cancer patients in view of its effect as a stimulator of prolactin release.

A suitable alternative agent may be difficult to find as the phenothiazine derivatives, which include prochlorperazine, are also known to stimulate lactation and to raise serum prolactin levels. It is possible that for patients we may have to return to the use of older remedies such as pyridoxine.—I am, etc.,

J. S. Bunting

Department of Radiotherapy,
Royal Berks Hospital, Reading

Dr H. W. C. Ward (20 July, p. 169) criticizes the use of metoclopramide in the treatment of radiation sickness in patients with breast cancer. This criticism is based on the finding that the drug stimulates prolactin secretion and the hypothesis that in so doing it may increase the growth rate of metastases. In its place he advocates continued use of one of the common drugs used for this purpose, a-ergot alkaloids, which is widely and successfully used in the treatment of this disease. 1 Female patients who have received long-term treatment with phenothiazines have chronically elevated prolactin levels, but there is no evidence of an increased incidence of breast cancer. 2 In the Westminster Hospital group’s work on prolactin dependence in breast tumours in tissue culture quoted by Dr Ward 3 a “near physiological concentration” of ovine prolactin is added to the medium. 4

The suggestion that prochlorperazine should replace metoclopramide because of the latter’s effect on prolactin release further supports the view that there is no relationship between elevated circulating prolactin levels and human breast cancer.—I am, etc.,

RONALD G. WILSON

Department of Surgery,
General Hospital, Nottingham


The Unproductive Minority

Sir,—Professor A. D. B. Clarke, speaking on mental subnormality at the B.M.A. Scientific Meeting (27 July, p. 240), gave a balanced assessment of the potential of subnormal and severely subnormal patients, adding that there are about 5% who will certainly not achieve anything as regards productivity. He is reported as saying: “It could be questioned whether one should strive too heroically to prolong their existence.”

It is, however, unch蕉nic to condemn efforts to prolong their lives simply because they themselves are unproductive. Certainly one would not wish to prolong painful or intolerably uncomfortable lives by unnatural means. But one must never condone the assessing of the worth of human beings according to their productivity. If we did, the euthanasia lobby would have a field-day collecting supportive statistics from our geriatric services. I doubt whether Professor Clarke really meant to imply such an attitude, but one must be on one’s guard.—I am, etc.,

HARRIET Pritchard-Jones

Pontyclun, Glamorgan

Gastric Balloon Displacement in a Sengstaken Tube

Sir,—Dr. C. J. Hawkey and Mr. N. R. Peden (6 April, p. 58) reported a case in which the gastric balloon of a Franklin Sengstaken-Blakemore tube was forced away from its filling lumen to a position where it could no longer be filled or deflated. We wish to draw attention to a similar failure in a Swedin female patient with breast cancer. The oesophageal varices tube which made it impossible to apply tamponade to the lower third of the oesophagus.

A 57-year-old woman was admitted with haematometra and swelling of the lower abdomen. In order to control the bleeding a Warner Sengstaken (Blakemore type) oesophageal varices tube was passed and the gastric balloon was inflated with 50 ml of 25%, Hypaque and impacted at the hiatus. The oesophageal balloon was then inflated with saline. Two pounds (0·9 kg) of traction was applied to the tube via a pulley. A chest x-ray confirmed that the gastric balloon was impacted at the hiatus. Twenty-four hours later it was noticed that the upper end of the oesophageal balloon was in the mouth. A repeat chest x-ray showed that the position of the gastric balloon was unchanged. The patient went into hepatic coma and died 36 hours after the insertion of the tube. After death the Sengstaken tube was removed and it was found that the gastric balloon had slipped down the tube and was inverted upon itself (see fig.). This had allowed the oesophageal balloon to pass up the oesophagus and tamponade would have been applied over the lower third of the gullet.

This Sengstaken tube and another of identical type made by the same manufacturer and a small radio-opaque marker was detected at the hiatus. At the end of the procedure the patient’s chest x-rays were then re-examined and the marker was visible three vertebral bodies above the tip of the balloon. This has never been noted in life but its significance was not appreciated. Inspection suggested that it may be relatively easy for the gastric balloon to become inverted upon itself and allow the oesophageal balloon to pass up into the oesophagus. It would thus seem desirable, as Dr. Hawkey and Mr. Peden suggested, for Sengstaken tubes to be presented on the lines of a Foley urinary catheter with continuous rubber balloons.

This occurrence is reported so that others may be aware of it and also to point out that it is possible to detect tube failure on routine chest radiographs as the small radio-opaque marker should always be seen to be in close proximity to the gastric balloon when this is filled with radio-opaque material. Separation of the marker from the gastric balloon should arouse suspicion of detachment of the gastric balloon and with it the loss of effective oesophageal tamponade.

At present the promotional literature which accompanies these balloons states: “The rubber-ove (type) oesophageal varices tubes does not record the presence of the radio-opaque marker or its relationship to the two balloons.”

We, Dr. George Taylor (Princess Margaret Hospital, London) and ourselves, have had a similar occurrence with their Sengstaken (Blakemore type) oesophageal varices tube.—I am, etc.,

J. B. BOURKE

Department of Surgery,
General Hospital, Nottingham

Stresses of Management Selection Courses

Sir,—It has recently become fashionable to hold intensive management and executive hotel selection courses on a residential basis. These are usually held in hotels or similar settings and participants are encouraged to communicate freely without their usual defences or conventions. Intense rivalry may be deliberately encouraged and the participants may be subjected to “leadership” exercises. Alcohol flows fairly freely and participants know that they are under continuous observation and are often forced into interactions of a “game” type, which are familiar to the trained professional but cause the inexperienced intense anxiety. They dare not reveal this as they fear it would be seen as a sign of weakness or unsuitability. Latent feelings—for example, of sibling rivalry, of anti-authority resentment, or even unconscious homosexual fears—may become mobilized and, particularly in marginally adjusted individuals who may be only partly coping with their job and are suddenly transplanted to such a situation, psychiatric breakdown may occur.

Such courses may be seen as a valuable formative experience by the manufacturer and well suited and may well be useful to the sponsoring organization. The individuals conducting them are trained in the skilful use of stress to identify successful participants but usually not in the equally important task of identifying and salvaging the inevitable failures. The latter, therefore, may not only be caused intense anguish, loss of confidence, and impaired efficiency in subsequent work but, in cases that may present to the general practitioner, the
factory doctor, or the psychiatrist. In cases of apparently serious and sudden psychosis occurring after the middle-aged, once-middle-class male the possibility of such a ‘busman’s holiday’ needs to be kept in mind. Two recent illustrative cases follow.

A senior policeman, aged 43, presented with apparent hallucinations, with weeping, early waking, retardation, etc. He had recently been on a senior officers’ course, where he was overwhelmed by the management theory, the group interactions, and the amount of alcohol consumed. He had managed to work at considerable pressure before and after the course because of having been away on it and became depressed, self-critical, and morbidly suspicious of others. Eventually he had to retire despite treatment and is now a licensed master mariner.

A man aged 32 attended a salesmanship course at a hotel under the conditions outlined above and began to feel that people around him were against him. His thoughts became muddled and he harboured the delusion that Ford motor cars were following him and keeping an eye on him for example, when he telephoned his wife. Eventually he became over-active and peculiar in his behaviour and was picked up outside a local T.V. studio under the impression that he had been asked to appear on a well-known programme. He recovered rapidly with treatment.

—I am, etc,

Malvern, Wores

PETER HALL

Withdrawal of Rimadyl

Sir,—May we echo the views of Professor J. D. Williams (6 July, p. 44) that the withdrawal of rimadyl (Rifocin-M (Lepetil)) would be a retrogressive step. This drug attains exceptionally high levels in the biliary tree and has been described as “the only specific antibiotic” for choledystitis, and its loss would leave a considerable gap in the antibiotic armamentarium. 5-Fluorocytosine is another infrequently used but equally specific drug. This compound was supplied free by Hoffman La Roche (a company which has come under heavy criticism from other quarters) to hospitals on request for many years.

Though we realize the commercial considerations in a free-enterprise drug industry, we urge the Lepetil Pharmaceuticals Ltd to reconsider the withdrawal of Rifocin-M or make it available on personal request.

—We are, etc,

D. S. REEVES
R. WISE

Department of Pathology, Southmead Hospital, Bristol

1 Stratford, B. C., and Dixon, S., Medical Journal of Australia, 1966, 1, 1.

Inversion of the Appendix

Sir,—Occidental removal of the appendix is of undisputed prophylactic value and it is right that the technique should be as safe as possible. Some time ago I reviewed in some detail the methods of management of the appendix stump. There are those acceptable methods—amputation leaving a projecting stump, “burial” of the ligated stump with a retaining purse-string structure, and inversion of the ligated stump with retention by a purse-string suture. There is little to choose between these methods for the “cold” case but “burial” seems as safe as any; if this ever causes a small intramural abscess it may be treated percutaneously.

Inversion of the whole appendix after detachment of the meso-appendix is now advocated by Mr. F. S. Tait (29 June, p. 726). Even though in a large series he has not, so far, produced any late complications, I doubt if this proposal is wise. After Edebohls introduced this technique in 1895 there were reports of bleeding from the inverted appendix and of colonic intussusception. Mr. G. H. Dickson (18 May, p. 385) has added lately the additional complication of re-emergence of the appendix with ileal obstruction by adhesions.

I fear that if total inversion is generally adopted there will be a crop of obstructions by intussusception. Spontaneous inversion of the appendix, a rare but well-documented condition, is well known to cause colonic intussusception. It seems wrong to create knowingly a situation which may give rise to such a dangerous complication.

In passing I would put forward the plea that surgeons should inform their patients more precisely when they remove the appendice in the course of an abdominal exploration. Too often one is faced in emergency with the situation where one may suspect that the appendix is encountered, particularly during a gynaecological procedure, but the patient has not the faintest idea of the answer.—I am, etc,

Liverpool

JOHN SHEPHERD

Anoxic-Ischaemic Brain Injury

Sir,—In your leading article on this subject (13 July, p. 73) you say that the common clinical impression is that consciousness is lost after about six seconds of total arrest of cerebral circulation. I would say that it is a gross deal less than this. It is a time interval which is difficult to measure objectively, especially as the term “loss of consciousness” is not a precise one. A fairly accurate estimate can be made if it is possible to watch the patient and to take a continuous electrocardiogram at the time of a cardiac arrest. Such an opportunity will rarely occur, but I had the chance to do this on one occasion, and on two others when ventricular standstill was provoked by carotid sinus pressure.1 In all three patients it seems that consciousness was lost immediately or, say, within one second of the stopping of the ventricle. After a few seconds signs of epilepsy appeared, and this was something that could be measured more or less exactly. This is consistent with the classic and chronic contractions of the limbs could be timed by their effects on the electrocardiogram, and this varied from five to eight seconds after the ventricle stopped beating.—I am, etc,

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HAROLD COOKSON

Lynchett, Maravers, Devon

1 Cookson, H., British Heart Journal, 1952, 14, 350.

Sterilization of Fibrescopes

Sir,—Your leading article on fibroscopy (20 July, p. 131) made interesting reading and encouraged a potential patient to expect faster and less traumatic diagnostic procedures when his time comes. However, as chairman of the Central Sterilizing Club, my heart sank at the prospect of yet more unsterilizable and even more expensive instruments becoming available. The only really satisfactory procedure for sterilization is by autoclaving; others are, with low-temperature steam and formic-acid, ethylene oxide, and liquid chemicals in descending order of usefulness. To make matters worse many instruments are now so expensive that no one dare lend us one to test in case of damage.

May I plead for manufacturers and designers to remember the problem and to state clearly what methods, if any, can be used? If anyone has actually found a satisfactory way of dealing with specific instruments I would be grateful to hear about it so that the information can be made available to those who need it.—I am, etc,

J. C. KELSEY
Deputy Director, Public Health Laboratory Service
Colindale Hospital, London N.W.9

Call to Arms

Sir,—It has now, I think, been made quite clear that the profession as a whole has been short-changed by the Review Body and indeed that “wise men” themselves are not too happy about their findings. The time has come, therefore, to forget any internal differences that we may have and turn solidly to the support of the B.M.A. in the policy that it proposes—namely, graduated sanctions culminating, if necessary, in mass resignation.

My only fear regarding the B.M.A. is that it will “chicken-out” as the Review Body and indeed that “wise men” themselves are not too happy about their findings. The time has come, therefore, to forget any internal differences that we may have and turn solidly to the support of the B.M.A. in the policy that it proposes—namely, graduated sanctions culminating, if necessary, in mass resignation.

The call for a national disharmony is long overdue. The medical profession has been too complacent for too long. It needs some concrete action—now. Should resignation come, then the patient must be expected to pay as was the case prior to N.H.S. It is true to say that no patient must be allowed to suffer physical hardship, but a squeeze on their pockets would help a great deal towards having our demands met and the N.H.S. reinstated.

Young doctors with mortgages etc. and old doctors with an eye on their pension should not worry about resignation—strong action and the fight will be short-lived. Support the B.M.A. and we shall win.—I am, etc,

J. MILLER ATKEN

Dundee

Rescuing the N.H.S.

Sir,—There is no doubt that the Health Service is in a desperate state in many areas, where chronically underpaid and scarce staff face ward closures, lengthening waiting lists and deteriorating standards of care. On top of this, recent disputes have often proved crippling to all workers in the service.

The B.M.A. belief that what is needed is an immediate injection of £500m. is an