Cholera

SIR,—I have read with interest the paper by Drs. N. K. Dutta, M. V. Panse, and H. I. Jhala (May 4, p. 1200). May I be permitted to refute the suggestion of these authors that the work of Gupta *et al.*[1] was confirmed by me ?[2] Citing the latter (page number incorrect), the authors have commented on the "closed loop" technique which, however, was *not* the technique used in this work of mine. The comments, therefore, are neither relevant nor warranted. This is not the occasion to harp on the value of the rabbit loop technique, which has been amply confirmed. It should be pointed out, however, that a different method—viz., one for experimental production of diarrhoea in adult rabbits—was employed in my work under reference. All six strains of *Vibrio cholerae*, three out of five strains of non-agglutinable (NAG) vibrio from cases of gastroenteritis, two out of six strains of El Tor vibrio, and both the two strains (O.55 and O.111) of *Escherichia coli* produced diarrhoea in these rabbits. This work was continued next year when none of the eight strains of water vibrio belonging to different Heiberg's groups could cause such diarrhoea.[3] I have expressed caution in assessing the value of this technique in my monograph[4] where these results have been incorporated.

The authors in summarizing their paper state that the method of production of experimental cholera in infant rabbits "is shown to be specific, since no other intestinal organisms, such as *E. coli* and *Salm. typhi*, could cause such a malady." This statement is based on the use of only two strains of *E. coli* and one of *Salm. typhi* as "controls." Even then, the *E. coli* strains after rabbit passage could produce diarrhoea often ending fatally. It will be difficult for many to accept the conclusion drawn from such results with so few controls.

The "cholera-like disease in infant rabbits" was produced by these workers more frequently and more typically with the two water vibrios (either before or after rabbit passage) than with seven NAG vibrios from cases of gastroenteritis. One may wonder whether this result supports the technique on infant rabbits as a specific test for choleragenic property of different vibrios as claimed by the authors or disqualifies it. Further, it is not clear how anuria was detected in infant rabbits passing rice-water stools.—I am, etc.,

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REFERENCES

1 Gupta, N. P., Gupta, S. P., Mangalik, V. S., Prasad, B. G., and Yajnik, B. S., *Indian J. med. Sci.*, 1956, **10**, 781.
2 De, S. N., Indian Council of Medical Research, Report of Scientific Advisory Board, 1957, p. 122. Job Press, Kanpur.
3 —— ibid., 1958, p. 149.
4 —— *Cholera, its Pathology and Pathogenesis*, 1961, p. 72. Oliver and Boyd, Edinburgh.

Dangers of Lignocaine

SIR,—The letters on this subject show that certain aspects of the use of solutions for producing local analgesia are not sufficiently appreciated. It might be fitting to enumerate them here: (1) The recommended maximum dose of any analgesic agent refers to that quantity that may be employed safely for *a fit adult of average weight*. It follows, therefore, that in children and undernourished adults this maximum dose must be *reduced* in accordance with the patient's body weight. In the elderly it is too frequently overlooked that metabolic processes become sluggish, so that the excretion of drugs will be delayed, consequently in such patients the maximum quantities administered must be considerably reduced—this is true of narcotics and barbiturates as well as local analgesics. (2) It is generally believed that solutions deposited around fractured ends of bone are absorbed almost as rapidly as from an intravenous injection. (3) The maximum recommended dose of lignocaine of 500 mg. refers to solutions containing a haemostatic such as adrenaline, but when a vasoconstrictor is not employed the maximum should never exceed 300 mg. (15 ml. of a 2% solution) *in a fit adult*. (4) Lignocaine is almost twice as effective as procaine, therefore except in exceptional circumstances (such as oral surgery) it is seldom necessary to employ a greater concentration than 1%, thus reducing the risk of overdose.

By common consent lignocaine has taken its rightful place as the most efficient local analgesic agent at present in use. It is a pity that neglect of elementary principles should lead to unpleasant sequelae. Consequently I take the liberty of encroaching upon your valuable space to state these simple facts in the hope that greater care may be taken by all those who employ local analgesia.—I am, etc.,

London W.1. VICTOR GOLDMAN.

SIR,—Dr. K. P. Singh (June 29, p. 1741, and July 6, p. 55) reports two cases of collapse associated with local injections of lignocaine and hydrocortisone. For each he gives an excellent clinical description of vaso-vagal syncope, so it is surprising that you should publish these letters under the heading of "Dangers of Lignocaine" and thereby imply that the drug rather than fear was the likelier cause of the patients' reactions.

Incidentally, if Dr. Singh's patients were to lie down during procedures of this sort, perhaps fewer of them would faint.—I am, etc.,

Buckhurst Hill, Essex. P. SHARPSTONE.

POINTS FROM LETTERS

Parkinsonism in Organists

Dr. MURRAY COX (London N.W.9) writes: I wonder whether my recent observation that at least three church organists suffer from advanced Parkinsonism is anything more than coincidental. . . . If the disease strikes before the first organ lesson, does this suggest an Adlerian attempt to master the situation or is there a deeper correlation between the musical personality and a diathesis towards Parkinsonism ?

Care of the Aged

Dr. TREVOR HUGHES (Ruthin) writes: I think that the urgency of care for the aged is recognized by everyone, and the Minister of Health himself stated that the only person who knew what was needed for the treatment of an individual was the general practitioner. Why have the general practitioners not been brought into the councils, at any level, in this very important matter of co-ordination ? It is understood that the Minister of Health is waiting for reports from the hospitals, local authorities, and others, to formulate a plan conjointly. Surely this is a waste of time when they work in water-tight compartments where there is little or no interchange of views nor an attempt at co-ordinated action.

Cigarette-smoking and Lung Cancer

Dr. JULIUS LIPETZ (Edinburgh 9) writes: I would like to add my support to Dr. Norman Macdonald's excellent letter on cigarette-smoking (May 18, p. 1346). In our general practice of just over 4,000 patients, we have started what we call "our roll of honour" on which are listed the names of those patients whom we have persuaded to stop smoking. We record the average number of cigarettes smoked and the date of stopping smoking. This list at present numbers 61 males (less four who have re-started smoking) and 34 women (less two re-starters). The practice doctors' names are, of course, included in the list. I would further report that in certain chest wards in one of our hospitals smoking is prohibited. Also, the almost complete absence of cigarette-smoking at medical meetings in Edinburgh over the last two or three years is worthy of note.

"Comatosed"

Mr. JOHN POTTER (Oxford) writes: If it is agreed that "comatosed" is incorrect, could we not do away also with its companion "stuporose" (June 29, p. 1724) and be satisfied with *comatose* and *stuporous* ?

Correction

We regret that two typographical errors appeared in the letter on "Penicillamine and Cystinuria" from Dr. D. F. Evered (July 13, p. 120). In the first paragraph "penicillamine (β-β-dimethylcysteine) may be complete with these compounds" should have read "penicillamine (β-β-dimethylcysteine) may compete with these compounds." In the last paragraph of the letter "the relative innocuous condition" should have read "the relatively innocuous condition."