

a live baby was made. Caesarean section through a Pfannenstiel incision revealed a posterior type III placenta praevia but no sign of accidental haemorrhage. A healthy girl was delivered. During examination of the ovaries a clot of blood was removed from the left paracolic gutter and considerable bleeding was apparent from the splenic area. A large left paramedian incision was added and the haemorrhage controlled by packs. Rapid splenectomy was then performed with double ligation of the splenic artery proximal to the aneurysmal dilatation. Recovery was uncomplicated and the patient and her daughter were discharged on the twelfth day.

Rupture of splenic artery aneurysm during pregnancy has been reviewed in detail.<sup>2,3</sup> The average age of patients is 32 and 80% of ruptures occur in the last trimester or in labour. The maternal mortality is 69% and the fetal mortality 97%. Survival appears to be related to early diagnosis and treatment. The present case is only the third<sup>2,4</sup> in which both mother and child survived and the first such case in Britain. It seems likely that this case was an example of a "double rupture," with a limited initial rupture producing symptoms and a latent period<sup>5</sup> before the subsequent severe haemorrhage. This success can be attributed to early intervention, albeit on mistaken diagnostic grounds, and to the rapid implementation of resuscitative measures.

The diagnosis of ruptured splenic artery aneurysm should be borne in mind in any case of obstetric shock and immediate laparotomy should be carried out if it is considered a possibility.

We would like to thank Mr. G. T. Hammond for allowing us to report this case.

—We are, etc.,

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### Sleep Epilepsy

SIR,—The findings of Drs. F. B. Gibbs and M. C. Bateson (25 May, p. 403) relative to the incidence, time of occurrence, and prognosis of sleep seizures are consistent with our experiences reported in 1954.<sup>1</sup> Our findings, however, are in contradistinction to their statement that "the age of onset in idiopathic daytime epilepsy is nearly always between 10 and 30 years." The most common age at onset in our group of more than 15,000 patients with idiopathic diurnal epilepsy was from four to seven years, with the highest incidence from five to six years. After the seventh year of age the onset of idiopathic epilepsy was distinctly less prevalent, though there was a moderate but significant increase in the 11th and 12th years. Also, in contrast to the authors' statement that sleep seizures "tend to be symptomatic rather more often than daytime seizures," the incidence of symptomatic seizures in our series of patients with sleep epilepsy was considerably lower than that in our patients whose attacks occurred only diurnally.

The prime purpose of this communication is to present our methods of treating sleep seizures, with particular emphasis on the use of dextroamphetamine sulphate, since Drs. Gibbs and Bateson did not discuss this subject specifically but recommended that "we should be cautious before using medication to suppress sleep seizures." We have found that sleep epilepsy is frequently resistant to the standard antiepileptic drugs such as phenobarbitone, phenytoin, and primidone; however, the following therapeutic regimens have proved effective in some patients.

For early nocturnal seizures (those which occur soon after falling asleep) the patient should initially be given the appropriate dosage of phenobarbitone three times a day. The first dose with lunch, the second with supper, and the third at bedtime. If the seizures should persist the second (supper) dose should be increased by increments of 32 mg, the first and third doses remaining the same, until a satisfactory control of seizures is attained or the limit of tolerance is reached. For late nocturnal or early morning seizures (those which occur shortly before the usual time of awakening or soon after awakening) the patient should be treated with phenobarbitone as above except that, if the seizures should persist or recur, it is the third (bedtime) dose that should be increased in increments of 32 mg. If phenobarbitone fails to control or appreciably reduce the frequency of the patient's seizures it should be gradually replaced by another major motor (grand mal) antiepileptic agent, preferably primidone; phenytoin is our drug of third choice for the treatment of sleep epilepsy.

We are definitely convinced, however, that the most efficacious drug for the control of sleep seizures is dextroamphetamine sulphate administered in a sustained release dosage form (Spansule) at bedtime. We have obtained very good and sometimes spectacular results with the following dosage schedules.

For older children and adolescents we institute dextroamphetamine therapy with a 5-mg Spansule taken at bedtime. If the seizures recur we raise the dosage to 10 mg and, if necessary, to 15 mg. For adults therapy is inaugurated with a 15-mg dextroamphetamine Spansule taken at bedtime. If this dosage proves ineffective we increase it to 25 mg.

We emphasize that our experience with the use of dextroamphetamine sulphate has demonstrated that side effects are minimal. Inomnia and anorexia, if present, generally disappear within a week or two after the initiation of therapy. In many of our patients dextroamphetamine was prescribed during childhood and continued for a period of years without weight loss, retardation of growth, or other significant side reactions, and on termination of therapy no evidence of serious withdrawal symptoms was noted.

For reasons that at present remain obscure, adults rather than infants or very young children and patients with early rather than late nocturnal seizures respond better to dextroamphetamine therapy. In addition, we are unable to explain the mechanism of action of dextroamphetamine in controlling sleep seizures; it may be due to: (a) its anticonvulsant properties<sup>2,4</sup>; (b) diminution of the depth of sleep,<sup>5</sup> particularly stage IV; (c) reduction of rapid eye movement sleep<sup>6</sup>; (d) increase in the proportion of

time spent in stages II and III sleep<sup>7</sup>; (e) a combination of these effects; or (f) other factors.—We are, etc.,

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- 1 Livingston, S., *The Diagnosis and Treatment of Convulsive Disorders in Children*, pp. 125-127. Springfield, Thomas, 1954.
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### Alcoholism

SIR,—A sample census of alcoholics in the Brighton Health District has been made possible by the collaboration of my colleagues in general practice. This has resulted in an estimated total of 800 alcoholics known to their G.P.s in the Brighton and Hove area. The figures, which are completely anonymous, demonstrate that most are not skid-row characters but are poor devils who are trying to carry on a job or a home but are in the stranglehold of alcohol. They and their families do not need sermons, they need the help which does not at present exist.

Many potential patients in these circumstances do not consult their G.P.s. My colleagues and I are therefore convinced that the figure of 800 for Brighton and Hove is a gross underestimate and that many more require support and reclamation.—I am, etc.,

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### Practolol and the Eye

SIR,—I read with great interest the letter of Mr. P. Wright (8 June, p. 560). One of my patients, a woman aged 62 years who has been suffering from angina for five years, has been taking practolol 400 mg a day for 18 months. Recently she presented to me complaining of pain, photophobia, and difficulty in opening the eyes. I referred her to an ophthalmologist who diagnosed keratoconjunctivitis sicca. She had dryness of the eye, and with rose Bengal there was no corneal staining but conjunctival staining with some filamentous changes in the conjunctiva and adhesions and obliteration of the lower fornices (essential atrophy of the conjunctiva). Practolol was stopped and she was put on methyl cellulose drops and Sofradex, with marked improvement. She had no skin eruptions.—I am, etc.,

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### Progestogen-only Oral Contraception and Ectopic Gestation

SIR,—Mr. J. Bonnar (16 February, p. 287) and Mr. D. F. Hawkins (2 March, p. 387)

## Outcome of Unplanned Pregnancies in Trials of Progestogen-only Oral Contraceptives

| Drug and Dose                 | Study               | No. of Unplanned Pregnancies | Outcome of Unplanned Pregnancies |            |             |                   |             |         |
|-------------------------------|---------------------|------------------------------|----------------------------------|------------|-------------|-------------------|-------------|---------|
|                               |                     |                              | Livebirth                        | Stillbirth | Miscarriage | Ectopic Gestation | Termination | Unknown |
| Chlormadinone acetate 0.5 mg  | F.P.A.              | 20                           | 9                                | 0          | 4           | 0                 | 7           | 0       |
| " " "                         | Yugo A <sup>1</sup> | 4                            | 0                                | 0          | 0           | 1                 | 3           | 0       |
| " " "                         | Yugo B <sup>2</sup> | 2                            | 0                                | 0          | 0           | 0                 | 2           | 0       |
| Ethinodiol diacetate 0.5 mg   | F.P.A.              | 3                            | 0                                | 1          | 1           | 0                 | 0           | 1       |
| Lynoestrenol 0.5 mg           | F.P.A.              | 1                            | 1                                | 0          | 0           | 0                 | 0           | 0       |
| Megestrol acetate 0.5 mg      | F.P.A.              | 8                            | 5                                | 0          | 0           | 0                 | 2           | 1       |
| " " 0.7 mg                    | Yugo B              | 6                            | 0                                | 0          | 0           | 1                 | 5           | 0       |
| Norethisterone 0.35 mg        | F.P.A.              | 12                           | 5                                | 0          | 1           | 0                 | 4           | 2       |
| Norethisterone acetate 0.3 mg | F.P.A.              | 8                            | 6                                | 0          | 0           | 1                 | 1           | 0       |
| " " "                         | Yugo A              | 1                            | 0                                | 0          | 0           | 0                 | 1           | 0       |
| " " "                         | Yugo B              | 2                            | 0                                | 0          | 0           | 0                 | 1           | 0       |
| " " 0.3+0.6 mg                | F.P.A.              | 2                            | 1                                | 0          | 0           | 0                 | 1           | 0       |
| " " 0.6 mg                    | F.P.A.              | 2                            | 2                                | 0          | 0           | 0                 | 0           | 0       |
| Norgestrel 0.05 mg            | Yugo A              | 3                            | 2                                | 0          | 0           | 0                 | 1           | 0       |
| " " 0.075 mg                  | F.P.A.              | 3                            | 1                                | 0          | 1           | 0                 | 1           | 0       |
| " " "                         | Yugo B              | 1                            | 0                                | 0          | 0           | 0                 | 1           | 0       |
| Total                         |                     | 77                           | 32                               | 1          | 7           | 3                 | 30          | 4       |

The outcome of 21 pregnancies occurring among 43 women taking megestrol acetate 0.25 mg in the Yugo A study have been omitted since this dose of the steroid was clearly a very ineffective contraceptive.

have both reported an excess of ectopic gestations among the unplanned pregnancies occurring in women using progestogen-only oral contraceptives. Their findings stimulated us to review the outcome of unplanned pregnancies occurring among the participants in the trials of progestogen-only oral contraceptives conducted by the Family Planning Association and in similar trials carried out in Ljubljana, Yugoslavia, with which one of us (M.P.V.) was associated.<sup>1,2</sup> The results are shown in the table. Of the 73 pregnancies of known outcome 3 (4.1%) were extrauterine.

These data are closely similar to those that have been reported in relation to intra-uterine devices. Lehfeldt *et al.*,<sup>3</sup> for example, found that 4.3% of pregnancies occurring with an intrauterine device in situ were ectopic, while Vessey *et al.*<sup>4</sup> reported a corresponding figure of 8.9%. The implication is that progestogen-only oral contraceptives, like intrauterine devices, are much more effective at preventing uterine implantation than extrauterine. From the practical point of view we agree with Mr. Hawkins that the doctor responsible for the care of a patient who has become pregnant while using progestogen-only oral contraceptives must be on the alert in case the pregnancy is ectopic.—We are, etc.,

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## Catecholamine Excretion Levels in Neuroblastoma

SIR,—Dr. Jane V. Bond (31 August, p. 574) referred to our paper on neuroblastoma (3 August, p. 301). She pointed out that no mention was made of the use of catecholamine estimations and suggested that this might have been because in the period 1962-7 routine examinations were not being carried out. In fact, several hospitals were using these estimations as diagnostic tests and also during the follow-up of surviving

children, though the incidence of these tests increased during the later years.

Out of our total number of 639 children, we found only 109 patients who had definite reports of vanillylmandelic acid (VMA) estimations being carried out at the time of diagnosis. In 90 of these the level was raised, in 17 it was normal, and in two it was unspecified. We had records of 33 patients who were followed up over a period of time with VMA estimations being used regularly, and within the limits of our data our findings confirmed the fact that a quick return to normal levels is associated with good prognosis and vice versa. However, in view of the fact that our source material came from many different hospitals and these tests were carried out by different laboratories and under varied conditions we did not consider it worth while to publish such incomplete information in a paper largely concerned with natural history and prognostic factors.—I am, etc.,

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## Status of Ward Sisters

SIR,—When the recent pay award to the nursing profession was announced there was general jubilation at this much-needed pay rise. However, when the details were made known<sup>1</sup> it was found that the ward sisters, who hold key positions in the nursing profession, came out badly compared with other branches of the profession. District nurses and health visitors are in Grade I and will receive a higher salary than ward sisters, who are placed in Grade II.

All nurses in training are influenced by the standards of ward sisters, patient care depends directly on their competence, and the entire organization of the ward is their responsibility. I feel these important factors have been neglected by the Halsbury Committee. It has downgraded the ward sister's position so that it becomes quite intolerable for skilled nurses to continue as ward sisters and they are being forced out of the wards, and in some cases they are leaving the profession altogether.

This lack of recognition of the ward sister's value is also seen in the limitation of the salary increments to six, which forces

nurses into nursing administration when their interest is still patient care.—I am, etc.,

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<sup>1</sup> Report of the Committee of Inquiry into the Pay and Related Conditions of Service of Nurses and Midwives. London, H.M.S.O., 1974.

## Tissue for Transplantation

SIR,—While I am unable to accept many of Mr. J. R. Salaman's conclusions in his frank if somewhat despondent communication (21 September, p. 736), he makes one very germane point.

There is a great and, as Mr. Salaman suggests, misplaced reluctance within the nephrological and renal transplant spheres to approach close relatives of patients in terminal renal failure to obtain live donor kidneys. The advantages of transplanting a kidney which functions immediately are considerable apart from the expected greater long-term viability. The procedure of removing a kidney from a healthy donor is very safe (18 May, p. 344).—I am, etc.,

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SIR,—Many persons are willing to donate kidneys (or any of their organs) for transplant surgery.

Some time ago a patient told me she wished to donate her eyes. She had informed her solicitor. Her medical record file had been accordingly endorsed. She was killed in a road accident. Neither her solicitor nor I heard of her death for some considerable time. Similar happenings must be quite frequent.

Why not an internationally agreed symbol tattooed, say, in the mid-lumbar region, indicating willingness to donate one or any organ?—I am, etc.,

J. N. WARREN

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## Gilbert's Disease and Postanaesthetic Jaundice

SIR,—Further to the discussion of the role of halothane in postanaesthetic jaundice I