compensated neurotic taking a small dose of amphetamine to a highly distressed human being making excessive demands on an already busy service.

In my view there is a strong case to be made for excluding patients who have been on amphetamines for several years from the current witch hunt, although I agree that no nootropics should be started on the drug at this point in time. I am, etc.,

COLIN BERRY
Central Hospital, near Warwick

Sir.—Sir George Godber is reported as saying (17 July, p. 176) that “there was almost nothing that amphetamines could do which was not done better by other drugs,” but he does not spell out what are the exceptions that he has in mind.

Before anti-amphetamine enthusiasm reaches the climax of a total ban, may I mention one type of case in which amphetamine is so far as I am aware, superior to any other drug? It is nocturnal enuresis in those patients whose sleep is exceptionally deep. Admittedly such cases are not very common. As a general practitioner I see about two a year; but some of these are adults on whom other treatments—tricylic antidepressants, for example—have been tried and failed.

Dexamphetamine may be presumed to be effective in such cases not only because it lightens sleep, but also because of its action in facilitating conditioning and habit formation. The dose has to be exact, just below that level at which it will prevent sleep. But once the dose is found by experiment, the response is usually gratifyingly rapid. It would be a great pity if, because of widespread abuse of this drug, we were to be left without any effective treatment for a very distressing condition. I am, etc.,

J. R. JAMES
Southsea, Hants.


Halotheine Hepatitis

Sir,—The article by Professor William W. Mushin and his colleagues (3 July, p. 18) illustrates one of the problems inherent in attempting to keep comprehensive anaesthetic records.

By the time a problem needs investigation, it is too late to obtain all the relevant information from the best of such records. To give but two examples—it appears to be impossible to be sure that the breathing apparatus used to administer the halothane was free from infection, and the method of preparation of the degree of purity of the halothane is not stated. I am, etc.,

T. H. S. BURNS
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Sir,—Postal problems have prevented me from commenting earlier on the article “Halothane Hepatitis—A Prevenable Disease?” (20 February, p. 448).

The narrow concentration of interest in halothane as the main cause of postoperative jaundice is blinding doctors to the wider problem of liver function changes and even jaundice which occurs in patients who have never had halothane. In the Liverpool area the reporting of cases of postoperative jaundice was certainly biased in favour of patients who had received halothane, but 4 out of 11 patients were known to have had a non-anaesthetic anaesthetic.

Anaesthetists are aware of the fact that anaesthesia disturbs liver function, sometimes fatally. They are also aware that almost every drug used has at some time been accused of causing jaundice. However, anaesthesia does not involve only the administration of drugs, but it also causes alterations in physiology. Some of these physiological changes are known to disturb liver function or blood flow, and some of these factors must operate in the patient who does not have halothane and becomes jaundiced. Why should they not also operate in the patient who is given halothane?

Let us be sure of the extent to which halothane, and halothane alone in anaesthetic doses in man, causes liver damage before condemning a most useful drug. I am, etc.,

M. E. DODSON
Department of Anaesthetics, Mulago Hospital, Kampala

1 Johnstone, M., British Journal of Anaesthesia, 1964, 36, 718.

Penicillin Prophylaxis

Sir.—In “Therapeutic Conferences” on upper respiratory tract infections (10 July, p. 101), your experts recommend that all upper respiratory infections should be treated conservatively except in “special risk” cases. By their own admission it is impossible to distinguish between viral and bacterial tonsillitis and it is impractical to swab all cases.

There are various reasons for the reduction in the number of cases of rheumatic fever and nephritis, and one of these must be a result of the treatment of tonsillitis with penicillin. It has been my own practice to treat all cases of tonsillitis with penicillin, realizing that many of these are viral (I obviously select an alternative antibiotic for those who are allergic to penicillin). I swab all cases that I do not treat.

I would agree that too many antibiotics are too freely prescribed, but surely this is the exception to the rule. If we are not conservative in the swabbing policy we may not increase in the number of "at risk" cases. I am, etc.,

GEOFFREY GOVER
Horsham, Sussex

M. G. WRIGHT
Gordon House, London S.W.1

Sir,—I feel that one point from your Therapeutic Conference (10 July, p. 101) requires further clarification.

It is stated that patients who have had rheumatic fever should have treatment with penicillin to cover such operations as dental extractions. If these patients are already taking chemoprophylaxis with penicillin, it is obviously the last antibiotic one would choose to cover the operation as resident mouth flora would already be resistant to penicillin. I am, etc.,

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