated the probable high frequency of undiagnosed genital infections according to their results on 1,000 women who were not suspected of having gonorrhoea. Their discovery of a 19% incidence of specific infection, and possibly a similar amount of non-

specific infection, seems a convincing argument for routine testing by general practitioners of the sexually-active women patients on their lists. Even if a large majority of women examined should prove to be free from any form of genital infection, routine screening programmes—wherever carried out—offer the only means of eventually controlling sexually-transmitted disease.—We are, etc.,

S. SELWYN
J. K. OATES

Westminster Medical School and Hospital,
London S.W.1

¹ Pariser, H., Farmer, A. D., and Marino, A. F., *Southern Medical Journal*, 1964, 57, 688.

² Benfield, J. M., *Community Medicine*, 1971, 126, 168.

Diagnosis of Appendicitis

SIR,—I was interested in the simple and practical points Mr. G. D. F. McFadden (13 November, p. 430) mentions in connexion with the diagnosis of appendicitis. But he states that he has failed to see in print that coughing often causes pain in acute appendicitis. In recent editions of *Short Practice of Surgery* this test has been described, and in the last edition reference is made on page 984.¹

The other points mentioned in the letter are also very useful guides in the diagnosis of acute appendicitis.—I am, etc.,

MCNEILL LOVE

Brickendon, Hertford

¹ Bailey, H., and McNeill Love, R. J., *Short Practice of Surgery*, 15th ed. London, H. K. Lewis and Co., 1971.

Cavernous Chylangioma of Jejunal Mesentery

SIR,—Mr. E. S. Field's account (3 April, p. 27) reminds me of a girl of 12 whom I explored in 1961 for suspected appendicitis. A loop of plum-coloured, fibrin-coated ileum had to be resected as it was clearly in jeopardy. The related mesentery was a mass of chylous vessels which were obstructing venous drainage. On opening the bowel, the mucosa presented a remarkable white papillary surface like the head of a cauliflower—the engorged villi were visible to the naked eye.

Alas! Ill-advised deep-freezing spoiled the specimen for posterity, but the appearances still seem worth recording.—I am, etc.,

A. C. BRANFOOT

Department of Morbid Anatomy,
Westminster School of Medicine,
University of London,
London S.W.1

The Lungs in Ankylosing Spondylitis

SIR,—Your leading article (28 August, p. 492) now accepts upper lobe fibrosis as an occasional feature of this systemic disorder. It would be premature to assume that this is part of the primary pathological process in view of the non-specific lung histology. Furthermore, such fibrosis is not necessarily of ominous significance, since in one case I reported¹ bilateral upper lobe fibrosis has existed for 21 years with little pulmonary disability except for an intercurrent aspergilloma.

Manometric studies have shown a very high incidence of impaired oesophageal motor

function in patients with ankylosing spondylitis.² One may speculate that these may predispose to aspiration pneumonitis, especially in the upper lobes, where mechanical ventilation is defective. The association of such pulmonary abnormalities and ankylosing spondylitis calls for a careful radiographic and manometric assessment of oesophageal motor function, even when symptoms do not point to a primary oesophageal disorder.—I am, etc.,

B. A. SCOBIE

Gastroenterology Unit,
Wellington Hospital,
Wellington, New Zealand

¹ Scobie, B. A., *Australasian Annals of Medicine*, 1970, 19, 131.

² Scobie, B. A., in *Proceedings of the Third Asian-Pacific Congress of Gastroenterology*, Melbourne, Vol. 1, p. 263, 1968.

Diazoxide and Hypertension

SIR,—Over the past five years intravenous diazoxide has been our first choice for the emergency treatment of severe hypertension with renal failure. We confirm the satisfactory results now reported by Drs. J. E. F. Pohl and H. Thurston (16 October, p. 142).

Since these authors presented their work at the Medical Research Society¹ we have also used diazoxide orally for long-term management. It has been given to patients suffering from severe renovascular hypertension, many of whom had severe postural hypotension while on treatment with conventional hypotensive agents. By using diazoxide in addition to methyldopa and or bethanidine it has been possible to obtain control with a small dose (100–200 mg daily) and we have not so far encountered hyperglycaemia requiring tolbutamide therapy. With this combination it has also been possible to reduce the dose of methyldopa and bethanidine and thereby reduce the incidence of side effects.—We are, etc.,

L. H. SEVITT
D. K. PETERS

Department of Medicine,
Royal Postgraduate Medical School,
London W.12

¹ Pohl, J. E. F., and Thurston, H., *Clinical Science*, 1971, 40, 11.

Anticoagulant Interactions

SIR,—May I be allowed to clarify some points of detail in the leading article (16 October, p. 128) "Anticoagulant Interactions"?

The question of chloral hydrate-warfarin interactions is at present very much debated. Sellers and Koch-Weser's work indicated that a chloral hydrate metabolite, trichloroacetic acid, and not chloral hydrate itself caused warfarin displacement from albumin binding sites.^{1–3} A similar chloral hydrate induced potentiation of warfarin has now been reported by Weiner,⁴ though this observation was made only on a single patient.

Recently, however, several groups of workers have failed to observe any potentiation of warfarin by chloral hydrate.^{5–7} Griner and his co-workers stating that "the clinical significance of any interaction between warfarin and chloral hydrate is negligible for patients receiving long-term therapy with warfarin under the conditions of this study." The last few words of this statement are perhaps the most significant. Sellers and

Koch-Weser⁸ have countered these results by asserting that the potentiation occurs soon after chloral hydrate administration and will only be transient, but still of clinical significance.

One interesting factor which arises in comparing these studies is that Sellers and Koch-Weser's work was carried out using healthy volunteers, while the authors who failed to observe any potentiation of warfarin by chloral hydrate carried out their studies on patients who were already receiving long-term warfarin therapy for various conditions. The single case observed by Weiner does, however, fail to fit this pattern.

The fatal haemorrhage which Cucinell *et al.*⁹ suggested was caused by chloral hydrate reducing the anticoagulant effect was observed with a combination of chloral hydrate and bishydroxycoumarin. Here there is always the possibility of a different mechanism of interaction.—I am, etc.,

P. F. COOPER

Uxbridge, Middx

¹ Sellers, E. M., and Koch-Weser, J., *New England Journal of Medicine*, 1970, 283, 827.

² Sellers, E. M., and Koch-Weser, J., *Annals of the New York Academy of Sciences*, 1971, 179, 213.

³ *British Medical Journal*, 1971, 1, 360.

⁴ Weiner, M., *Annals of the New York Academy of Sciences*, 1971, 179, 226.

⁵ Griner, P. F., Raisz, L. G., Rickles, F. R., Wiesner, P. J., and Odoroff, C. L., *Annals of Internal Medicine*, 1971, 74, 540.

⁶ Udall, J. A., *Annals of Internal Medicine*, 1971, 75, 141.

⁷ Breckenridge, A., Orme, M. L'E., Thorgerisson, S., Davies, D. S., and Brooks, R. V., *Clinical Science*, 1971, 40, 351.

⁸ Koch-Weser, J., and Sellers, E. M., *Annals of Internal Medicine*, 1971, 75, 141.

⁹ Cucinell, S. A., Odessky, L., Weiss, M., and Dayton, P. G., *Journal of the American Medical Association*, 1966, 197, 366.

Hazards of Colostomy Closure

SIR,—Your leading article on the "Hazards of Colostomy Closure" (13 November, p. 380) offers much needed wisdom on this procedure, which is all too often regarded as easy and safe when compared with resection of the colon. May I draw your attention to another hazard of colostomy closure which can be disastrous; this is the development of postoperative infective diarrhoea. Patients who have previously had no such trouble may develop this owing to the activation of organisms present in the bowel at the time of operation. The most dangerous of these in our experience in *Clostridium welchii*. To prevent these hazards a swab should be taken from colostomies prior to closure, or a routine single dose of penicillin given on the day of operation.—I am, etc.,

G. T. WATTS

Edgbaston,
Birmingham 15

Hamster-hair Hypersensitivity

SIR,—May I suggest that the onset of asthma in Dr. J. A. Wilson's Case 3 (6 November, p. 341), as well as the failure to improve when the hamsters were removed, was due to coincidental disease of the adrenals. Dr. Green and I¹ reported two patients with Addison's disease who presented with asthma, and postulated that their asthmatic tendency had been unmasked by deteriorating adrenal cortical function.

The "striking adrenal cortical atrophy" found at necropsy may have been due to Addison's disease rather than to cortico-