A sleep regimen has been in use for many years and the regimen has received favourable comment. The purpose of such treatment is to reduce the neural and humoral consequences of anxiety and pain. In practice, 25 mg of promethazine hydrochloride is mixed with 50-100 mg of pethidine hydrochloride in one syringe and injected intravenously during a period of four or five minutes until the patient becomes pleasantly drowsy, lying either supine or with the upper body propped up to an angle of about 30°. The treatment is particularly useful when the patient has to be moved from home to hospital from one place of the hospital to another, and when pulmonary oedema begins to aggravate the anxiety. Not only the relatives but even the doctors and nurses become less anxious when peaceful sleep replaces pain and fear. The treatment may need to be supplemented with procainamide or lignocaine, but usually small doses seem to be effective in the sleeping patient.

It is interesting to note that Lauter Brunton described the risk of sudden death in frightened patients in 1891, and on 4 March 1975 a jury was satisfied that a coronary patient died “as a direct result of being put in a state of fear and alarm.” Brunton described that a coronary care unit must add to the fear and alarm of the majority of patients, and common sense calls for the effective and speedy relief of their suffering.

This clinical application of the neuro-depression of sleep is supported by animal experimentation. Lown et al. have written that the neural effect of sleep is highly potent, and for a number of patients sleep reduced ventricular premature beats when antiarhythmic drugs such as quinidine, propanolol and propranolol were without effect and it is concluded that the treatment of sporadically occurring ventricular premature activity in some patients may require attention to the neurological trigger, rather than the cardiac target.”—I am, etc.,

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2 Marriott, H. J. L., 1975, personal communication.
4 The Lancet, 5 March 1975, p. 4.

**Gamma-glutamyl Transferase and Cholesterol during Anticonvulsive Treatment**

**Drugs for Addicts**

Sir,—I was heartened by Dr. A. J. Laidlaw’s clear-sighted letter (1 February, p. 270) recommending “appropriate action” to develop nationally a sensible method of supply of drugs to addicts. In the present type (age 13-30) the system of supplying opiate drugs through retail pharmacists is counter-productive to the addict population, to the potential future addict, and to the pharmacist, whose stocks invite frequent burglary.

In the Newcastle area I estimate that up to 20% of prescribed drugs are sold to others. Some of this supply is the source from which, for example, girl-friends and wives are initiated into drug use and addiction. Likewise abstinence addicts who are still ambivalent about a life without drugs are often purposefully helped to relapse. In any case they know who is on prescription and from which chemist. It is all too easy for an abstinent addict to relapse in a moment of temporary “weakness.” Furthermore, the involvement of notified addicts in carrying illegal supplies is frequent. An addict can always claim that the drugs he is carrying are prescribed drugs. Provided he ensures that the illegal supplies he carries are of the same type he can and does saw a go-between between the illegal source and the illegal user. He is the only citizen who can thus evade the law of the land. The daily round of collecting, buying, and selling drugs helps the addict to cling to his illusion of having an interesting, exciting life. This is counterproductive for his eventual rehabilitation.

At the Newcastle Regional Addiction Unit a pilot project in which drugs were prescribed only if they are used completely on the premises under supervision has been in operation for six months. One addict was immediately driven to work through boredom and the “quits” made him rush and another accepted inpatient withdrawal, which he had previously firmly resisted. Two illegal addicts who had been living together with some of these notified addicts came forward for treatment within a few weeks and accepted a withdrawal-rehabilitation programme. The results of this controlled drug prescribing and administration are that from a starting point of seven known addicts in the area and five unknown, there are now three known addicts, with four abstinent and five illegal users who came forward and accepted a withdrawal programme. That is, a total of 12 regular opiate users has now been reduced to two, and the local police confirm that there has been a vast reduction in the number of drug-related crimes in the area. Further plans are being made in cooperation with the local health authority of a neighbouring area which has a large criminally active drug addict population.

The principles of psychiatry are helpful in rehabilitation but the principles of preventive medicine are needed in tackling this potentially serious yet totally unnecessary problem in Britain.—I am, etc.,

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1 Barrels, H., Petersen, C., and Schulze, W., Monatschrift für Kinderheilkunde, 1974, 122, 674.

**Splenectomy and Susceptibility to Malaria and Babesia Infection**

Sir,—We were interested to read Mr. P. G. Shute’s letter (1 March, p. 516) concerning splenectomy and susceptibility to malaria and Babesia infection with some species of Babesia. One small correction: the human case, diagnosed by Professor P. C. C. Garnham, and reported to us, was, after death, tentatively diagnosed as Plasmodium falciparum malaria, but no amniliarial drugs were ever given.

To our knowledge only six human cases of babesiosis have been confirmed. Anderson et al., reporting on the sixth documented case, review some of the features of all six. The three deaths all occurred in splenectomized patients. Of the three patients who recovered one had had a splenectomy and the other two had intact spleens; in these patients there appeared to be a favourable response to antimalarial drugs. It may be that the outcome may well depend on the degree of parasitaemia or the Babesia species and not on the presence or absence of a spleen.—We are, etc.,

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3 Anderson, A. E., Cassaday, P. B., and Ho, M., American Journal of Clinical Pathology, 1974, 62, 612.