of us spotted that he had fainted; we all mistook the faint for the onset of smooth anaesthesia, and but for a warning cried out by the technician who was following the blood pressure on the recording apparatus the patient might well have died.

Dr. Tomlin's case outlined above, Dr. Tomlin, 2 November, p. 288) somewhat surprisingly attributes the death to pulmonary oedema. I have pointed out that in cases of sudden collapse and death in the dental chair when fainting was the only rational explanation pulmonary oedema seems to be a constant necropsy finding. Indeed, Dr. Tomlin himself has reported this finding.5 The case was that of a woman aged 22 sitting up in the dental chair who lost consciousness and collapsed during the injection within the mouth of 1.5 ml of a local analgesic solution. She died and "the post-mortem revealed acute pulmonary oedema." Discussing the cause of this death, Dr. Tomlin makes no mention of the pulmonary oedema. He attributes the death either to acute sensitivity to the analgesic agent or to "a severe dysrhythmia or a faint."—I am, etc.,

J. G. BOURNE

Salisbury, Wiltts

6 Tomlin, P. J., Anaesthesiologist, 1974, 29, 551.

John Locke

Sir,—I was interested to read Mrs. Hilda M. Stowell's letter (30 November, p. 530) about my article on John Locke (5 October, p. 34). I am sorry if one sentence in my article gave the impression that Locke was in exile for the whole period 1660–89. In fact there is nothing in the article to suggest that Locke followed Shaftesbury into exile in 1683 (that is, during Charles II's reign), lay low to avoid association with those involved in Monmouth's rebellion, and returned with William III in 1688. My article refers to Locke's five years in the Netherlands, which makes it clear that he went there in 1683. As Mrs. Stowell cares to read my book on Locke1 she will, I think, find little to quarrel with.—I am, etc.,

M. V. C. JEFFREYS

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Imported Diseases

Sir,—The recent articles on imported diseases are useful and point to some of the possible causes. But articles of this kind, designed for the general reader, must take special care to inform and not to misinform. I was interested to read with Professor H. Hedley Geddes (23 November, p. 454) on several points.

A paragraph is devoted to Lassa fever. This is far from common, even in Africa, and few in British here, see even a single case of this highly infectious, distressing, and often fatal disease. The same amount of space is given to dengue fever, but no mention at all is made of the multitude of other diseases attributable to mosquitoes—sandflies, or ticks and which are known to be responsible for disease in man (usually fever but sometimes manifestations such as encephalitis) not only in tropical and subtropical regions but also in areas as close to Britain as the south of France, Italy, and Cyprus. Viruses of this type are also known to be active in Scandinavia, Austria, and Portugal. Details of these viruses are probably a matter for the specialist, but their existence should be recognized by all practitioners. Diagnosis in the cases of Lassa, dengue, and yellow fever is dismissed rather cavalierly, as "confirmed by serum antibody studies." This is so, but the pertinent question is where can these be done? To my knowledge there is no virus laboratory in the United Kingdom where a service is available for the routine diagnosis of arbovirus infections. This is a small but important lacuna and one which it would be relatively inexpensive to fill.—I am, etc.,

R. N. P. SUTTON

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Medical Necromesis

Sir,—The gist of your leading article on Ivan Illich's Medical Necromesis (7 December, p. 548) is that, while clearly much is wrong with medicine, there is nothing that doctors and other citizens cannot set to rights, that Illích is a somewhat wild man, if interesting, and that one cannot put the clock back. Of the three reviewers of his book (7 December, p. 573) one, Dr. A. Paton, gracefully accepts almost the whole Illichian thesis and two reject much of it.

Professor G. Discombe makes four chief points. First, that Illích is often obscure; agreed. Second, that he is talking mostly about American medicine, to which the right answer is that increasingly American medicine is the kind that dominates the West and its outposts in underdeveloped countries. (Professor Discombe is, I am sure, aware that the U.S.A. is importing some 400 doctors a year, many from underdeveloped countries, and at a time when the American male's expectation of life at birth is falling). Third, he seems to think that Illích would approve of those who choose the products of Western medical technology of "the shackles of ignorance, of disease, and of starvation from which the third world is trying to escape." In fact, I think, Illích would disapprove only if the price of such removal were to be a take-over of the indigenous culture by Western technology. After all, it is Professor Discombe, not Illích, who says, in an Africa's town or village most people seem to be fairly happy and contented. But appearance is no guide to the load of sickness—"to which Illích would add that if he had to choose between destroying the load of sickness and preserving that of happiness he would choose the latter. He has no fear of the barefoot-doctor approach (or of alternative technology generally), only of its practitioners learning from doctors to professionalize themselves by means of a College of Barefoot Doctoring. Fourth, Professor Discombe thinks Illích an enthusiastic romantic—that is, that Illích is not a realist.

Professor P. Rhodes, the third reviewer, adds various points—for instance, that "many would reject the thesis that pain, sickness, and death are to be welcomed." If what is meant is all pain, sickness, and death, then Illích would be one of the many. He says (Medical Necromesis, p. 121), "De-professionalization does not mean the abolition of modern medicine... it disregards the special needs which people manifest at special moments in their lives: when they are born, break a leg, become crippled, or face death." Professor Rhodes, as a man who thinks Illích thinks man is to be just that: Illích thinks industrial man is an island and that no man ever should be. Finally, Professor Rhodes, too, thinks Illích offers as a solution a retracing of our steps: "his solution is now not possible if it ever was."

One common thread is clearly that Illích is not a realist (unlike doctors). As your reviewers and your leading article indicate, Illích regards medical necromesis as a part of a more generalized industrial necromesis, and it cannot be understood except in that larger context. As an unashamed romantic—in the Illíchian mode—I think Illich is not a prophet of industrial (or medical) necromesis: like the rest of us, he is now a witness of its occurrence. The clock is visible going back. In what manner the doctor should start going "forward" again—when that becomes possible—is perhaps the major question of our time. Illích supplies an answer to it.—I am, etc.,

John S. Bradshaw

How Caple, Hereford

1 Illich, I., Medical Necromesis. London, Calder and Boyars, 1974.

Vitamin D Deficiency in Rheumatoid Arthritis

Sir,—Drs. P. J. Maddison and P. A. Bacon (23 November, p. 433) omitted to give adequate details of the drug history in their rheumatoid arthritis patients who had clinical and biochemical evidence of osteomalacia. If they had been receiving long-term mild analgesics and anti-inflammatory drug therapy, I wonder if the authors had considered the role of a drug-induced disturbance of vitamin D metabolism in the aetiology of their patients' bone disease?

There is now considerable evidence that long-term treatment with anticonvulsants can disturb the hepatic metabolism of this vitamin, probably by virtue of their powerful microsomal enzyme inducing properties.1 It is known that many mild analgesic drugs have a similar effect on liver enzymes,2 and their chronic administration could therefore create a state of increased turnover of the vitamin in patients whose dietary intake and exposure to sunlight are already below average.

Measurements of urinary p-glucaric acid excretion3 or plasma antipyrine or quinoline half lives,4 which are indices of hepatic enzyme induction, would be interesting in these patients.—I am, etc.,

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[Br Med J. first published as 10.1136/bmj.1.5949.94 on 11 January 1975. Downloaded from http://www.bmj.com on 9 June 2022 by guest. Protected by copyright.]