Zoster in Families

SIR,—I was interested in Dr. R. E. Hope-Simpson's report of zoster in three siblings (7 September, p. 626), and would like to report two cases of zoster which may be of some interest. These occurred not in siblings, but in husband and wife. They had recently returned from holiday abroad and were in perfectly good health when within a day of each other they both developed herpes zoster, affecting the ophthalmic division of the trigeminal nerve in the wife and a thoracic segment in her husband.

In view of the current theories of the aetiology of this condition I thought these two cases were of some interest.—I am, etc.,

J. MACKENZIE

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Spontaneous Primary Hypothyroidism with Unilateral Exophthalmos

SIR,—The relationship between thyroid status and ophthalmopathy in Graves's disease is still incompletely understood. In most cases the eye signs develop either together with or following the treatment of hyperthyroidism, but it has been known for a long time that ophthalmopathy may precede clinical hyperthyroidism,¹ while some patients with ophthalmopathy apparently never become hyperthyroid. More rarely, eye signs develop in a patient with primary hypothyroidism who has never shown symptoms of thyrotoxicosis.² We recently saw a patient without a history of hyperthyroidism in whom the development of unilateral exophthalmos preceded the onset of clinical hypothyroidism by over three years.

A 49-year-old man was referred to this hospital in May 1974 because of symptoms of fatigue, cold intolerance, and listlessness of one month's duration. In March and April 1971 he had been seen elsewhere by an internist, an ophthalmologist, and a neurologist because of protrusion of the right eye. He appeared clinically euthyroid, his serum hormonal iodine was 5.2 µg/100 ml (normal 3.0-6.0 µg/100 ml), and no neurological disturbances were found. In February 1972 he was admitted to the department of ophthalmology of the University of Amsterdam (Wilhelmina Gasthuis) for an extensive examination, including stereoscopic radiography, planigraphy, phlebography, arteriography, ultrasonography, electromyography, and brain scintigraphy. There was a right-sided proptosis of 3 mm and the patient complained of diplopia, but the motility of the eye was hardly impaired. Apart from a stricture of the superior ophthalmic vein no other abnormalities were found. The patient appeared clinically euthyroid; the serum thyroxine (T₄) level was marginally elevated (14.0 µg/100 ml; normal 5.0-13.5 µg/100 ml), the T₄ binding index was normal (0.95; normal 0.85-1.20). Endocrine ophthalmopathy was considered probable. The radioiodine uptake, determined in May 1972, was normal (19, 29, and 42% at 2, 6, and 24 hours respectively; normal limits at 24 hours 20-50%); however, these values were virtually unchanged during triiodothyronine suppression, which confirmed the endocrine nature of the eye signs.

When the patient was seen in our outpatient department the eye signs were not appreciably changed, but signs and symptoms of hypothyroidism were obvious. In addition to the symptoms mentioned above, his movements had become slow and his voice lower, and he had gained 10 kg in weight over a period of eight weeks. The thyroid gland was hardly palpable. Primary hypothyroidism was confirmed by laboratory tests: serum T₄ 1.6 µg/100 ml; serum thyroid-stimulating hormone 45 µU/ml; 24-hour radioiodine uptake 15%.

Endocrine ophthalmopathy may develop while the patient is clinically either hyperthyroid, euthyroid, or hypothyroid. Some of

the euthyroid patients eventually become hyperthyroid. To our knowledge, hypothyroidism developing spontaneously in a previously euthyroid patient with endocrine ophthalmopathy has been reported only once before.³—I am, etc.,

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- 1 Werner, S. C., *American Journal of Medicine*, 1955, 18, 608.
- 2 Fox, R. A., and Schwartz, T. B., *Annals of Internal Medicine*, 1967, 67, 377.
- 3 Haydar, N. A., *Journal of Clinical Endocrinology*, 1963, 23, 215.

Management of Lithium Treatment

SIR,—The paper by Dr. J. L. Crammer and others (14 September, p. 650) regarding plasma lithium levels is timely. In many quarters an exaggerated respect is shown to the value of a serum or plasma lithium estimation with little regard to when the blood specimen was taken. Amdisen¹ has cogently pointed out how essential it is to take blood for serum lithium 12 hours after ingestion of the last lithium tablet, and this point is correctly emphasized in the paper. There are, nevertheless, a number of points that we would like to qualify, some of which are at variance with our own work.

Though a number of sustained-release tablets do not release their active drug except in an alkaline medium, this is not the case with Priadel and Lithium Phasal, the two sustained-release preparations used by Dr. Crammer and his colleagues. Both these preparations are designed to disintegrate slowly irrespective of the pH of the medium in which they are present. We have found no difference in the rate of release of lithium in vitro from Lithium Phasal in artificial gastric and intestinal fluids under similar conditions, while the rate of release of lithium from Priadel is slower in intestinal juice than in the acid medium.² It is also stated by Dr. Crammer and his colleagues that "fasting may be expected to produce delay [in pyloric opening] like propantheline," thus leading to delayed absorption of any drug administered in the fasting state. The converse is in fact the case; simultaneous ingestion of food with a drug delays absorption of the drug by decreasing gastric emptying.³ More variable results are therefore likely to be obtained if lithium (or any other drug) is given after breakfast because of the different amount of food taken by each patient. The authors also suggest that the lithium dose be taken in the evening or when going to bed. We have shown an increased nocturnal excretion of lithium and so, in order to achieve the same plasma level, this practice would require a larger dose of lithium to be given at night than during the day.²

We are surprised at the claim that the faecal excretion of lithium in all preparations was less than 0.1 mEq/24 hours. The previous results on faecal excretion of lithium from this unit, to which the authors refer⁴ (though the reference is not actually listed), were obtained after administration of aqueous lithium citrate. Recent work with sustained-release preparations of lithium by us has shown faecal excretions as high as 7 mEq/24 hours.²

Finally, Dr. Crammer and his colleagues suggest that a lithium tolerance test be per-

formed on patients before beginning lithium treatment in order to determine the most appropriate dosage. Geisler *et al.*⁵ have already described a method of determining renal lithium clearance from the results of which one is able to determine the dose of lithium that the patient should receive at the start of treatment. A new test seems unnecessary.—We are, etc.,

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- 1 Amdisen, A., *British Medical Journal*, 1973, 2, 240.
- 2 Birch, N. J., *et al.*, *British Journal of Clinical Pharmacology*, in press.
- 3 Goodman, L. S., and Gilman, A., *The Pharmacological Basis of Therapeutics*, 4th edn., p. 6. New York, Macmillan, 1970.
- 4 Hullin, R. P., *et al.*, *British Journal of Psychiatry*, 1968, 114, 1561.
- 5 Geisler, A., Schou, M., and Thomsen, K., *Pharmakopsychiatrie NeuroPsychopharmologie*, 1971, 4, 149.

Prazosin in Hypertension

SIR,—We have read with interest the report by Drs. G. S. Stokes and M. A. Weber (11 May, p. 298) on the effectiveness of prazosin in the management of hypertension. As most of their patients suffered from uncomplicated essential hypertension we would like to communicate our initial experience in a group of 25 patients of whom 16 had secondary hypertension and 16 had renal impairment.

Poorly controlled hypertension was the reason for initiating therapy with prazosin, and in all instances the agent was added to pre-existing hypotensive agents. Five patients had exudative retinopathy, another four had diastolic blood pressure readings equal to or greater than 130 mm Hg, and another nine had evidence of left ventricular hypertrophy. The group received an average of five months' therapy and nine patients required a total daily dose of 10 mg or more of prazosin. The diastolic blood pressure was lowered to 100 mm Hg or less in 17 patients, and five of these achieved a diastolic pressure of 80 mm Hg or less. Two patients died from the vascular complications of their hypertension and one patient defaulted. Though side effects were attributed to prazosin in nine cases, in none did this necessitate withdrawal of the drug.

We conclude that prazosin is valuable in achieving control of hypertension in refractory hypertension states when used in combination with other medications and may be used in the presence of renal insufficiency.—We are, etc.,

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La Condition Humaine

SIR,—What a depressing Personal View has been written by Dr. S. Bradshaw (14 September, p. 682). It cannot go unchallenged.

If science has destroyed the spirit of Christianity, has scientific analysis of the pigments also destroyed the beauty of the great paintings? Scientific archaeology, far

from dismissing, has actually confirmed many of the historical sites described in the Bible. As to the artefacts—some peoples' hearts must still be in the right place judging by the money forthcoming and the technical skill demonstrated which together have accomplished the costly and immensely difficult task of restoring York Minister. And what about Coventry Cathedral? The problems of pollution, overpopulation, and famine are being tackled as never before, while the problem of nuclear weapons has stimulated more responsibility in their handling than I would have thought possible. Far from making us omnipotent, it is these very weapons and their power which makes some of us realize how insignificant we are.

As regards medicine, of course science is helpful—partly by cutting the birth rate. We know of the problems of cigarettes and lung cancer, but preventive medicine has always been unpopular. There will always be doctors who beef about conditions and, much as we would like to forget it, cash—necessary so long as we must pay our way. As regards foreign doctors in our hospitals, let us never forget the many British doctors serving in foreign (mission) hospitals.

Is Christianity really as meaningless and void as Dr. Bradshaw would have us believe? Each challenge must be met and tackled in a spirit of hope, for it will do no good to despair.—I am, etc.,

GRAHAM HUNTER

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Economies in the N.H.S.

SIR,—For many years the "sterile" water supplied for use in lotion bowls in our operating theatres has been prepared locally at very little cost. In recent months the Department of Health has specified that this water should be particle-free and this has made it necessary for us to purchase sterile water from a commercial source at a cost of £30,000 per year for our district alone.

We believe that a distinction should be made between lotions for intravenous administration, which must of course be particle-free, and lotions for washing gloves and preparing moist packs in the operating theatre, which we believe to be safe provided they are sterile.

Every possible economy must be made if our Health Service is to run efficiently, and it makes us angry to see money needlessly spent while essential maintenance and capital schemes are curtailed.—We are, etc.,

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THEO SCHOFIELD
HOWELL JOHN
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New N.H.S. Management

SIR,—As an administrator I was interested to see the letter from Dr. M. Goldman (21 September, p. 745). There is a strong body of opinion among administrators that would agree with Dr. Goldman that the reorganization of the N.H.S. has introduced one

layer of management too many and the sooner either the regional or area tier is removed the better.

I am sure that many doctors will be pleased to know that the Department of Health and Social Security has recently imposed a fairly severe restriction on the number of senior and middle-graded administrators that may be appointed in each region. It would be most unfortunate if the creation of regional and area levels resulted in inadequate numbers of the above administrators at district level. Great emphasis has been placed on the importance of the district as the operational and health care planning level. It is at this level that administrators can provide the greatest amount of help and support to their medical, nursing, and other colleagues.

As we are compelled to have regional and area tiers at present, it is vital that they should not become bureaucracies containing large numbers of administrators, appearing to hinder rather than aid the smooth running and development of the operational level where the majority of administrative work should take place in close co-operation with colleagues from all disciplines in the Health Service.—I am, etc.,

R. I. SPENCER

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Doctors' Pay

SIR,—In the past year or so your correspondence columns have contained letters from general practitioners and hospital specialists about the poor terms and conditions of service for doctors within the Health Service. Many of these letters highlight the inequalities that exist in the mode and level of payments of doctors in various parts of the Service.

I beg the courtesy of your columns once again to comment more generally on our problems. Those like myself in whole-time hospital practice feel especially badly treated. It is, however, petty and divisive constantly to compare our lot with that of others. Nobody in N.H.S. medicine is adequately paid today. The general practitioners, who are doing rather better than the specialists, are certainly not overpaid. It needs to be recognized that the whole pyramidal pay structure of doctors has slipped in relation to other groups both in the Health Service and outside. As we are employed by a monopoly employer, the Government, it is supremely difficult for our negotiators to establish a yardstick for our pay structure, as there is nothing outside the N.H.S. with which to compare. It would be very interesting to know how the pyramidal pay structures of doctors in European countries was related to the pay of other professional and non-professional groups as compared with Britain. Under the present circumstances only the doctors can decide what they are worth and I believe we should do this and state it very clearly.

In addition, our other problem is the failure of our organizations to present our true situation to the public, who regard all doctors, and hospital specialists in particular, as rich and powerful. My own experience indicates that the popular conception of a doctor's material well-being is so far ahead of the truth that it is difficult to convince all but one's most intimate non-medical

friends of the facts. It would seem that the B.M.A. could, with profit, make some effort to acquaint the public with the real facts. We might then have some popular support.—I am, etc.,

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Trade Union Tactics

SIR,—I must endorse Dr. P. E. Baldry's plea for unity within the profession at this time (21 September, p. 744). However, the British Medical Association represents all the factions which Dr. Baldry has listed and it would seem to be a more simple solution for all of the profession to come together and rally behind the major medicopolitical organization.

I would therefore appeal to those who have resigned to rejoin and to those who have not been members of the Association to join it. The Association can ill afford the loss of more radical practitioners, which only intensifies the excessively conservative nature of the B.M.A., which in turn arises from the excessively conservative nature of medical practitioners. When these more radical practitioners have joined the B.M.A. they should then lobby their proposals through the machinery so that they may influence the total policy of the Association. This is best done at the local division level as the local division has the facility to forward resolutions to the annual policy-making meeting of the Representative Body. If any member is unable to locate his local division he may get the name and address of the local honorary secretary from B.M.A. headquarters.

The appointment of a professional trade union experienced negotiator (non-medical) to the B.M.A. team of negotiators might well derive from such active lobbying. It has been not adopted in the past only because it seems that the majority of the profession do not want it.—I am, etc.,

DERMOT LYNCH

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N.H.S. Contraceptive Services

SIR,—At last there are signs of common sense breaking through with the Family Planning Association chief medical officer's plan for nurses to repeat prescriptions for the pill.¹ Many will agree with his forecast that within the next decade the pill will be on open sale.

"Money for old rope" is my view as a general practitioner of the present B.M.A. recommended rate of £1.56 for the yearly private pill prescription. The exorbitant demands of our negotiators are slowly pricing us out of the market. The only professional skill required in most cases is on the initial visit, when a few minutes' history can be taken at the same time as blood pressure reading and pelvic and breast examination. Follow-up blood pressure checks, cervical smears, and breast examination can be undertaken by a competent practice nurse. I give my patients credit for the intelligence to report any side effects and find they are not slow to come forward.