dipes; (2) high relative humidity in the room; (3) preoperative dehydration; (4) atropine and other anticholinergic drugs.

Heatstroke is a highly fatal disease unless promptly treated. But it is also a preventable disease. Surgeons and anaesthetists should consider what can be done to alter the conditions in the operating-room and the condition of the patient. As a single important way to prevent fatal heatstroke in the operating-room, I suggest monitoring of body temperature during surgery. This is easily done, and, because the patient is unconscious, can provide the only clue to diagnosis in time.

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REFERENCES

Outpatient Anaesthetics

SIR,—Dr. R. K. Gilbert (3 March, p. 637) draws attention to the necessity of solving the anaesthetic problems of outpatient operating, and thereby does a service to anaesthesia. However, we can assure him that for the series in question (Mr. J. A. Williams and Dr. D. Dean and Dr. R. R. Wilkinson (18 January, pp. 174 and 176)), surgeon and anaesthetist have been in the closest possible liaison from the beginning of the study.

Anaesthetic aspects of outpatient operating were not included in the original publication because we, as the consultant anaesthetists associated with the team, have found that these aspects pose no problems, and no departure from our usual practice is necessary or desirable. Modern anaesthesia makes possible prompt awakening of the patient, and a great freedom from postoperative vomiting and 'hangover,' provided the traditional opiate premedication is avoided. We do not think the traditional opiate premedication is desirable for inpatients either, for a variety of reasons which are also relevant to the outpatient.

Of course, success in outpatient operating is greatly dependent upon a careful selection of the patients, attention being paid particularly to their general health and their social conditions. This selection has been performed more successfully by the surgeon and the general practitioners. The decision to allow the patient to return home the same day rests with the anaesthetist. In no case has it been necessary to retain the patient in hospital.—We are, etc.,

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Fresh Onions and Blood Fibrinolysis

SIR,—Allium cepa, the common onion, has been investigated by several workers and has been found to contain a hypoglycaemic agent. However, the active principle responsible for the hypoglycaemic effect was found to be very unstable.

Recently my colleagues and I demonstrated that fried or boiled onions increased the blood fibrinolytic activity. The study reported below is a follow-up of our previous findings, and was undertaken to discover if the property which causes this increase in fibrinolysis was present in the raw onion or brought about by the process of heating (boiling or frying).

Effect of Fresh Onions and the Water in which Onions were Boiled on Fibrinolytic Activity

Engelobulin Lysis Time (in units)

<table>
<thead>
<tr>
<th>Subject</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breakfast Only</td>
<td>Breakfast + Liquidized Fresh Onions</td>
<td>Breakfast + Liquidized and Strained Fresh Onions</td>
<td>Breakfast + Water in which Fresh Onions were Boiled</td>
</tr>
<tr>
<td></td>
<td>9.30 a.m.</td>
<td>12.30 p.m.</td>
<td>9.30 a.m.</td>
<td>12.30 p.m.</td>
</tr>
<tr>
<td>1</td>
<td>15-6</td>
<td>13-2</td>
<td>13-0</td>
<td>14-9</td>
</tr>
<tr>
<td>2</td>
<td>13-0</td>
<td>11-6</td>
<td>11-3</td>
<td>11-3</td>
</tr>
<tr>
<td>3</td>
<td>65-9</td>
<td>37-9</td>
<td>36-2</td>
<td>37-9</td>
</tr>
<tr>
<td>4</td>
<td>35-9</td>
<td>25-7</td>
<td>25-8</td>
<td>45-7</td>
</tr>
<tr>
<td>Mean</td>
<td>32-7</td>
<td>20-0</td>
<td>19-6</td>
<td>38-9</td>
</tr>
</tbody>
</table>

Four volunteers were included in the study. On day 1, after fasting, samples of blood were collected for the estimation of the engelobulin lysis time using the method described by von Kaulla* slightly modified. The fibrinolytic activity has been derived from these lysis times and expressed in units by multiplying the

were made to rest throughout the experiment, since a previous study had shown that moderate exercise increases the fibrinolytic activity. Smoking was not permitted.

The Table shows the fibrinolytic activity of the four volunteers. The results indicate that after ingestion of breakfast the fibrinolytic activity is decreased. The addition of fresh onions did not prevent this reduction but caused a marked increase. The water in which the onions were boiled had, however, no effect on the fibrinolytic activity.

The results show that the property which causes an increase in the fibrinolytic activity is inherent in the fresh onions and not brought about by heating. The results also confirm that the factor responsible for the increase in fibrinolytic activity is not water-soluble. In the previous study we had shown that the factor is not only heat-stable but probably not water-soluble.—I am, etc.

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REFERENCES

“Cold” Cures and Monoamine-oxidase Inhibitors

SIR,—Prompted by the recent article (15 February, p. 404) warning of the potential hazard from the use of monoamine-oxidase inhibitors and phenylpropanolamine contained in various “cold” remedies, we thought it of interest to report the following case.

A 38-year-old woman had been treated for three months with phenelzine (Nardil) 15 mg. t.d.s. At the end of November last year she developed a “head cold” and on the evening of 8 October took one McNeil tablet containing 30 mg. phenylpropanolamine at approximately 10.15 p.m. About 15 minutes later she experienced the sudden onset of a throbbing frontal headache intense enough to cause her to cry out. She was seen by a doctor at 11 p.m., who found her to be in a state of shock. She recorded her blood pressure as 210/100 mm. Hg. A subarachnoid haemorrhage was suspected; the patient was given 100 mg. of pethidine intramuscularly and transferred to hospital.

On admission to this hospital at about midnight she was found to be disoriented but responding to simple questions and able to constitute a sentence. Vomiting followed, which was widely dilated and reacted sluggishly to light. Her fundi were normal. The reflexes were brisk and equal with bilateral extensor plantar responses. There was no neck stiffness, and Kernig's sign was negative. The pulse rate was 80 per minute and regular, and the blood pressure was 200/100. No other abnormal findings were detected. Lumbar puncture

that showed no abnormality.

REFERENCES