upon withdrawal and restoration of the drug. Despite this one must agree with Drs. William Sargant and Peter Dally that the cases most responsive are the group they have described as atypical depressions. This type of case is so frequently seen at psychiatric out-patient clinics, however, that I cannot regard them as atypical, and if the monoamine-oxidase inhibitors are to be correctly used it seems of considerable importance to decide what is the primary disorder in this group. I suggest that these cases are primarily mild endogenous depressions with secondary neurotic features, and think it is a mistake to regard them as primarily neurotic disorders. I base this view on the stability of the previous personality and the frequent lack of a history of environmental precipitation.

Psychiatry is already bedevilled by nosographic problems and it does not seem necessary to increase these difficulties on the basis of the activity of the monoamine-oxidase inhibitors. I feel there is a danger that in the confusion drugs such as phenelzine and phenoxypropazine will be used to alleviate anxiety when their real value lies in their antidepressant properties.

—I am, etc.,

Uffculme Clinic, Birmingham 13.

NORMAN W. IMSAH.

REFERENCES


SIR,—When I read the article by Drs. William Sargant and Peter Dally (January 6, p. 6) I started in the usual way with the summary. Fleetingly I anticipated an answer to the riddle, when is a depression not a depression? It seems instead, however, that another question has emerged—namely, are antidepressants really antidepressants?

I do not agree that monoamine-oxidase inhibitors (M.A.O.I.) used alone "can often be very effective in the treatment of certain anxiety states, even where there may be no obvious sign of depression." Certainly pure anxiety states are rarely seen in clinical practice, but though the addition of depression is common it is not invariable. I have used M.A.O.I. and chlорdiazepoxide hydrochloride, both in combination and singly in the way Drs. Sargant and Dally describe. My experience is that patients with anxiety states, and particularly the phobics, are aggravated by M.A.O.I. This was apparently so with some of their patients in group 3, in which the average length of illness was even longer than in the other groups. It is important to note, however, that all their patients were chronics who had attended the department "for considerable periods of time." I believe that M.A.O.I. are contraindicated for patients with anxiety states of recent onset, while chlорdiazepoxide may be helpful.

It is quite usual nowadays to find that depressed patients attending the psychiatric out-patient department for the first time have already been given M.A.O.I. by the general practitioner. Atypical depression thus often means a partly treated depression, and diagnosis of an attenuated illness can be difficult. Now more than ever it is necessary to pay close attention to the drugs which the patient has been taking recently, and referring general practitioners do not always mention them. It is to be hoped that Drs. Sargant's and Dally's article will not tempt general practitioners to use the double attack in acute psychiatric illness, for this is likely to prove very confusing indeed.—I am, etc.,

St. Helen Hospital,
Carshalton, Surrey.

MICHAEL RAYMOND.

SIR,—I am sure that the author of your leading article "Drugs for Anxiety" (January 6, p. 38) could not have been a G.P. It states that the era of valerian is over. Pot. brom. and valerian is still a sovereign remedy for nerves, etc., and I think it cures more headaches than any other drug which I have used for this purpose. Three bottles of pot. brom. and valerian and the headaches stay away long after the last bottle.—I am, etc.,

M. E. LAMPARD.

Progressive Patient Care

SIR,—Is it not a sad reflection on the National Health Service mentality that Mr. R. W. Raven's excellent article on "Progressive Patient Care" (January 6, p. 43) can find only an isolated example in this country where an efficient, modern method of treatment is in being—although the method has been tried in other countries and has been found to be economical in nursing personnel, of which there is a shortage? It is sad also that he has to end the article by a semi-apology looking for brickbats instead of applause as he deserves.

I can sympathise with him, as I am on a working party for the design of new operating theatres in a hospital group. In preliminary discussions, when I pressed for a recovery unit I was told by the architect that it was not the board's policy to have a recovery unit.—I am, etc.,

GILBERT DALLEY.

Hospital Bed

SIR,—In these days when science is being wooed in every land to make life more tolerable or more dangerous, it might be considered whether the best brains, covered with the longest hair, could stoop to review the hospital bed in all its aspects.

Here is something that half a century has done little to alter. In the face of the too popular nurses' ricked backs, and the old patients' fractured femurs (due to staff shortage, I believe), a great step forward would be made if every hospital bed were equipped with pneumatic legs, adjustable through piped compressed air to any height from 9 inches (23 cm.) above hospital floor level to the convenient height for a long-backed nurse, and operated by a simple foot pedal.

Each bed must be capable of being easily lowered to near floor level when required, to reduce the possibility of a patient's night fall where supervision is difficult. It must be adjustable to a height for the facile transfer of the patient to the commode, with the return journey as easy.

It must be easily brought to the height that will make the attending nurse say " this bed is now neither too high nor too low for me." The sting would then have been taken out of nursing.—I am, etc.,

Hextam, Northumberland.

RICHARD BELL.

Vertebral Fractures in Tetanus

SIR,—I read with interest the article by Mr. John Comrie (January 6, p. 31) under the heading of "Unusual Presentation of Tetanus," in which he described compression fractures of the dorsal vertebrae caused by muscular spasm. A somewhat similar but more extreme incidence may be of interest.

A boy of 9½ years was seen on March 15, 1949, complaining of severe pain in the upper dorsal region for the
previous three days. There was no history of local injury and no sign of any wound. It was noticed that he had a slight asymmetry of the face, which was thought at the time to be due to a mild degree of torticollis. Apart from stiffness of his dorsal spine no clinical abnormality could be found. His temperature was 99.4° F. (37.4° C). An x-ray was taken of his dorsal spine which was normal. He was admitted for observation.

By the following morning it was clear he had more general muscle spasms which were now affecting the jaws and there was no doubt he had tetanus. He was treated by intramuscular antitetanic serum (25,000 units for three days), penicillin (50,000 units four-hourly), and rectal paraldehyde in doses of \( \frac{1}{3} \text{ fl. oz. (14 ml)} \) as required. As swallowing became painful he was fed through a Ryle tube for several days. He later developed severe attacks of opisthotonos. He was examined as little as possible during the acute phase of his illness, but by April 4, when he was considerably better, it was noted that he had developed marked dorsal kyphosis. An x-ray now showed severe compression fractures of the 4th to 9th dorsal vertebrae. He was later transferred to the Lord Mayor Treloar Orthopaedic Hospital, Alton, under Mr. E. Stanley Evans, where he was treated by extension and a plaster bed. He finally made an excellent and complete recovery with almost no ultimate radiological changes in his dorsal spine.

The mechanism of the fractures seems to be that spasm of the abdominal muscles flexes the thoracic cage forwards, at the same time spasm of the extensor muscles of the lumbar region is sufficiently strong to split the lumbar vertebrae. The extendors of the dorsal spine are very much weaker and hence the compression fractures occur in that region.—I am, etc.,

Farnham Hospital, Farnham, Surrey.

S. C. RAW.

Antitetanus Immunization

Sir,—It is the practice in most hospital casualty departments to give antitetanic serum to any unimmunized patient who has an injury which breaks the skin surface, however trivial the injury. This is the advice of the consultant in charge, because tetanus can follow even very trivial injury however and wherever caused. Indeed this was so in the only case of tetanus I have so far seen. Most people must suffer dozens of trivial injuries every year. So, to my mind, this practice is just not a practical proposition really.

I think people should be told that it would be best if they only had antitetanic serum once in their lives; that in quite a lot of people its protecting powers diminish with repeated injection and that the chances of reactions increase; that if they want good protection from tetanus all the time for all injuries then they should be actively immunized; that if they won't be bothered to get immunized they would be better advised to save the antitetanic serum for an actual attack of tetanus, if by an odd chance they got it; that their chance was not a very big one at all in view of the frequency of injuries.—I am, etc.,

Wisbech, Cambs.

C. A. RUSHMER.

Treatment of Bladder Tumours

Sir,—In Mr. D. P. B. Taylor's article on "Vesical Haemorrhage After Megavoltage Radiation" (December 2, p. 1462) I was interested to learn that the cause was thought to be a residual or recurrent tumour area. In his suggested methods of therapy one notes omission of chemotherapy. This method of therapy has been highly effective in palliation of metastases in serous cavities where a high dose of the drug can be given to produce a local cancercidal effect without severe systemic complications.

At the Toronto East General Hospital we have initiated a study using intravesical vincleucoblastine. The results on two terminal bladder-carcinoma patients have been sufficiently encouraging to warrant a wider study of this method of palliation. It would be of value if trials could be initiated using the alkylating agents, antimitabolites, and other antitumour drugs for their local palliative effect against painful haematuria resulting from resistant bladder tumours.—I am, etc.,

Toronto 6, Ontario, Canada.

GERALD D. HART.

Industrial-bullet Wound

Sir,—I was interested to see Dr. L. Klenerman's letter (December 30, p. 1785) on the cartridge-operated pin-driving tool used by builders in steel and concrete, and am stimulated to cap his story with a personal encounter with this new industrial hazard.

In 1961 two builders were received in the casualty department of St. Mary's Hospital, London W.2, both in pain, rather shaken, but not clinically shocked. The elder of the pair, in demonstrating the safety of a "epimatic" for firing unthreaded pins about 2 inches (5 cm.) long, had pressed the loaded tool against his own left palm. The resulting detonation sent the pin through his hand, shattering two metacarpals, then on to strike his workmate. The pin tunneled through the second man's skin over the left pectoralis major, emerged at the anterior fold of the axilla, re-entered through the left deltoid, drilled a neat channel through the upper end of the humerus, finally passing out through the skin posteriorly, to drop down harmlessly inside the man's overall sleeve. Subsequent exploration of the track recovered a small plastic sleeve that had ensheathed the pin. No major nerve or vessel had been damaged. The external wounds in both patients were remarkably inconspicuous.

This doublet is quoted to emphasize the perils of skylarking with a tool of lethal potentiality.—I am, etc.,

Royal West Sussex Hospital, Chichester, Sussex.

PETER J. E. WILSON.

Suppression of Cough

Sir,—I generally accept the leading articles in the Journal as being authoritative, but when I find a preparation in Prescribing Category O ('"tessalon"—benzonatate) being recommended (December 9, p. 1549) as "particularly valuable when chronic cough is associated with bronchospasm" then my loyalty to two differing authorities is strained.

As a matter of principle should substances in Category O be recommended?—I am, etc.,

Glascow.

DAVID A. PRIMROSE.

POINTS FROM LETTERS

Presentation of Glyceryl Trinitrate

Dr. R. J. JAMESON (Huddersfield) writes: I tried the new white ones for a short period and soon gave up because of the many complaints from the patients. I then began to use "Tabs. brown glyceryl trinitrate" on all my prescriptions, and after one or two telephone calls from various chemists experienced no further difficulty. I am sure Mr. D. C. Mackenzie (November 4, p. 1227) and Dr. F. Ross (December 2, p. 1502) would be able to do the same for their patients.