Suicidal Attempt with Propranolol

Str,—With reference to the letter from Drs. P. Karhunen and G. Härter (21 April, p. 178) dealing with the effect of a massive dose of propranolol on a healthy heart we would like to present some additional information on suicidal attempt with propranolol.

We have recently observed a man aged 45 with occasional bouts of supraventricular dysrhythmia which had been treated with small doses of propranolol. In this case the attempt took approximately 50 tablets of propranolol (2,000 mg) and arrived in hospital two hours later in good general condition. A vial which had contained 50 tablets was found empty in his pockets and fragments of tablets readily identifiable as propranolol were recovered on washing out his stomach. The blood propranolol level was not measured. His heart rate was 80/min, the pulse normal, blood pressure 120/80 mm Hg. E.C.G. showed normal sinus rhythm. He stayed in hospital for five days without any signs of cardiac disturbance.

Propranolol is known to possess the most potent negative inotropic and chronotropic activity of all beta-blockers. Nevertheless in our case a massive dose of propranolol produced no signs of a depressant action on the heart. It seems therefore that the question of the effect of propranolol on the healthy heart needs to be reconsidered.—We are, etc.,

ROBERT A. NABATOFF
DAVID C. C. STARK

New York

SIR,—In your leading article (18 August, p. 365) you state that "if the treatment of hypertension in young adults comes to be accepted as beneficial...the screening of 20-year-olds will be easily justified." Screening of that age group would be difficult. Assuming that raising blood pressure in childhood means hypertension in adult life, then it would be easy to identify children with a raised blood pressure prior to leaving school. School medical staff could fit this into the present medical examinations. The names of those found at school to have a raised blood pressure would be sent to the relevant family doctor. N.H.S. records of these children would be identified as a suitable symbol on the envelope with the year that the patient attains the age of 20. In that year, the family doctor, or possibly the health visitor in a practice with such an attachment, would re-check the blood pressure and treatment would be instituted if necessary.

I feel this to be a practical way in which potential hypertensives could be identified without the difficulty of examining all young adults, and one in which the school health service could make a valuable contribution. I suggest that a pilot scheme be begun in the area of one health authority.—I am, etc.,

W. E. HADDEN
Wareham, Dorset

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Wareham, Dorset

Detection of Hypertension in Childhood

Str.—I beg to question the assumption, upon which your leading article (18 August, p. 365) seems to rest, that essential hypertension is a distinct disease entity of which the early preventive treatment may justifiably be discussed.

Essential hypertension is diagnosed by exclusion of all known causes of hypertension. We may well have to accept that it may be impossible to discover all the factors which produce it. The causes may vary with each individual case; they may be diverse and interrelated (genetic, biochemical, psychological, etc.). At present we can but consider essential hypertension as a clinical sign of some disturbance of normal homeostasis whose nature we do not understand. It follows that what your article implies by prophylaxis and treatment really relates to the modification of symptoms and signs of a complex morbid process which cannot be totally avoided or healed. The only available treatment is symptomatic. Symptomatic treatment will often leave open the causes of the illness unaffected. It can be considered prophylactic only if it be maintained indefinitely in order to effect some degree of reduction in the potential morbidity of the disease process.

It seems to me that whereas the treatment of the causes of illness may be a matter for public concern and for screening, the treatment of symptoms can be ethically justified only by the specific request of the individual. Symptomatic treatment does not heal; it only pretends to do so. To offer symptomatic treatment in the later years of life seems reasonable, and may even be considered as a form of medicine; but I find horrifying the thought of advising a hypertensive young person to "improve" the rest of his life with drugs—"every symptom distressing"—without the full cognizance and active concurrence of that individual or his legal guardian.

Your article gives the impression that the persuasive introduction of symptomatic drug treatment for hypertension may in future be justified because of the savings of economics and acceptance as beneficial by the medical profession. I submit that there is more to it than that.—I am, etc.,

J. F. GORDON
Warlingham Park Hospital, Surrey

Aspirin in Prophylaxis of Ischaemic Heart Disease

Str.—It is now five years since O'Brien published his paper on the "Effects of Salicylates on Human Platelets" which showed that aspirin inhibited adenosine diphosphate (ADP) release from platelets. This release contributes to the adhesion of platelets and is increased by adrenaline. If Duguid's hypothesis that an intimal tear and platelet aggregation are the first steps in the development of the athero-erotic plaque is correct, aspirin might protect against the development of atherosclerosis. Aspirin might also be expected to reduce the likelihood of thrombosis occurring in an atherosclerotic artery. Adrenaline plays a part in inducing platelet aggregation; in particular it induces a second wave of closer and firmer aggregation. Aspirin abolishes this second