financial provision in the event of a com- 
opassionate situation arising which forces him 
to seek resignation within this five-year 
period.
My own predication may serve to illustrate the 
application of these terms of service. On 1 April 1974 formal 
application was made to resign my commission on com- 
passionate grounds. One hundred and sixteen 
days later this application was passed to and 
approved by the Army Retirements Board. 
At interview with the Army Medical 
Directorate I was informed that (a) the re-
cruiting booklet is not legally binding and 
(b) you don’t have to point out the bad 
features when you’re trying to sell some-
thing—only the good ones.
While agreeing that it is impossible to 
include all the detailed rules in a recruiting 
booklet, I do take exception to the evident 
lack of concern to explain these matters to 
those who may reasonably need such infor-
mation in providing for the welfare of 
their families. Now, after 12 years’ con-
tinuous commissioned service, I am not 
eligible for any terminal gratitude since, as 
a result of advice given at the time, I had 
served only 41 years’ regular commission.
—I am, etc.,

KENNETH HEDGES
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Diagnostic Test for Multiple Sclerosis

SIR,—In the recent letter from Dr. M. A. 
Crawford and Mr. A. G. Hassan (18 
January, p. 150) which referred to the 
linoleic acid effects in the macrophage 
electrophoretic mobility test in multiple 
sclerosis patients1 there seems to be some 
confusion about the method applied.
In fact, it is not patients’ macrophages 
which are used in the assay, but their 
ashed and separated blood lymphocytes.
The incubation of these cells with antigen 
and the subsequent cytophotometric 
measurements are carried out in a serum-
free medium. The macrophages used are 
then unimmunized guinea-pigs.—I am, etc.,

J. MERTIN

Transplantation Biology Section, 
Division of Surgery Sciences, 
Clinical Research Centre, 
Harrow, Middlesex

1 Mertin, J., Shenton, B. K., and Field, E. J., 
"Whosagin, 1977, 2, 277.
2 Mertin, J., et al., British Medical Journal, 
1974, 3, 567.
3 Field, E. J., Shenton, B. K., and Joyce, G., 
British Medical Journal, 1974, 1, 412.

Hazzards of Argyll Trocator Catheter

SIR,—I should like to draw attention to the 
Argyll trocater catheter that is now widely 
supplied for use for intercostal thoracic 
drainage. This consists of a plastic catheter 
that is passed through a trocar, but when pressure 
on the trocar is increased it will penetrate the 
chest wall and considerable force is needed.
As there is no flange, there is no means of 
 arresting the passage of the trocar and 
cannula and I have now seen a number 
of instances in which vital organs have been 
perforated owing to the unchecked passage 
of this instrument, and indeed such com-
 plications should have been anticipated.
A disposable catheter can be used through the 
 normal trocar and cannula, which has a 
flange and is short.—I am, etc.,

LESLIE J. TEMPLE
Liverpool Cardio-Thoracic Surgical Centre, 
Broughton Hospital, Liverpool

"Locked-in" Syndrome

SIR,—Dr. C. H. Hawkes (16 November, p. 
379) ascribes to Dr. F. Plum and me the 
suggestion that patients with the "locked-in" 
syndrome and with a kinetic mutism should 
be grouped under the persistent vegetative 
state. In fact we stated the opposite, that 
these conditions should be distinguished 
from each other. In our description of the 
vegetative state we mentioned how the 
eyes might follow objects the patient would 
never signal appropriately by means of eye 
movements. The term "locked-in" was in-
deed coined by Plum and Posner,2 and in 
the second edition of their monograph they 
emphasized that it should not be confused 
with the vegetative state.—I am, etc.,

Department of Neurosurgery, 
Institute of Neurological Sciences, 
Southern General Hospital, 
Glasgow

1 Jennett, B., and Plum, F., Lancet, 1972, 1, 734.
2 Plum, F., and Posner, J. B., Diagnosis of Stupor 

Pseudopatients

SIR,—Your leading article (28 December, p. 729) 
takes a singularly negative view of Rosenhan’s paper "On 
Being in Insane Places." To me it seemed it would be a pity if 
this were to deter people from taking the trouble to read an 
unusual and painstaking study. Rosenhan is meticulous in distin-
guishing between the facts he reports and the 
discussion of their implications. Above all, his work 
displays concern and a sober 
avoidance of the dramatic and 
polemical. I am afraid the same cannot be said of your 
response. Since Rosenhan is trying to widen 
our knowledge in an area where reliable 
information is very hard to obtain, we cannot 
afford to neglect what we get.
Many specific points could be taken up, 
but I will confine myself to one. The central 
argument in your article is that no reliance 
can be placed on conclusions from an 
unaccustomed inquiry which begins with deceit and lies; at 
the same time the author is criticized for not 
using such language, surely deceit and lies 
are similarly the basis for most respectable 
double-blind trials. I respectfully suggest 
that we cannot have it both ways. The actual 
findings of the study do not particularly 
surprise me after 15 years’ experience in 
psychiatry.
I could take issue with Rosenhan in re-
spect of his tendency to underrate the 
degree of agency exercised by patients them-
Selves. In my experience they often know as 
much and sometimes more than the staff
about how the mental hospital really func-
tions. Patients play an active rather than a 
passive role in maintaining the unhappy 
situation in which they live.—I am, etc.,

Wembley, Middlesex
D. C. WALLBRIDGE

Unusual Reaction to Pentagastrin

SIR,—May we report an unusual reaction to a 
subcutaneous injection of pentagastrin? A 
male patient of 40 with a chronic duodenal 
ulcer received 500 μg of pentagastrin by 
subcutaneous injection during the course of a 
test to estimate the peak gastric acid out-
put. He had not received a previous dose of 
this agent so far as we are aware. There 
were no immediate effects and the test was 
completed normally. Approximately 17 hours 
 later he woke with intense itching of his 
trunk, arms, thighs, and legs associated with 
periocular oedema. The skin was covered 
with a blotchy erythematous rash but there 
was no systemic evidence that pulse and 
blood pressure were normal. He was 
given an antihistamine and within 
approximately 10 hours, the rash had faded.
He did not receive any other medication 
before the development of the rash. It is 
unlikely that he was sensitive to 
some component in his bedding as the rash 
did not return after it had faded.
We report this incident as it is the only 
reaction of this type that we have seen in 
over 300 of these tests.—We are, etc.,

C. WASTELL
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Nerve Lesions and Finger Wrinkling

SIR,—Following Mr. S. O’Raisin’s interesting 
study (22 September 1973, p. 615) on the 
loss of skin wrinkling in response to hot 
water in peripheral nerve lesions, in which 
this sign seemed to correlate well with 
denervation, we studied this association 
in patients referred to the electrodiagnostic 
department. Their symptoms were suggestive 
of the carpal tunnel syndrome, but none had 
marked wasting of the thenar eminence or 
complete loss of sensation in the median 
territory.
The nine patients studied had definite 
muscle weakness at the wrist with increased 
latencies and delayed, reduced, or absent 
antidromic sensory 
volleys. In none of these was there evidence 
of decreased finger wrinkling in the area 
served by the median nerves compared 
with the ulnar territory after immersion in 
hot water at a temperature of 40-45° C for 
30 minutes.
I suggest therefore that decreased skin 
wrinkling is an insensitive sign of 
denervation. It has been demonstrated only in cases 
in which other signs were sufficient to allow 
the surgeon to operate without E.M.G. 
confirmation and it is certainly not reliable in 
diagnosing difficult peripheral nerve 
problems.—I am, etc.,

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