different ($t = 1.63$, $P = 0.20$) and breast and bottle feeding were equally distributed between the two groups ($\chi^2 = 0.054$; N.S.). Though the mean duration of infusion of oxytocin in group 1 (10.8 ± 8.7 hr) was greater than in group 2 (8.0 ± 7.1 hr) the difference was not statistically significant ($t = 1.49$, $P = 0.14$).

We agree with Dr. B. Alderman and Professor J. M. Beazley (7 September, p. 624) that the first and sixth days are not ideal times to detect peak neonatal bilirubin levels. However, as we pointed out in our paper, the sixth day was a time at which blood was already being taken routinely for amino-acid screening and this timing of samples avoided exposing the infants to additional blood-letting. Though the recorded peak values in our data may be lower for this reason, any increase in neonatal hyperbilirubinaemia should still be reflected in a higher mean value on the sixth day.—We are, etc.,

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Coroners and the Public Interest

SIR,—We are concerned, as you evidently were (10 August, p. 374) that the Westminster coroner should not allow you to have copies of the depositions put before his court at the inquest following the collapse of a young man which had occurred recently. We understand that in that unfortunate case both methohexitone and diazepam were given intravenously. The potency of this combination of drugs administered in this way is clearly stated in *M.I.M.S. Annual Compendium 1969-1970* (p. 248) and *A.P.B.I. Data Sheet Compendium 1974* (p. 609) and was emphasized by the medical expert at that inquest.

Recently (11 September 1974) we attended a coroner's inquest inquiring into the death of a young girl occurring during anaesthesia for conservative dentistry. In our opinion the tragic death of this girl, possible due to a combination of these two drugs, might not have occurred if your journal had been allowed to give wide publicity to the previous tragedy.

Surely coroners' inquests have a value in preventing a repetition of the circumstances producing the death in the case before them. It must, therefore, be questioned whether the coroner concerned can feel that this function of that inquest was fulfilled.—We are, etc.,

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Danger of Saline Emetics in First-aid for Poisoning

SIR,—Drs. C. J. C. Roberts and M. J. Noakes (14 September, p. 683) refer to your leading article (26 January, p. 130) and once more warn of the harmful effects sometimes met in giving sodium chloride in an attempt to produce emesis.

In a recent case a female psychiatric patient aged 35 years had taken a moderate overdose of salicylate and was given a tablespoonful of salt in a tumbler of water in an attempt to produce emesis, and this was repeated on three occasions in rapid succession in all good faith by the nurse involved. Emesis was not induced but there was almost immediate onset of watery diarrhoea. This delayed the transfer to the accident and emergency department, where gastric lavage was performed, producing some tablets and blood-stained fluid.

The plasma electrolyte levels became disturbed, that of sodium reaching 200 mmol/l., chloride 157 mmol/l., and bicarbonate 15 mmol/l. The salicylate level reached 54 mg/100 ml. Some six hours after ingestion of the salicylate and the salt the patient became deeply unconscious, the intra-ocular tension became low, and she died. Necropsy showed watery fluid in the whole intestinal tract with high sodium and chloride levels in the stomach, jejunum, and proximal and distal colon. There was a thin covering of blood over an area measuring 5×4 cm on the surface of the right temporal lobe, a few small areas of haemorrhage on the endocardial surface of the left ventricle, and congestion and oedema of the lungs. Death was attributed to the ingestion of salicylate and sodium chloride.

The training in first-aid at each of the nurse training schools of which I have made personal inquiry follows that of the first-aid manuals, which, as has been pointed out, do not warn of the dangers of excess. Surely the time has come for reappraisal and greater use to be made of the facilities for the treatment of poisoning in accident and emergency departments in preference to the administration of ineffective and potentially dangerous first aid measures. The Standing Medical Advisory Committee of the Central Health Service Council issued reports in 1962 and 1968^{1,2} which have led to a review and improvement of the facilities available.—I am, etc.,

C. A. K. BIRD

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¹ Central Health Services Council, *Emergency Treatment in Hospitals of Cases of Acute Poisoning*. London, H.M.S.O., 1962.

² Central Health Services Council, *Hospital Treatment of Acute Poisoning*. London, H.M.S.O., 1968.

SIR,—Drs. C. J. C. Roberts and M. J. Noakes (14 September, p. 683) "recommend that first-aid books which carry recipes for salt emetics should also warn against overdose." In the latest edition of *New Essential First Aid*¹ this recommendation is already in print on p. 147, where we state "it is dangerous to give more than the recommended dose (two tablepoons of salt in a glass of warm water)." We further recommend on p. 148 that "15 ml of ipecac syrup U.S.P. is probably the best thing to use as an emetic. As a means of removing poison from the stomachs of young children ipecac syrup is suitable for home use and is much faster acting than sending a child to hospital for a wash-out; it is also more effective than a stomach wash-out."—We are, etc.,

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¹ Gardner, A. W., and Roylance, P. J., *New Essential First Aid*, revised edn. London, Pan Books, 1972.

Fenfluramine and Psychosis

SIR,—Your leading article entitled "Anorexia" (14 September, p. 639) quotes my colleagues and me to the effect that

fenfluramine does not cause psychiatric or sleep disturbance. Certainly that was what we initially but, alas, wrongly reported in your columns.¹ We had been unwise enough to draw conclusions from single-dose studies. Later, also in your columns, we described how fenfluramine in chronic use causes sleep disturbances² and psychological depression on eventual withdrawal.³ The depression on withdrawal has since been confirmed,^{4,5} while others have written also of psychological disturbance during fenfluramine administration, most recently Dr. P. J. Shannon and others (31 August, p. 576).—I am, etc.,

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¹ Oswald, I., Jones, H. S., and Mannerheim, J. E., *British Medical Journal*, 1968, 1, 796.

² Lewis, S. A., Oswald, I., and Dunleavy, D. L. F., *British Medical Journal*, 1971, 3, 67.

³ Oswald, I., et al., *British Medical Journal*, 1971, 3, 70.

⁴ Steel, J. M., and Briggs, M., *British Medical Journal*, 1972, 3, 26.

⁵ Harding, T., *British Journal of Psychiatry*, 1972, 121, 338.

Screening for Hypertension

SIR,—Two recent papers on this subject illustrate the current confusion caused by lack of uniformity in recording the diastolic blood pressure. In the paper by Dr. W. E. Miall and Miss Susan Chinn (7 September, p. 595) the diastolic pressure was recorded at the point of muffling of the Korotkow sounds (fourth phase) and in the paper by Dr. V. M. Hawthorne and others (p. 600) at the point of disappearance of the sounds (fifth phase). Since the average difference between fourth and fifth phase readings is over 5 mm Hg^{1,2} this is a matter of considerable importance when estimating the incidence of mild hypertension. Thus Dr. Hawthorne and his colleagues report that 15% of the subjects they examined had a diastolic pressure of 100 mm Hg or more. If, however, they had been recording at the fourth phase instead of the fifth the proportion would have been nearer 25%—the figure they give for those found to have a diastolic pressure of 95 mm Hg or over.

There should really be no uncertainty about the definition of the diastolic pressure. The fourth phase has been standard in Britain since 1939³ and in the U.S.A. since 1967.¹—I am, etc.,

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¹ Kirkendall, W. M., et al., *Circulation*, 1967, 36, 980.

² Oram, S., *Clinical Heart Disease*. London, Heinemann, 1971.

³ Cardiac Society of Great Britain and Ireland and American Heart Association, *British Heart Journal*, 1939, 1, 261.

Ruptured Aneurysm of Splenic Artery in Pregnancy

SIR,—Aneurysm of the splenic artery is relatively more common in women of child-bearing age¹ and rupture of such an aneurysm is a rare but dangerous complication of pregnancy.^{2,3}

A 41-year-old primigravida at term was admitted to hospital with a four-hour history of severe upper abdominal pain. Pulse and blood pressure were normal and the fetal heart was heard. The uterus was hard and locally tender on the left side and a diagnosis of concealed accidental haemorrhage with