weeks' duration or more or where fibrotic reactions appeared to be marked. (2) Diazepam 5 mg three times daily. (3) Anti-inflammatory drugs (phenylbutazone). The effect of the diagnostic injection of lignocaine lasted a few hours to a few days and was rarely permanent. Early return of pain was a poor prognostic sign. Injections of lignocaine and 1% alcohol once a week with medication cleared 60% of the symptoms in six weeks and 90% in 12 weeks. Headaches were often devastating initially but resolved more rapidly than the neck and back symptoms.

In 26 patients serious bone and brain injuries were identified; two of these died and six were operated on. Twenty patients showed objective signs of lumbar intervertebral disc rupture with nerve root compression, but only three were operated on, as their symptoms resolved over a period with conservative management by injection. —I am, etc.,

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Mixed Connective Tissue Disease

SIR,—Your leading article (11 November, p. 315) shows that the delineation of "mixed connective tissue disease"¹ as a distinct entity appears at present to be rather more than an exercise in nosology. It remains to be seen, however, whether or not further experience will blur the edges of the currently fairly clear-cut situation.

Among the classical connective tissue diseases, progressive systemic sclerosis showing features of systemic lupus erythematosus (S.L.E.)² can provide diagnostic problems. In 1965 we³ drew attention to the occurrence in S.L.E. of small stiff lungs giving rise to severe dyspnoea. It is now apparent that "lupus lung" is not specific for S.L.E. but can occur in systemic sclerosis, as the following case report shows.

A 55-year-old Italian housewife presented in October 1968 with a two-month history of bilateral Raynaud's phenomenon and severe ischaemia of a finger-tip. She was known to have a hiatus hernia and had taken amphetamines (Durophet) for many years as an anorectic. In December 1968 she was admitted to another hospital with pleurisy, fever, and consolidation of the right lower lobe of the lung, which cleared after 10 days. In January 1969 she complained of severe breathlessness on slight exertion. Her left diaphragm was now elevated and later a linear shadow appeared at the left base. Her respiratory function was impaired: FEV₁ 1.0 l., FVC 1.5 l. A lung scan was suggestive of multiple pulmonary emboli.

In May 1969 she was severely dyspnoeic at rest and unable to climb stairs. There was pain in the lumbar and shoulder regions, especially on deep breathing, together with severe Raynaud's phenomenon. She later brought up undigested food and gave a history of dysphagia for some months. On examination her fingers looked sclerodermatous. Heart and lungs were clinically normal, blood pressure 130/80 mm Hg. There was no evidence of pulmonary hypertension. Investigations: Hb 14.9 g/100 ml, W.B.C. 6,800 mm³, differential normal, E.S.R. 10–20 mm in 1 hr. Tests for antinuclear factor, L.E. cells, and rheumatoid factor (latex) negative. Serum flocculation tests strongly positive. Chest x-ray showed bilateral high diaphragms with linear basal shadows. E.C.G., right heart catheterization, and pulmonary angiogram normal. FEV₁ 0.5 l., FVC 0.9 l. Skin biopsy not diagnostic. Barium swallow suggestive of systemic

sclerosis. Blood urea and electrolytes and urine analysis normal.

She was treated initially with warfarin and later with prednisone, on which she felt less breathless. Her respiratory function tests improved a little. She had several episodes of nocturnal pulmonary aspiration, in one of which she had a cardiac arrest and died in August 1969.

Postmortem showed the classical histological changes of systemic sclerosis in the skin and oesophagus. The lungs showed changes of chronic bronchitis but no evidence of pulmonary fibrosis, embolism, infarction, or arteritis. The heart, pericardium, and pleural spaces were normal.

This patient had a fulminating disease, dying of progressive systemic sclerosis less than 12 months after her initial symptoms. The chest picture, with severe breathlessness, gross restrictive impairment of ventilation, a radiological picture resembling pulmonary infarction, and the absence of specific lung pathology was identical to that found in S.L.E.³ There are thus at least two causes for dyspnoea in progressive systemic sclerosis in addition to the well-recognized pulmonary fibrosis. One is pulmonary arteritis,⁴ the other "lupus lung." —I am, etc.,

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- 1 Sharp, G. C., Irvin, W. S., Tan, E. M., Gould, R. G., and Holman, H. R., *American Journal of Medicine*, 1972, 52, 148.
- 2 Dubois, E. L., Chandor, S., Friou, G. J., and Bischoff, M., *Medicine*, 1971, 50, 199.
- 3 Hoffbrand B. I., and Beck, E. R., *British Medical Journal*, 1965, 1, 1273.
- 4 Case Records of the Massachusetts General Hospital, *New England Journal of Medicine*, 1972, 286, 91.

Poisoning Treatment Centres

SIR,—We were interested to read the article by Dr. Peter Kennedy, (4 November, p. 255) comparing the prognosis in paracetamides admitted to a poisoning treatment centre with that in those treated by a psychiatrist as an outpatient or by a general practitioner.

In a recent paper¹ we described the medical aspects of acute poisoning as seen in a general medical unit and showed that the results compared favourably with those obtained in more sophisticated centres. The social and environmental aspects of acute poisoning in the same area have also been described.² Of 131 patients admitted to our unit during 1970 after attempted suicide, only 11 (8.4%) had a further episode during 1970–1. Our recurrence rate is thus lower than Dr. Kennedy's figure of 13% despite the fact that we have included all our patients admitted in 1970 (not merely those admitted for the first time), and we have included recurrences in these patients until the end of 1971 rather than 1970. This low recurrence rate in a general medical unit without immediate psychiatric cover suggests that Dr. Kennedy is justified in being cautious about his conclusion that special units like the one in Edinburgh should be set up in other regions.

Dr. Kennedy compared only the results of management in a regional poisoning treatment centre with outpatient psychiatric care and general practitioner care. It would have been more reasonable to compare treatment in general hospitals (where most patients with self-poisoning are still treated) with treatment at home or in a sophisticated centre. It is possible that admission to hos-

pital, by temporarily withdrawing the patient from a hostile environment, may be therapeutic quite apart from psychiatric intervention. In contrast to Dr. Kennedy, we concluded¹ that it was "possible to treat successfully the vast majority of acutely poisoned patients in any general medical unit." This statement was concerned primarily with medical treatment, but we feel it is also applicable to psychiatric intervention.

We would continue to support the concept of a limited number of Regional Poisoning Treatment Centres as areas where sophisticated toxicological and epidemiological studies can be performed, but there seems little justification for the full implementation of the Hill Report.³—We are, etc.,

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Milesmark Hospital,
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- 1 Lawson, A. A. H., and Mitchell, I., *British Medical Journal*, 1972, 4, 153.
- 2 Mitchell, I., and Lawson, A. A. H., *Community Medicine*, in press.
- 3 Department of Health and Social Security, Central and Scottish Health Services Councils, *Hospital Treatment of Acute Poisoning*, London, H.M.S.O., 1968.

Herpes Simplex Encephalitis

SIR,—In the interesting and important paper by Dr. A. D. Dayan and others (18 November, p. 405) there is a reference to our work¹ which is flattering but inaccurate. In our series of electroencephalographic findings in herpes simplex encephalitis (which is the largest series in the literature) we found that the electroencephalogram reflects the severity of the illness and the site of maximum damage rather than the pathology. We also pointed out that similar changes may be seen in cerebrovascular disease, raised intracranial pressure, and other conditions. The electroencephalogram in herpes simplex encephalitis is only "diagnostic" in the sense that it may help to make the diagnosis, but we would like to stress that the electroencephalographic findings are in no way pathognomonic.—We are, etc.,

L. S. ILLIS

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Southampton General Hospital,
Southampton

- 1 Illis, L. S., and Taylor, F. M., *Lancet*, 1972, 1, 718.

Causes of Failure in Antibiotic Treatment

SIR,—Professor L. P. Garrod (25 November, p. 473) points out that Mr. D. S. Tindal and I¹ did not say how many wound infections in a controlled series of patients given a single parenteral dose of ampicillin were due to penicillin-resistant staphylococci.

We were concerned only with the clinical control of wound infections, and in many cases pus swabs were not taken. A few swabs grew more than one organism. Altogether, 164 patients were given ampicillin and there were 22 infections. In 12 cases no pus swab was taken and in four it was sterile. Five patients were infected with staphylococci insensitive to ampicillin and two had coliform organisms, also insensitive to ampicillin. In the control series of 185 patients not given ampicillin, 25 developed a wound infection. In 12 cases no

swab was taken, in four the pus grew staphylococci sensitive to ampicillin, and in two staphylococci insensitive to ampicillin were grown. Eleven grew coliform organisms; six of these were sensitive to ampicillin and the other five not.

Professor Garrod's conclusion that the failure of ampicillin in this series may have been due to the presence of resistant organisms seems to be supported by the present analysis. I regret it is not more complete.—I am, etc.,

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¹ Pollock, A. V., and Tindal, O. S., *British Journal of Surgery*, 1972, 59, 98.

Causes of Failure in Antibiotic Treatment

SIR,—Professor L. P. Garrod's article (25 November, p. 473) was both informative and interesting, with many important points relevant to current practical problems of antibiotic therapy.

One point needs clarification however. Professor Garrod affirms his strong belief that bacteriostatic and bactericidal drugs in combination should *always* be avoided. Most bacteriologists would agree with him in principle, but a few necessary exceptions must be made. A well-established example of combined therapy with bactericidal and bacteriostatic drugs is in the standard treatment of tuberculosis with streptomycin and isoniazid (both bactericidal) and PAS (bacteriostatic).

Should not an exception also be made in the treatment of brucellosis, especially since co-trimoxazole has not proved to be as effective as was first hoped?¹ Richardson and Holt² have shown a degree of synergism in the action of streptomycin and tetracycline (bacteriostatic) on intracellular *Brucella abortus* in tissue culture, and clinically the combination of streptomycin and tetracycline appears to be the most effective treatment we have for brucellosis.³ Would Professor Garrod agree that brucellosis is another exception, or what treatment would he recommend for acute brucellosis?—I am, etc.,

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¹ Hassan, A., Erian, M. M., Farid, Z., Hathout, S. D., and Sorensen, K., *British Medical Journal*, 1971, 3, 159.

² Richardson, M., and Holt, J. N., *Journal of Bacteriology*, 1962, 84, 638.

³ Williams, E., *Lancet*, 1970, 2, 604.

Infertility after the Pill

SIR,—I agree with Mr. E. E. Philipp (4 November, p. 294) that the two or three-day hormonal tests for the diagnosis or exclusion of pregnancy are uncertain. They cause unnecessary delay with increasing risks to the patient if the question of termination is being considered. I would, however, not go as far as condemning the use of these preparations altogether.

In cases of amenorrhoea after the pill the possibility of a missed abortion may also have to be considered. A negative pregnancy test does not rule it out, but a negative pregnancy test after amenorrhoea of at least 6 weeks, followed by withdrawal bleeding after two to three days' administration

of an oestrogen-progestogen preparation, excludes a missed abortion and may be followed by resumption of regular menstrual cycles.—I am, etc.,

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General Knowledge of Cancer

SIR,—One welcomes a leading article on such a subject as "General Knowledge of Cancer" (18 November, p. 381) with comment on the valuable work carried out in Manchester with the support of the Department of Health and Social Security and in south-east Wales by the Tenovus Cancer Information Centre in Cardiff. It is a pity that you did not mention the latest publication of the Manchester survey, as Dr. John Wakefield has provided a masterly review of the social behaviour analysis in the Manchester region, and also that no comment was made on the other organizations which have done so much stalwart work in the field of publicity and health education.

What is more significant than the results given in your leading article is the fact that at long last the cancer research organizations and the D.H.S.S. are beginning to provide funds for this vital area of research into publicity, education, and the analysis of population response. For all too long cancer information and prevention organizations have had to manage on what they could obtain through meagre fund-raising efforts of their own, with an occasional donation from certain munificent or dedicated trusts. I refer especially to the Women's National Cancer Control Campaign, started in 1964, which now, with Sir John Peel as president and Lady Llewelyn-Davies as chairman, is supporting screening programmes in numerous boroughs and counties with both static and mobile caravan clinics, and is providing a substantial programme of information, education, and the preparation of a population for a screening programme. It is only by proper pre-selection and preparation of the target population that prescriptive screening will achieve an acceptable priority in competing for the limited N.H.S. funds. But it is the multiple and varied approach to the different herd groups that creates the greater population response and the best economic result.

It is fortunate that such organizations as the W.N.C.C.C. and other more regional ones are now being taken under the wing of the Health Education Council and British Cancer Council, with direct financial support. It is to be hoped that these funds will increase in the future. With judicious control and advice these voluntary organizations will provide an inestimable service in the field of preventive disease.—I am, etc.,

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Corticosteroids in Retroperitoneal Fibrosis

SIR,—Ureteric catheterization is necessary in most cases of retroperitoneal fibrosis both as a diagnostic step and for kidney drainage in renal obstruction. We report a case here which suggests that if corticosteroid therapy

is given at the time of catheterization and maintained afterwards further surgical intervention for ureteric obstruction may be avoided. Opinions differ on whether corticosteroids can be a substitute for surgery or only adjunctive to it.¹⁻⁷

A 68-year-old man was admitted to hospital complaining of lower abdominal discomfort and backache of eight week's duration. He had a persisting pyrexia, a raised E.S.R., and serum albumin of 2.3 g/100 ml in total serum proteins of 6.8 g/100 ml. Anuria developed suddenly after 27 days. This responded at first to intravenous diuretics, but after 48 hours there was almost complete anuria and the blood urea, previously normal, rose to 230 mg/100 ml. The intravenous pyelogram appearances were compatible with bilateral ureteric obstruction. Cystoscopy and bilateral ureteric catheterization confirmed that the bladder was empty and a free flow of urine was obtained from both catheters. Anuria again developed when the catheters were withdrawn after 36 hours, and further drainage was necessary. Bilateral ureterolysis was performed a fortnight later, when the blood urea was 77 mg/100 ml. The patient was discharged after 24 days. He was passing urine normally, the blood urea was 23 mg/100 ml, and the E.S.R. 4 mm/1 hr.

Six months later he complained of feeling unwell and two months after that the E.S.R. was 120 mm/1 hr and the blood urea 76 mg/100 ml. After ensuring that the urine was not infected, treatment with prednisolone 40 mg daily was begun. Improvement in the subjective symptoms was dramatic and has been sustained for 14 months. During the past 10 months the maintenance dose of prednisolone has been 5 mg twice daily. The E.S.R. is now 44 mm/1 hr and the blood urea 65 mg/100 ml.—We are, etc.,

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¹ Ross, J. C., and Tinckler, L. F., *British Journal of Surgery*, 1958, 46, 58.

² O'Regan, R., Treahy, P. A., and Prior, I. A. M., *New Zealand Medical Journal*, 1961, 60, 518.

³ Chew, C. K., Jarzyllo, S. V., and Valberg, L. S., *Canadian Medical Association Journal*, 1966, 95, 1183.

⁴ Charlton, C. A. C., *Proceedings of the Royal Society of Medicine*, 1968, 61, 875.

⁵ Buckberg, G. D., Dilley, R. B., and Lomomire, W. P., *Surgery, Gynecology and Obstetrics*, 1966, 123, 729.

⁶ Mitchinson, M. J., Withycombe, J. F. T., and Arden Jones, R., *British Journal of Urology*, 1971, 43, 444.

⁷ Morandi, L. P., and Grob, P. J., *Archives of Internal Medicine*, 1971, 128, 295.

Pulmonary Aspiration after Fibre-endoscopy

SIR,—I was interested in the article (4 November, p. 269) entitled "Pulmonary Aspiration after Fibre-endoscopy of the Upper Gastrointestinal Tract" by Drs. B. J. Prout and C. Metreweli and, in particular, in the technique of preparing the patient for the procedure.

The analgesic-sedative technique used in this hospital for fiberoptic gastroscopy consists of conventional premedication (pethidine and atropine) followed just before the procedure by an intravenous injection of a mixture containing 0.05-0.1 mg of fentanyl and 5-10 mg of droperidol. This is followed by the intravenous injection of diazepam in a dosage sufficient to cause drowsiness, usually less