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.

In the boy's case outlined above, Dr. Tomlin (2 November, p. 288) somewhat surprisingly attributes the death to pulmonary oedema. I have pointed out[3] 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.[6] 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 standard 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, Wilts

1 Bourne, J. G., *Studies in Anaesthetics*, p. 131. London, Lloyd-Luke, 1967.
2 Bourne, J. G., *Anaesthesia*, 1970, **25**, 473.
3 Bourne, J. G., *Lancet*, 1973, **1**, 35.
4 Bourne, J. G., *Lancet*, 1957, **2**, 499.
5 Bourne, J. G., *Lancet*, 1966, **1**, 879.
6 Tomlin, P. J., *Anaesthesia*, 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.

If Mrs. Stowell cares to read my book on Locke[1] she will, I think, find little to quarrel with.—I am, etc.,

M. V. C. JEFFREYS

Lyndhurst, Hants

1 Jeffreys, M. V. C., *John Locke; Prophet of Common Sense*. London, Methuen, 1967.

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 especial care to inform and not to misinform. I must therefore take issue with Dr. A. M. 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 Britain have seen 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 viruses transmitted by mosquitoes, sandflies, or ticks and which are known to be responsible for disease in man (usually fever but sometimes more severe 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 fevers 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

King's College Hospital Medical School, London S.E.5

Medical Nemesis

SIR,—The gist of your leading article on Ivan Illich's *Medical Nemesis*[1] (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 Illich 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 Illich 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 4000 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 Illich would disapprove of the removal by means of 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, Illich 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 Illich, who says, "In an African town or village most people seem to be fairly happy and contented. But appearance is no guide to the load of sickness"—to which Illich would add that if he *had* to choose between destroying the load of sickness and perpetuating 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 Illich an enthusiastic romantic—that is, that Illich 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 Illich would be one of the many. He says (*Medical Nemesis*, p. 121), "Deprofessionalization does not mean the abolition of modern medicine . . . [or] disregard for 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 thinks "no man is an island," but believes that Illich wants man to be just that: Illich thinks industrial man is an island and that no man ever should be. Finally, Professor Rhodes too thinks Illich 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 Illich is not a realist (unlike doctors). As your reviewers and your leading article indicate, Illich regards medical nemesis as a part of a more generalized industrial nemesis, and it cannot be understood except in that larger context. As an unashamed romantic—in the Illichian mode—I think Illich is not a prophet of industrial (or medical) nemesis: like the rest of us, he is now a witness of its occurrence. The clock is visibly going back. In what manner we should start going "forward" again—when that becomes possible—is perhaps the major question of our time. Illich supplies an answer to it.—I am, etc.,

JOHN S. BRADSHAW

How Caple, Hereford

1 Illich, I., *Medical Nemesis*. 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 arthritic 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.[1-3] It is known that many mild analgesic drugs have a similar effect on liver enzymes,[4] 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 D-glucaric acid excretion[5] or plasma antipyrine or quinine half lives,[6 7] which are indices of hepatic enzyme induction, would be interesting in these patients.—I am, etc.,

ALAN RICHENS

Department of Clinical Pharmacology, St. Bartholomew's Hospital Medical College, London E.C.1

1 Richens, A., and Rowe, D. F. J., *British Medical Journal*, 1970, **4**, 73.
2 *Lancet*, 1972, **2**, 805.

3 Silver, J., Neale, G., and Thompson, G. R., *Clinical Science and Molecular Medicine*, 1974, **46**, 433.
4 Kuntzman, R., *Annual Review of Pharmacology*, 1969, **9**, 21.
5 Hunter, J., *et al.*, *Lancet*, 1971, **1**, 572.
6 Stevenson, I. H., *et al.*, *British Medical Journal*, 1972, **4**, 322.
7 Padgham, C., and Richens, A., *British Journal of Clinical Pharmacology*, 1974, **1**, 352P.

The HBAg Carrier

SIR,—Your leading article (23 November, p. 427) failed to consider the troublesome problem of the nurse who is a persistent carrier of hepatitis B antigen. At present routine tests for HBAg are done only for nurses in renal or blood transfusion units. At this stage they are well advanced in their careers and the knowledge that they are carriers of HBAg may subsequently limit the scope of their professional work.

I suggest that it might be worth while to screen every nurse for HBAg carriage on entry to the nursing profession. At this time blood specimens are often collected from nurses for assessment of immunity to rubella; such specimens would also serve for HBAg tests. Any entrant found to be a carrier of HBAg might then be advised to discontinue nursing as a career.—I am, etc.,

CONSTANCE A. C. ROSS

Ayrshire Central Hospital,
Irvine

Poisoned Children

SIR,—We would like to echo the concern expressed by Dr. J. R. Sibert (26 October, p. 231) regarding the letter from Mr. M. Calnan (28 September, p. 802) in which he criticizes the current concern over the high rate of poisoning in children as being alarmist and implies that many of the admissions to hospital for this cause are unnecessary. He states that over 65% of the alleged incidents were in fact "poisoning scares"—that is, no symptoms developed or the substance was relatively innocuous. He implies that parents should be educated to discern whether or not the child has taken a significant amount of a poisonous substance and hence reduce the numbers of children coming to casualty departments, and that once they arrive there the casualty officer should be much more ready to send them home without even emptying the stomach if he thinks that it is only a poisoning scare. He surely is not being realistic. It is only in retrospect that one knows that no symptoms have developed and that the poisoning scare was in fact unfounded.

In the confusion and stress of a domestic poisoning scare a parent can hardly be expected to make rational judgements, and surely any parent worried that his child may have taken a poisonous substance should be encouraged to seek medical advice. Indeed, Dr. Sibert has pointed out that there is often considerable stress in the household before the poisoning episode and this makes clear thinking even less likely. Similarly, even experienced doctors find it impossible to tell which child may develop symptoms, and those providing primary care in the accident and emergency department are perhaps the least experienced. Surely it is better to err on the side of safety and treat all cases of suspected poisoning in children as potentially serious. The attitude expressed by Mr. Calnan can surely lead only to an increase in the number of children dying each year in England and Wales.

We believe the current debate on this problem is not alarmist but fully justified and are pleased to note that after years of pressure official action is being taken to prevent some of the poisoning by tablets—that is, if the Medicines Commission's proposals[1] ever come into effect.—We are, etc.,

A. W. CRAFT
R. H. JACKSON

Children's Department,
Royal Victoria Infirmary,
Newcastle upon Tyne

1 Medicines Commission (Working Group), *Report on the Presentation of Medicines in Relation to Child Safety*. D.H.S.S., 1974.

More Abortions?

SIR,—Your headline "More Abortions" (30 November, p. 541) and your opening sentence about the "record number" of abortions notified in 1973 might give the uninitiated the impression that there has been a significant increase in British abortions during the past two years. This is not the case. The number of abortions carried out on British residents has remained virtually unchanged since 1972 as shown below.

Year	England and Wales	Scotland
1972[1]	108 500	7500
1973[2]	110 500	7500
1974*	111 500[3]	7000[4]

* Estimated from figures for first nine months

The increases recorded since 1972 have been very largely confined to patients coming to England and Wales from countries in Europe where the abortion law has not yet been reformed. Recently abortion law reform bills have been passed in both Germany and France, which sent us 46 000 abortion patients in 1973. These figures will certainly decline sharply next year.

Women are coming here in increasing numbers from the Republic of Ireland. A recent parliamentary reply[5] suggests that 17% more arrived here in 1974 than 1973. In addition, many more Irish women having abortions in London give local English accommodation addresses. The Irish Hierarchy is so concerned about this that a subcommittee of its council for social welfare has been asked to prepare a report on this problem. Thus it is possible that the very small increase in "resident" abortions since 1972 is in fact caused by "non-residents."

Mr. James White, M.P., in an interview in *The Scotsman* on 28 November, said he intended to obtain an amendment to the Abortion Act to keep out patients from overseas. It will be interesting to see whether he can devise a method of keeping out patients from Eire and the Common Market countries and, if so, whether the new Common Market legislation permits this.—I am, etc.,

MADELEINE SIMMS
Research Fellow,
Eugenics Society

London S.W.1

1 *Registrar General's Statistical Review for 1972, Supplement on Abortion*. London, H.M.S.O., 1974.
2 *Registrar General's Statistical Review for 1973, Supplement on Abortion*. London, H.M.S.O., 1974.
3 *Registrar General's Weekly Returns for England and Wales*. London, H.M.S.O., 1974.
4 *Hansard*, House of Commons, 22 November 1974. Written Answers, col. 556.
5 *Hansard*, House of Commons, 25 November 1974. Written Answers, col. 83.

"Negative Pressure": a Dangerous Myth

SIR,—A commonly advocated method for the limitation of "negative pressure" in suction circuits is to interpose a bottle containing a quantity of water between patient and suction course, the inlet and outlet tubes opening above the water-level. A third tube, open to the atmosphere, is inserted through the bottle stopper and dips "H" cm below the water. It is a surprisingly common belief that the suction is now limited to "H" cm H_2O if air is bubbling through the water from the bottom of the tube. I feel this belief to be a potential source of danger to patients, particularly as I have seen the method used postoperatively in neonatal chest cases.—I am, etc.,

D. WAKELY

East Glamorgan General Hospital,
near Pontypridd

"Locked-in" Syndrome

SIR,—While we feel that Dr. C. H. Hawkes (16 November, p. 379) has performed a valuable service in focusing more attention on the entity of the "locked-in" syndrome, we would like to make two further points.

(1) The motor response which permits communication in these patients is eyelid opening rather than vertical eye movement; indeed, the diagnosis is often first suggested by eye opening to verbal command.

(2) We doubt that Jennett and Plum[1] ever intended the term "locked-in" syndrome to be replaced by "persistent vegetative state." They emphasized that "locked-in" patients are "entirely awake, responsive, and sentient" in contrast to persistent vegetative patients, who are "capable of growth and development but devoid of sensation and thought."—We are, etc.,

R. JOHN LEIGH
N. E. F. CARTLIDGE

Department of Neurology,
Royal Victoria Infirmary,
Newcastle upon Tyne

1 Jennett, B., and Plum, F., *Lancet*, 1972, **1**, 734.

Antiemetics for High-dose Cyclophosphamide

SIR,—Vomiting is a distressing and often intractable side effect of cytoxic chemotherapy. It is particularly undesirable in high-dose cyclophosphamide regimens during which a high urinary output is necessary to prevent haemorrhagic cystitis.

In children with solid tumours cyclophosphamide 1200-2000 mg/m^2 is given here over one to five days as part of cyclical combination chemotherapy protocols. During this intensive therapy promethazine hydrochloride 75 mg m^{-2} 24 hr^{-1} given intravenously 6-8 hourly has been substituted for other antiemetics in seven cases. As a result vomiting is no longer a problem and has been abolished in most of the patients. A urinary output of over 1500 ml m^{-2} 24 hr^{-1} is easily achieved and protein calorie intake, previously negligible on cyclophosphamide, is now very satisfactory.