our epileptic patients who died during sleep. Both were found with their faces buried in their pillows and postmortem examinations confirmed that they had died of suffocation, presumably in the course of a grand mal seizure. Subsequently three further cases from different parts of the country came to our notice.

Since these deaths usually occur in the home, information about them is difficult to acquire, though such an event, with its inevitable heart-searchings and background of tragedy, is not readily forgotten. In an attempt to determine the frequency of suffocation in their pillows as the cause of death in these unfortunate patients, therefore, the 48 general practitioners in Dumfriesshire were circulated to find out whether they had knowledge of any such cases in the past 10 years. All the questionnaires were returned and two further cases were identified. Thus in 10 years, in a population of about 89,500, four such cases had occurred, or, if this incidence was typical, over 20 cases each year in Scotland or 200 in the U.K. All but one of the seven victims identified were young or middle-aged males.

What of the prevention of this unfortunate complication of grand mal epilepsy? The obvious solution would seem to be the provision of some kind of smother-proof pillow such as was introduced some years ago for babies. As a result of our original report[1] such pillows have already been introduced to a hostel in Edinburgh for epileptic women, while the Epileptic Institute in Heemstede have taken this precaution for some time. In none of the cases so far identified was such a pillow used, and study of this series of cases would suggest that provision of suitable smother-proof pillows could prevent the occurrence of further cases. In this book *Epilepsy and Convulsive Disorders in Children* Bridge[2] makes the recommendation, referring presumably to children, that "no epileptic patient should sleep on a pillow or soft mattress."

So far as I am aware the only manufacturers prepared to supply such pillows are Melco Products Ltd., of Tottington, whose experimental product made of polyether foam is developed from their Divine baby pillow. Their pillow is washable and is relatively cheap.—I am, etc.,

JOHN B. WILSON

Lochmaben, Dumfriesshire

1 Lonsmore, H. J. A., and Wilson, J. B., *Lancet*, 1970. 2, 782.
2 Bridge, E. M., *Epilepsy and Convulsive Disorders in Children*, New York, McGraw Hill, 1949.

Delayed Drug-induced Dystonias

SIR,—The production of abnormal dystonic movements by phenothiazines and butyrophenones commonly occurs in general medical and psychiatric practice. Such reactions may be very unpleasant for the patients, yet may not be recognized for what they are, even by experienced medical and nursing attendants, especially when the onset of symptoms occurs some time after the administration of the drug. Akathisia, for example, often starting after the causative drug has been taken for some time, may not be reported by the patient, who does not associate that curiously uncomfortable sense of restlessness with his tablets. If reported, it may be mistaken by the doctor for simple agitation, leading to an increase in the dosage of the very drug responsible for the symptoms.

With recent months I have seen two separate and dramatic cases of acute and severe drug-induced torsion dystonias and oculogyric crises which were not initially recognized by the nursing or junior medical staff. Both cases occurred after suicidal young male patients had been given a single dose of 15 mg of haloperidol with 10 mg of procyclidine as an accompanying anti-parkinsonian agent. They were well sedated and comfortable for the rest of the day, but in the afternoon of the following day began to develop severe, painful, and frightening reactions, with dystonic spasms and posturings of the neck, trunk, and limbs and marked oculogyric movements. One boy assumed a position of opisthotonos and the other showed mouth movements resembling marked *schnauzkrampf*. As no drugs had been administred that day, the possibility of a drug reaction was not considered by the staff, who regarded them as probably hysterical and attention-seeking responses to anxiety. In each case, called to the patient, I found it possible to relieve all symptoms easily and within two minutes by administering 10 mg of procyclidine intravenously.

Both patients had a history suggestive of minimal brain damage earlier in life. One boy described an earlier episode when he had developed a similarly severe oculogyric crisis some days after receiving an intramuscular injection of fluphenazine and procyclidine. This episode had been similarly unrecognized when he sought help at a teaching hospital casualty department.

It would seem, then, that some patients are especially sensitive to the dystonic effects of phenothiazines and butyrophenones, and sufficiently so to produce an acute dystonic reaction more than 24 hours after the drugs have been given and after the protective effects of an accompanying anti-Parkinsonian agent have obtained.
—I am, etc.,

MICHAEL A. SIMPSON

Department of Psychiatry,
McMaster University,
Hamilton, Ontario

The Point of the Lancet

SIR,—In your recent eulogy of the *Lancet* (29 September, p. 680) on the occasion of its 150th anniversary celebrations I was disappointed but not particularly surprised to notice that you omitted the following phrase from the preface to the very first number, published on 5 October 1823.

"We shall exclude from our pages the semibarbarous phraseology of the Schools, and adopt as its substitute, plain English diction. In this attempt we are well aware that we shall be assailed by much interested opposition. But, notwithstanding this, we will fearlessly discharge our duty. We hope that the age of Mental Delusion has passed, and that mystery and concealment will no longer be encouraged."—We are, etc.,

ROGER PROWSE

Bristol

Points from Letters

Incidence of Postoperative Deep Vein Thrombosis in the Tropics

Mr. L. F. TINCKLER (Wrexham) writes: I refer to the article by Mr. M. A. Hassan and others (3 March, p. 515) on postoperative deep vein thrombosis in the Sudan in Sudanese patients, and the subsequent letter from Mr. K. B. Orr (9 June, p. 615) recounting his experience in Vietnam. Their findings of decreased incidence of postoperative thromboembolism in their patients compared with the incidence of that complication in British hospitals using objective means of investigation is interesting. . . . It seems to me that in Britain there is now an unrivalled opportunity to distinguish between genetic and environmental factors in relation to this discrepancy as in some parts of the country there are immigrant populations of Afro-Asian origin in which the incidence of postoperative thromboembolism could be compared with the incidence in indigenous people in the same area. Whatever the outcome of such a controlled investigation might be, it would have potentially important implications for management of the postoperative patient and perhaps throw light on the question of the genesis of postoperative deep venous thrombosis.

Surgery for Coronary Occlusion

Dr. S. TALBOT (Sheffield) writes: I was interested in your leading article (25 August, p. 420) which appears to advocate the widespread use of vein grafts for coronary occlusion. The literature on the subject is in favour of such a view but British experience with such operations is limited. I have recently returned to England after spending a year in cardiology in the U.S.A., and my experience there would lead me to a different conclusion. Opinion among cardiologists is still divided as to the merits of the operation. In particular there is considerable doubt that ventricular function is improved and myocardial infarction averted. Symptoms, particularly angina, improve following the operation, but assessment of objective improvement is difficult after such a financially exacting procedure. Beta-blockers are still not used fully for the relief of angina, and only propranolol is available in some centres owing to Food and Drug Administration restrictions. Many patients undergoing the operation might have achieved comparable improvement with beta-blockers. . . .

Ring Tourniquets for Fingers

Mr. S. C. CHEN (Enfield, Middlesex) writes: I wish to draw the attention of your readers to the dangers of using the above device—especially of the transparent plastic variety—in hand surgery. During the past year in the Enfield group of hospitals two ring tourniquets were inadvertently left behind on fingers after minor surgical procedures. They were discovered only after a lapse of several hours, when the patients returned to the casualty department complaining of pain in one case and numbness of the finger in the other. Fortunately the outcome in both cases was not disastrous, although both fingers were blue and one was insensitive to light touch, by the time the mistakes were discovered. . . .

Long-term Retention of Oesophageal Foreign Body

Dr. R. B. BRUCE (Auckland) writes: With reference to the case reported by Mr. R. H. Johnson (26 May, p. 461), it may be of interest to recount that in 1946 a boy of 8 came into Green Lane Hospital, Auckland, with a history of vomiting blood. The history was that he had swallowed a penny some eight months previously, but had been *x*-rayed and the penny was not seen. The child died during that night, and at postmortem the penny was found in the oesophagus, having ulcerated through into the aorta. . . .