injected intramuscularly, the recommended dose is 0.25 mg.

Classical or common attacks of migraine rarely occur more than two or three times a week, so that the weekly dose of ergotamine tartrate required is very small. Patients with a cluster headache may, however, require higher doses, but only over a relatively short period. Ergotamine tartrate should not be used prophylactically.

Overdose with ergotamine tartrate is common, and has been reported as affecting up to 10% of patients attending a migraine clinic. Mild toxic symptoms, including nausea, vomiting, headache, and a feeling of vague ill health may occur, symptoms which are similar to those of an attack of migraine. Many patients with these symptoms imagine that their migraine is not controlled, take more tablets, and thus establish a vicious circle. The more serious features of ergotism—for example, burning pain, venous thrombosis, and gangrene—are rare.

At a clinic supported by the Migraine Trust it has become apparent that patients recover more quickly if they can go to sleep, and a significant proportion of those coming to the clinic for treatment of an acute attack do this. In these circumstances only about one in ten of those attending, for whom attacks of a definite character, have a true acute attack of either classical or common migraine requires ergotamine tartrate. Most patients improve with an antineuralgic, a simple analgesic, and a sedative.

J N BLAU

Macdonald Critchley

R W Gilliatt

Raymond Greene

Edna Hannington

The Migraine Trust

London WC1

Tranexamic acid in chronic urticaria

Sir,—Following the short report (26 August, p 608) from Drs R A Thompson and D D Felix-Davies on the successful use of tranexamic acid in "idiopathic" recurrent angio-neurotic oedema, I tried this drug on two patients with previously intractable chronic urticaria. One had been investigated at a leading skin hospital, no cause or effective treatment having been found. The other patient presented to me with recurrent urticaria following exertion and showed no response to antihistamines. Both were given tranexamic acid 1 g four times daily, and both reported an appreciable reduction in the frequency and the severity of their attacks, which was sustained when the dose was reduced to a maintenance level of 0.5 g twice daily. Perhaps a trial of this drug is merited in other patients with this troublesome condition.

Darryl Tant

Luton, Beds

What is a cohort?

Sir,—Dr V H Springett has rightly pointed out the correct use of the term "cohort" (13 January, p 126). As he says, the term was introduced by Frost and this valuable method of epidemiological analysis is usually referred to as “Frost’s method.” I think it ought to be recognised that the method was in fact devised some years earlier by Andvord, who used the Norwegian word _kull_ ("brood" or "litter") to designate all members of a population born within a particular time period (in Andvord’s paper five years). Reference to his paper will show that he used the method exactly in the way subsequently adopted by Frost and that his current showing of tuberculous mortality rates by age in consecutive _kull_ groups are the prototype of those published in Frost’s later paper.

In Frost’s paper (posthumously published in 1939, probably written in 1938) he stated that the original idea was Andvord’s and gave the relevant reference. If eponymous terms are to be used in medicine it is surely right that the names be those of the true originators.

A L Jacobs

London N3

Not the language of medicine

Sir,—In his reply (13 January, p 120) to your leading article “Not the language of medicine,” Lord Smith of Marlow appears to be content that the executive director of the Royal Society of Medicine replied on his behalf and in his absence to the writer of a long critical letter to the president, but this was unlikely to have satisfied the writer. Those of us who enjoy the services of personal secretaries expect them to acknowledge our mail in our absence, deal with urgent inquiries, and tell our correspondents that we will answer other points on our return. Could not a similar arrangement be made at the RSM for a president who has said he wishes to be “accessible”? Important as the complaints are, they could surely wait for the president’s return and his personal attention.

Incidentally, had Lord Smith wished to answer some of these doubts “in full and in public,” as your leader urges, he might in his lengthy reply have devoted some of the space to them rather than to the personal philosophy concerning the “freedom to disagree.”

Barbara Evans

London NW8

Cataracts

Sir,—Referring to Mr P A Gardiner’s paper on cataracts (6 January, p 36), I should like to point out to doctors that they have a good opportunity to observe the development of their own cataracts if—as they should be—they are in possession of a microscope. No slide is required; plain daylight illumination of the visual field is sufficient. If the eye is removed about 1-2 cm from the ocular and the condenser diaphragm closed by about half the cataract obscures the visual field so clearly that it can easily be drawn. A comparison of such drawings made at intervals of about three weeks clearly shows the progress of the lenticular opacity.

E Elkan

Pinner, Middx

Kieland’s forces

Sir,—At a time when forces delivery is so frequently discussed in the public, it is for us to read in the two papers by Drs Malcolm L Chiswick and David K James (6 January, pp 7 and 10) that in the absence of evidence of fetal distress on cardiotocography, the use of forceps delivery is associated with no significantly increased mortality or significant morbidity. The only difference between the study group and the “control” group of spontaneous deliveries was that the former group showed a much higher rate of “abnormal neurological behaviour.” The validity of this observation is questionable in this retrospective study, neonates not having been checked routinely for abnormal neurological behaviour, which was brought to the attention of the paediatrician only if the mother or midwife was concerned. English mothers are more likely to be concerned about their babies if they have been delivered by forceps, as this mode of delivery is not yet regarded as normal in this country.

The increased mortality and morbidity in the whole study group compared with the control group cannot be attributed to the use of Kieland’s forces, since the control group did not have a malrotation necessitating some form of operative intervention. The only way of deciding whether the use of Kieland’s forces increases mortality and morbidity is to randomly allocate cases of malrotation with fetal asphyxia in which vaginal delivery could be considered to different methods such as Kieland’s forceps, ventouse extraction and caesarean section. Then by assessing fetal and maternal outcome one may be able to decide the best way to manage these cases.

M Maresh

Queen Charlotte’s Maternity Hospital, London W6

What sign that sight would be restored, only to find that the removal of the lens is in vain.

During the years from 1966 during which I provided ultrasonic diagnostic services at Moorfields High Holborn, I was astonished by how much patients were sent in for exclusion of retinal detachment. The ultrasonic diagnosis of eye tumours admittedly requires much experience and preferably modern equipment, but Mundt and Hughes showed how easily a retina detachment may be detected with the simplest portable unit. Now that ultrasonic apparatus is widely available a cheap ophthalmic transducer can be connected. When the device is applied to the closed lids with a little jelly the absence of a detachment can be shown in an examination lasting barely a minute with hardly any training.

DOUGLAS GORDON

The City University,

London EC1

Silver poisoning associated with an antismoking lozenge

Sir,—Dr D MacIntyre and others described a case of argyria associated with an antismoking lozenge, RespatoN, containing silver acetate and ammonium chloride (23-30 December, p 1749), and we wish to report a second case due to the same preparation.

A 63-year-old Englishman complained of gradual change in the colour of his skin. His only other symptoms were slight giddy feelings and tiredness, apparently originating from his being told that he looked “off colour.” On examination the striking feature was a bluish-grey colour of the skin exposed to light—on the face, a V-area of the neck, and the hands. The fingernails had a bluish shade. There was no pigment line on the gums but the patient was edentulous. The rest of the examination showed no abnormalities. Ophthalmological assessment revealed no abnormal eye pigmentation. A skin biopsy was taken from a pigmented area of the neck. Haematoxylin and eosin stain showed fine black granules in the region of the basement membrane of glands and hair follicles. After treatment of the sections with Lugol’s iodine solution and sodium thiosulphate, followed by retaining with haematoxylin and eosin, the black granules were visible, confirming the presence of silver. Silver concentrations in the hair, estimated by neutron activation, were normal, as were the results of investigation for argyria.

Our patient had taken RespatoN lozenges continuously for two years but he denied exceeding the manufacturer’s recommended maximum dose of six lozenges per day, unlike the patient previously described. Nine months after diagnosis his pigmentation remains unaltered, despite discontinuing the lozenges; his smoking habit persists.

Although the only adverse effect of chronic silver absorption is generally accepted to be discoloration of the skin, we raise the question of whether silver containing preparations should be freely on sale to the public.

We would like to thank Dr R Mills for the histology and Professor T Clark for permission to publish this case.

D SHELTON
ROY GOULDING
New Cross Hospital, London SE14

**Treatment of tuberculosis**

Sir,—I was very interested in the admirable letter from Sir John Crofton (6 January, p 52) on the treatment of tuberculosis. I was surprised and alarmed to learn that “deviations from the well-established rules of antituberculosis chemotherapy are still not too uncommon in some areas of Britain, especially among orthopaedic surgeons, urologists, and gynaecologists.” So far as gynaecologists are concerned, there is no justification whatever for this failure to conform to current therapeutic practice. During the past 25 years many articles have been published on the treatment of gynaecological tuberculosis, emphasising that it is essential to employ the same drug courses as those used in the treatment of pulmonary tuberculosis.

During the past 28 years, I have made a special study of tuberculosis of the female genital tract and more than 600 patients with this condition have been under my care. Throughout this period, all drug programmes have been planned in consultation with Dr R J Cuthbert, consultant chest physician at Southern General Hospital, Glasgow. In addition, he or one of his colleagues has examined every patient at the start of treatment and all patients with drug reactions of any kind. Even with these precautions a substantial recurrence rate has been found with every drug programme except the most recent ones incorporating ethambutol and rifampicin, where the period of follow-up is too short for comparison with the earlier regimens.

The lowest recurrence rate encountered to date has been 12-3%, the drugs employed being streptomycin, para-aminosalicylic acid, and isoniazid, administered for 18 months or two years.

Recurrence of gynaecological tuberculosis may be found several years after the conclusion of drug treatment. The longest gap between treatment and recurrence in my own series was 19 years. The view that a patient can be regarded as cured after one or two negative post-treatment examinations is incorrect. To class all patients as cured and to fail to carry out is not in the interests of the patients and is an indication of ignorance on the part of those adopting this view.

ARTHUR M SUTHERLAND
Glasgow

**Contribution of poor blood pressure control to strokes**

Sir,—There appear to be several confusing statements in the article on stroke and hypertension (9 December, p 1605) by Dr P Kennedy and Dr B Hoffbrand, who claim that the incidence of unsatisfactory blood pressure control in patients suffering "hypertensive" strokes is 62%. However, a closer look at the published figures reveals that 35 patients out of 65 had a high blood pressure reading at the time of the stroke; this gives an incidence of 53-85%. Moreover, if the three patients who were found to be hypertensive were not included—as is the case in the summary of the examination—then the incidence drops to 49-23% (32 patients); and finally, if the 12 patients who “had their blood pressure well controlled before the stroke” are also excluded then we are left with only 20 patients whose blood pressure was poorly controlled, and the incidence of unsatisfactory blood pressure control in patients who suffered strokes is only 77%. If the 57 hypertensive patients are considered, then 20 out of 35 had an unsatisfactory blood pressure control—an incidence of 57-14%; this incidence would rise to 65-71% if the three newly discovered hypertensive patients are included.

Regrettably, we are not given any information regarding the aetiology of the strokes. Do the authors assume that if the blood pressure is elevated, then whatever the stroke then hypertension is directly responsible for the event? Drs Kennedy and Hoffbrand also state that “these findings provide evidence that more effort needs to be made to ensure adequate treatment of patients already known to have hypertension than to finding new cases.” This we find puzzling as the morbidity and mortality associated with hypertension is now well recognised, even in the older population, and a stroke may be the first manifestation of hypertension. Finally, we feel that the dangers of overtreating hypertension in the elderly or reducing their blood pressure too rapidly should have been mentioned. It would have also been appropriate to emphasise the need to check at regular intervals the functions of the target organs while hypertension is being reduced, otherwise clinicians might fall in the trap of treating a blood pressure reading rather than the patient.

R HAMDI
M A NASAR
Department of Clinical Pharmacology
St John’s Hospital, London W11 2HJ

**Health risks from keeping cats**

Sir,—I am surprised that your expert’s answer (16 December, p 1700) about the dangers of cats to health did not include any mention of toxoplasmosis. Congenital toxoplasmosis is a serious and often fatal neonatal illness in which there is chorioretinitis, cerebral calcification, psychomotor retardation, hydrocephalus, and convulsions. Toxoplasma gondii is a protozoan which recently was de-