concentration of the dialysate still gave a negative result.

This woman clearly had a massive overdose of tricyclic antidepressants and it was considered that her chances of survival were extremely poor. It seemed to us that haemodialysis was responsible for a dramatic clinical improvement. This does not seem to be supported by the analyses for the drug we were able to make. In fact the decrease in plasma imipramine level did not approach the half-time of $3\frac{1}{2}$ hours reported by Ciba-Geigy (N.Z.) Ltd. (personal communication). From our results no increase in the rate of fall of plasma imipramine occurred during dialysis. Unfortunately the lack of samples prior to dialysis leaves some doubt on this point. Our inability to locate any imipramine in the dialysate may be explained by the interesting comments of Drs. Asbach and Schüller (24 August, p. 524) who claim that imipramine is taken up by the polyvinyl chloride of the extracorporeal blood-line system. Our limited experience, that of Harthorne *et al.*³ and the recent letters from Drs. Asbach and Schüller have encouraged us to give early consideration to this form of treatment in patients with severe poisoning. However, the recovery of significant amounts of drug by forced diuresis may yet indicate that this method is the most suitable way of eliminating absorbed imipramine and other tricyclic antidepressants.—We are, etc.,

ROSS R. BAILEY
JOHN R. SHARMAN
JENNIFER O'ROURKE
A. L. BUTTIMORE

Departments of Renal Medicine and
Clinical Biochemistry,
Christchurch Hospital,
Christchurch,
New Zealand

¹ Grove, J., and Halliwell, J. V., in *Manual of Analytical Toxicology*, ed. I. Sunshine, p. 189, Cleveland, Chemical Rubber Company Press, 1969.

² Niyogi, S. K., *Forensic Science*, 1973, 2, 67.

³ Harthorne, J. W., Marcus, A. M., and Kaye, M., *New England Journal of Medicine*, 1963, 268, 33.

Poisoned Children

SIR,—I was interested to read Mr. M. Calnan's letter (28 September, p. 802). I believe that the distinction he draws between true poisoning and poisoning scares is not clinically useful. In practice parents are rarely certain exactly how much of a poisonous substance their children have taken. Sending children home who have probably taken only a negligible amount of a poisonous substance would be bound to lead to the occasional disaster. Mr. Calnan, in defining "true poisoning," says that the presence of a symptom or sign is necessary. However, it is the aim of treatment by rapid stomach emptying to prevent symptoms or signs occurring. I am in the process of examining prospectively cases of child poisoning admitted to hospitals in Cardiff under the age of 5 years. Of 85 cases so far studied, in only seven was the substance ingested innocuous. Indeed, it seems from Mr. Calnan's own figures that if only 44% of his cases were admitted overnight, the majority of children taking innocuous substances would be sent home and not figure in the 16,500 children admitted nationally each year for accidental poisoning.

Mr. Calnan mentions unnecessary procedures performed on children which may in fact do harm; by that I suspect he means gastric lavage. However, now the majority of paediatric departments are using ipecacuanha emesis, a procedure that is as effective as gastric lavage with minimal risk.¹ I cannot believe that the current debate on childhood poisoning is alarmist if 22 children died in 1972 from this cause.² Many more would certainly have died without therapy.

I am sure that Mr. Calnan is right that the health education campaign may not be as beneficial as it has been hoped. This is not only because of his evidence that 79% of medicines were in use within 24 hours of the accident. We have found that so far in our study in Cardiff serious stress is commonly found in the families of accidentally poisoned children, and at such times the parents are unlikely to remember health education propaganda.—I am, etc.,

J. R. SIBERT

Department of Child Health,
Cardiff Royal Infirmary,
Cardiff

¹ Reid, D. H. S., *Archives of Disease in Childhood*, 1970, 45, 428.

² Registrar General's Statistical Review of England and Wales for 1972, Part 1, Tables, Medical, p. 176. London, H.M.S.O., 1974.

Liver Hamartomas in Patients on Oral Contraceptives

SIR,—The report by Dr. G. Vosnides and others (31 August, p. 580) of a case of liver hamartomas and its possible association with oral contraceptives merits comment in order to place this implied risk of adverse effects of oestrogen-progestogen preparations on the liver in perspective. Reports such as these might cause undue concern in women on the Pill.

The patient in question was receiving large doses of "oral contraceptives" and, in particular, was receiving doses of mestranol between 50 and 150 µg per day, well in excess of that recommended by the Committee on Safety of Medicines resulting from the findings of Inman *et al.*¹ We have shown² that in women taking this preparation there can be a high output of endogenous oestrogen at times. The significance of this remains to be clarified, but it does suggest that excessive ovarian activity can occur on occasion in women taking these preparations. In such a patient who is maintained on haemodialysis there is thus a possibility that large amounts of oestrogen, both exogenous and endogenous, might accumulate.

It would be preferable to use, and the menorrhagia is more likely to be kept in check by, an oestrogen-progestogen preparation which had a bias towards a major anti-oestrogenic effect on the genital tract such as the preparations containing larger amounts of norethisterone or its acetate with the oestrogen within the recommended dose rather than a low-dose combined preparation. If this proved to be inadequate to control the heavy bleeding the antioestrogenic effect could be augmented by adding extra norethisterone or its acetate as the case might be. This would obviate increasing the dose of both the oestrogen and progestogen as was done in the case reported. This would be particularly relevant

in the circumstances described and would minimize the risk of an accumulation of oestrogens within the body.—I am, etc.,

MAX ELSTEIN

Faculty of Medicine,
University of Southampton,
Southampton

¹ Elstein, M., *et al.*, *British Medical Journal*, 1974, 1, 11.

² Inman, W. H. W., *et al.*, *British Medical Journal*, 1970, 2, 203.

Cardiovascular Disease and Peptic Ulcer

SIR,—In your leading article (28 September, p. 760) you describe the problems in determining whether the association between cardiovascular disease and peptic ulcer is real. In two recent articles my colleagues and I discussed aspects of this association. In the first article¹ we reported 51 patients who underwent surgery for their abdominal aortic aneurysms. Twelve of these 51 patients were found to have an associated peptic ulcer at operation. Seven of these 12 patients developed complications following the resection of their abdominal aneurysm which were due to the associated peptic ulcer—namely, to haemorrhage or to perforation of the ulcer. On the basis of these findings we felt that this association was not only real but should influence the management of patients with abdominal aortic aneurysms.

In our second article² we analysed the amputation rates in 300 patients who underwent arterial reconstructive surgery for severe ischaemia of the leg. Seventy-one of these 300 patients also had an associated ulcer. In those with an ulcer the chances of losing a leg were from two to three times as high as in those without, and the chances of losing both legs were four times as high. In every other respect—sex, age, pattern of disease, and type of surgical treatment—the two groups (those with and those without an associated ulcer) were comparable.—I am, etc.,

A. P. BARABAS

West Suffolk Hospital,
Bury St. Edmunds

¹ Bouhoutsos, J., Barabas, A., and Martin, P., *British Journal of Surgery*, 1973, 60, 302.

² Bouhoutsos, J., Barabas, A., and Martin, P., *Postgraduate Medical Journal*, 1972, 48, 671.

Understanding Blindness

SIR,—Dr. J. A. Shaw in his Personal View (21 September, p. 738) does a great service not only in publicizing the difficulties of his unseeing fellows, but also in helping those of us who work with the visually handicapped by improving our insight into a situation which a sighted person can never fully appreciate.

I have always found personal accounts of illness written by medical men particularly helpful in my attempts to understand a patient's point of view. I believe we could learn a great deal if more doctors with impaired vision would put their thoughts on paper. I do not believe that doctors' awkwardness with the blind is simply a result of their frustration at not being able to cure blindness. Indeed, I think Dr. Shaw's suspicion that doctors' attitudes are no different from those of laymen is correct. Blindness is, after all, a state entirely beyond