thidine, and mecamlamine, the patient was given 10 mg of propranolol twice, six hours apart. She had no apparent response to the first dose; however, within two hours of the second dose her pulse rate fell from 120 to 60/min and her blood pressure from 240/120 to 90/50 mm Hg, and she became unresponsive. An intravenous infusion of isoprenaline was required for several hours to restore and maintain pulse rate and blood pressure at normal levels. Within a day thereafter, without additional medication, the patient's tachycardia and hypertension returned. She had no symptomatic or objective response of visceral or peripheral neuropathy to propranolol. Several days later the patient developed bleeding due to "stress" ulceration of the gastric mucosa. While receiving fluid and blood replacement she developed acute congestive heart failure and pulmonary oedema at a time when her blood pressure was low and clinically it was felt her intravascular volume depletion had not been corrected entirely.

We interpret these events as indicating that our patient was compensating haemodynamically for elevated blood pressure (before and during her acute attack) by β -adrenergic stimulation of cardiac function. This increase in β -adrenergic activities may have resulted from physiological reflex mechanisms and/or from an influence of acute intermittent porphyria on the sympathetic nervous system. In any event the positive chronotropic and inotropic effects of endogenous catecholamines appeared essential to cardiovascular homeostasis, which was adversely and severely affected even by a small amount of propranolol.

While propranolol is of benefit in some patients in porphyric relapse, it is not without risk in patients with incipient cardiac failure. It may also be of risk in the pronounced hypovolaemic states which have been observed in patients with acute intermittent porphyria⁶ in the absence of apparent excessive volume loss. Beta-adrenergic stimulation in some episodes of porphyria may provide haemodynamic compensation rather than being simply a manifestation of acute relapse.—We are, etc.,

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1 Beattie, A. D., et al., *British Medical Journal*, 1973, 3, 257.

2 Atsmon, A., Blum, I., and Fischl, J., *South African Medical Journal*, 1972, 46, 311.

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Idiosyncrasy to Phenothiazines in Phenylbutazone-associated Aplastic Anaemia

SIR,—The interesting paper by Dr. J. L. Cunningham and his colleagues (3 August, p. 313) suggested that poor paraoxidation of phenylbutazone may be a factor in the aplastic anaemia associated with phenylbutazone therapy. We have observed an idiosyncrasy to phenothiazines in a patient with phenylbutazone-associated aplastic anaemia.

A 27-year-old man developed aplastic anaemia as a result of 2½ years of phenylbutazone therapy for ankylosing spondylitis. He was admitted for bone marrow transplantation and, prior to this, received a buffy-coat transfusion followed by high-dose intravenous cyclophosphamide. The vomiting and nausea caused by the cyclophosphamide was treated with three 25-mg intramuscular doses of chlorpromazine over a two-day period and four 12.5-mg doses of prochlorperazine over the ensuing two-day period. This resulted in a dyskinesia manifested by oculogyric movements. Further phenothiazines were withheld and the dyskinesia passed off spontaneously in three hours.

Dyskinesias are a well-recognized side effect of the phenothiazines. They are not dose-related and can occur in the first few days of treatment, suggesting an individual predisposition.¹ It is of interest that the phenothiazines, while being metabolized in many different ways, undergo aromatic

oxidation² as one of their major pathways in a similar manner to phenylbutazone.³ We therefore wonder whether the two drug idiosyncrasies of this patient may indicate a defect in a common oxidation pathway, and would welcome reports of any similar interactions.—We are, etc.,

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Doctors' Pay

SIR,—We would like to voice our support for Dr. J. F. Nunn (31 August, p. 579).

The plight of young consultants is being overlooked by many of the older members of the profession who negotiate on our behalf. Many newly appointed consultants are in very difficult financial circumstances. They spend 8-10 years in junior hospital grades, frequently subsidizing their income by working for a deputizing service or undertaking general practice locums during their holidays. On appointment as a consultant they find themselves with an income barely sufficient to raise a mortgage and the prospect of 10 years until they reach the top of the consultant salary scale. To raise the maximum mortgage many start with full-time contracts, thus losing allowances for telephones and motor car depreciation, etc.

Is it surprising that many continue to scan the back pages of the *B.M.J.* to find employment in countries where the population is more appreciative of their talents? —We are, etc.,

H. P. PIM

M. J. PHILLIPS

DAVID CHALLACOMBE

C. D. COLLINS

N. J. KNIGHT

W. BUNTING

Taunton and Somerset Hospital,
Muggrove Park Branch,
Taunton

SIR,—Dr. S. Mehta and his colleagues (14 September, p. 690) are to be commended for directing attention to the question of consultant relativities, though these are not entirely new.

Clinicians are in clinical charge of patients after a relatively long and rigorously selective training. This includes a grounding in the complexities of dealing with the great British public wider than that of the more ancillary and subcontractual specialties and appropriate to those whose lot it is to stop most of the medical bucks going.

Lengths of apprenticeship in different specialties vary, which in turn affects total life earnings. If applicable, domiciliary fees and the differing incidence of merit awards compensate somewhat for longer pre-consultant training. Perhaps such things as work in operating theatres, anaesthetic or operative, and an incessant heavy load of emergency work deserve more recognition than at present. All graduates appear to

start with equal opportunities of seeking a consultancy in any specialty, without compulsion to enter a particular one. Applied consultant egalitarianism might prevent the future manning in full of the more exacting specialties.—I am, etc.,

A. F. ROBINSON

Nelson, Lancs

Trade Union Tactics

SIR,—Dr. P. H. Woodcock has expressed so aptly what most of us must feel about the present state of remuneration of the profession (21 September, p. 744).

We are told by the Secretary of State for Social Services that our recent small awards must stand for 12 months (17 August, p. 479), notwithstanding the recognition by the Review Body that it still leaves us behind in the financial stakes. If only other Ministers would dare say the same thing to those militant unions who are finding reasons why they should be exempted—unions whose members are among the higher paid workers.

Likewise, most of us will agree with what Dr. P. E. Baldry has said on the same subject (21 September, p. 744), but I would take issue with his suggestion that we should employ the services of an experienced specialist in trade unionism to help us protect our interests. We have our own able and experienced negotiators, the essential difference being that theirs have "teeth"—namely, the threat of industrial action—which they do not hesitate to use to achieve their aims without any hint of compromise. Are we prepared to give ours the same "teeth"? —I am, etc.,

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St. Mellons, near Cardiff

Dynamism and Inflation

SIR,—The latest issue of *B.M.A. News* (August/September 1974) contains the statement that "the new dynamising formula introduced for general practitioners in 1972 protects them against inflation over their careers in the build up of their pensions" (p. 37). This is not true.

The Review Body's Fourth Report reveals an anomaly which "results from the decision to use the increase in general practitioners' earnings as the 'dynamising factor' in the

calculation of the 'uprated' career earnings on which the individual pension is based, instead of movements in the retail price index" (para. 64).

If earnings lag behind inflation how is it mathematically possible for the dynamising formula to protect against inflation?—I am, etc.,

DAVID LIVINGSTONE

Alnwick, Northumberland

Private Practice and the N.H.S.

SIR,—Perhaps it would help Dr. H. C. Faulkner (21 September, p. 745) to understand better why private practice is essential if he considered a little further Winston Churchill's analogy of the National Health Service to the fire brigade giving its full assistance to the humble cottage as readily as to the most important mansion.

If the householder in either cottage or mansion were provident and had purchased a fire extinguisher he might have no need of the fire brigade and might thereby save everyone else a lot of money. Why rely on a State almost bankrupted by the heavy demands on it if you can fend for yourself?—I am, etc.,

P. A. T. WOOD

Foxall, Ipswich

"Continuing Clinical Responsibility"

SIR,—After considerable deliberation I have completed the questionnaire from the Joint Working Party on the Terms of Employ-

ment of Senior Hospital Medical and Dental Staff. Having done so, I feel that the answers in no way give any real indication of my day. Difficult though I found the task, it has at least allowed me to crystallize my thoughts on the problems facing the consultant in the National Health Service. I find myself completely disappointed and disillusioned, since the questionnaire demonstrates a complete lack of understanding of the "consultant case" and makes me extremely uncertain that any real value will result from the inquiry.

For two years I have been consultant obstetrician and gynaecologist (maximum part-time) to the Doncaster hospitals. My contract clearly states that my "duties are to be regarded as requiring substantially the whole of [my] time." My contract further states that among the duties assigned to me is "the continuing clinical responsibility for the patients in [my] care." Thus it is with surprise that I find that the questionnaire begins by asking me to define my normal working day—indeed, it goes further in that it attempts to suggest that this might be 9 a.m. to 5 p.m. As far as I and my contract are concerned, there is no such thing as a "normal working day." I submit that continuing clinical responsibility does not require defining. It thus becomes impossible to break my duties down in the manner suggested. I am continually available to my patients; operating sessions, outpatient sessions, ward rounds, and emergency calls last just as long as is necessary in the interests of my patients. The teaching of junior staff and administration are continuous processes.

As a junior consultant I was happy to sign my contract and remain so. I am completely happy to provide continuous clinical care for my patients—this, surely, is the essence of clinical medicine. I require no alteration in or inquiry into my working hours. I am sure that I am no more and no less dedicated than other consultants. I do, however, require an adequate financial return commensurate with this continuous clinical care—in terms of hours of work, responsibility, length of training, and value to the community.—I am, etc.,

F. A. HOWARD

Doncaster

SIR,—The Department of Health and Social Security has sent me a questionnaire about the time I spend in connexion with my work. It is almost incomprehensible and does not cover all the problems of a part-time pathologist.

Does the B.M.A. approve of this document and did its representatives on the Owen Working Party really agree to its issue in this form?—I am, etc.,

PETER HARVEY

Caton, near Lancaster

** The Secretary writes: "The questionnaire was issued by the Joint Working Party with the agreement of both the consultant representatives and those of the Departments. It is designed to obtain information on the general pattern of work of consultants in all specialties."—ED., *B.M.J.*

Points from Letters

Diaphragmatic Hernia

Dr. A. G. KHAN (London S.W.9) writes: A procedure that I have found of considerable diagnostic value in cases of diaphragmatic hernia, and one which very frequently affords rapid relief to the patient, is Valsalva's manoeuvre. . . . The rationale is self-evident; increased intrathoracic pressure pushes back the regurgitus and reduces herniation. Relief is rapid. Some patients have reported greatly decreased frequency and severity of the attacks after they had carried out this procedure for some days. One of the usual medications concurrently administered further helps in relieving pain due to mucosal inflammation or excoriation in the oesophagus. It also helps those with a low I.Q. to perform the manoeuvre: "swallow forcefully, closing your throat, as if pushing down the pain with the medicine." . . .

Treatment of Post-herpetic Neuralgia by Electric Stimulation

Dr. FRANK S. RICKARDS (Carnforth, Lancs) writes: With reference to the article by Dr. P. W. Nathan and Professor P. D. Wall (14 September, p. 645) I treat these patients with electro-acupuncture using an "acupuncture anaesthesia stimulator" which I brought with me from China earlier this year. The needles are placed in position deep into the proprioceptors in muscles underlying the area of

skin affected by the herpes and then connected to the stimulator—the frequency and amplitude of the pulse can be varied. I normally use 180 Hz and deliver a voltage (as the Chinese do) up to "the patient's tolerance." I allow the patients to control the intensity control switch. . . .

Penicillamine and Creaking Joints

Dr. B. McCONKEY (Birmingham) writes: With reference to the letter from Drs. R. D. Sturrock and P. M. Brooks (31 August, p. 575) a 45-year-old man with rheumatoid arthritis developed an easily audible squeak of his left thumb (interphalangeal joint) while he was having penicillamine. The drug was stopped because of proteinuria and the squeak is no longer there.

Treatment of Choking

Dr. C. O. PAYNE (Shiraz, Iran) writes: A patient of mine . . . had accompanied her husband, a British anthropologist, on a field expedition and was enjoying the customary lavish hospitality of a leading villager when a large piece of goat's meat became lodged in her pharynx. . . . Their Irani guide and interpreter promptly disappeared outside to return with a tail feather from a nearby cockerel. The warm end of this he deftly inserted over the tongue of the now cyanosed patient, relieving the obstruction

with a lateral hooking action. This remedy is apparently quite well known in the area. Could it be that the pheasant's feather of the neurologist ought to be transferred to the resuscitation trolley?

Pyloric Stenosis Presenting with Halitosis

Dr. GILLIAN E. SLADDEN (Tiverton, Devon) writes: With reference to the two cases reported by Drs. T. F. Tydd and N. H. Dyer (3 August, p. 321), some years ago I saw a man whose presenting complaint was also of halitosis, with a feeling of bloating after meals. . . . A barium meal showed a probable duodenal ulcer and, interestingly, his halitosis disappeared after treatment with antispasmodics and alkalis. Presumably the reason for his halitosis was spasm at the pylorus with gastric stasis.

Mid-trimester Termination

Mr. B. WILLIAMS (Boxgrove, Sussex) writes: May I support Dr. J. Slome (7 September, p. 631) in his disagreement with the opinion expressed in your leading article (17 August, p. 428) that laminaria tents are "hazardous or unreliable or both." They provide as simple and safe a method as any in terminating both early and later pregnancies. It is important to use as big a tent as possible, or several small ones, and to make sure that they are passed just through the internal os. . . .