tactical solution. Mr. Illich foresees a cata-
lytic collapse of our present institutional-
ized values and Dr. Bradshaw envisages a similar end. One would like to think that this particular era of La condition humaine will end "not with a bang but with a sigh."

There may be many small but vital pockets of hope and resistance standing out in the Western world. Let us hope that some of these have among their number "men of medicine."—I am etc.,

Iffracombe, Devon

N. S. BAKER

A girl aged 17 years had a history of grand mal epilepsy since the age of 5 and was accustomed to having one to two fits per day in spite of careful supervision and adjustment of conventional anti-
convulsant regimens. In several occasions she had been admitted in status epilepticus. This had usually responded, though sometimes only after 2-5 hours, to intramuscularly or par-
dylyde with intramuscularly phenytoin and pheno-
barbitone, together with appropriate supportive therapy as in your leading article (19 February, p. 460). In December 1973, however, status epilepticus occurred without use of the usual measures or to general anesthesia with endo-
tracheal intubation and assisted respiration in the intensive care unit. Eight days in status she appeared to be dying, but she was then given dexamethasone, whereupon her fits diminished and she recovered over the next three days. It was several weeks before she regained her former mental alertness and she was able to have daily fits in spite of medication (with phenytoin, phenobarbitone, and diazepam).

In June 1974 she was again admitted in status epilepticus. She was treated initially with the usual measures, but as she failed to improve after 12 hours she was given dexamethasome in view of her apparent response on the previous occasion. An infusion of chloramphenicol edematous (Hemi-
lycle avian line was also started and this prevented continuous attacks but had to be maintained at a dose which kept her convulsions in check except for brief periods during which E.E.G. monitoring showed generalized epileptic activity. After 10 days in this regimen of 100 mg four times a day was started and the dose was increased gradually to 600 mg four times a day or more weekly, the tablets being dissolved in water and the solution passed into the nasogastric tube. During this period she managed to stop the chloramphenicol gradually, the number of fits diminished as the dose of sodium valproate was increased, and she recovered.

She then made a remarkably rapid recovery, having been in status for virtually 15 days. Sodium valproate 600 mg four times a day was continued with a reduced dose of her previous anticonvulsant drugs; she had several days free from fits and was discharged home. On review six weeks later she had remained very much better, having had relatively few attacks of fits although the drugs had been stopped.

We hope that sodium valproate will con-
tinue to help in the long-term treatment of this patient's epilepsy, as in many of the cases reported by Drs. Jeavons and Clark. However, we believe that this is the first report of sodium valproate being used in the treatment of status epilepsy. The patient had failed to respond to the supportive measures and drugs generally used together with steroids and chloramphenicol over a period of 10 days. She was treated only when treated with increasing doses of sodium valproate during the next five days. It therefore seems worth assessing the poten-
tial value of this drug now in other cases of status epilepticus.

We thank Drs. T. Healy and A. Hodson and the nursing staff of the intensive care unit at this hospital for their help with the supportive treat-
ment of our patient, and we are grateful to Reckel and Colman for the supply of sodium valproate (Epileptin).

We are, etc.,

A. R. MANSHIRE

MICHAEL ESPIR

Department of Neurology, General Hospital, Nottingham

Price of Proctoscopy

Sir,—The article by Mr. S. Arygrou and

other hospital (24 August, p. 511) prompts us to write briefly about our experience with cryosurgery for prostatic obstruction at Northwick Park Hospital.

Of 16 patients with acute or chronic re-
tention of urine, selected for cryosurgery because of physical inability made them unsuitable for major surgery or general

anaesthesia, 13 left hospital after about 10 days relieved of obstruction and the three failures were subsequently successfully treated by conventional means. So far, no patient has relapsed after curettage up to 18 months. The operation was carried out under sedation and local anaesthesia with a liquid N₂O-cooled probe designed and made in the biolinguizing division of the Clinical Research Centre. The use of N₂O instead of liquid N₂ makes the instru-
ment and the operation much simpler and safer and avoids the sometimes disastrous complications that have occurred with liquid N₂O-cooled probes.

We intend to publish a detailed account of our procedure and results and to carry out a planned clinical trial on a wider range of patients, but meanwhile we would suggest that cryosurgery using N₂O may well be found to offer an acceptable alternative to transurethral resection, with all its advan-
tages and without the disadvantage of re-
quiring expensive equipment and a skilled and experienced operator. An instrument based on our design is being made and sold by Spemby Ltd., Newbury Road, Andover, Hants.—We are, etc.,

ARNO LD ELTON

B. M. WRIGHT

Northwick Park Hospital and Clinical Research Centre, Harrow, Middlesex

1 British Medical Journal, 1971, 2, 5.

2 Swimmers’ Ears

Sir,—Your leading article (27 July, p. 213) gives an excellent superficial summary but fails to point out the many restrictions on those whose recreation is swimming or scuba diving. With the scan-
ing technique of rapid reading the focusing of attention on the last sentence, which states that "when external otitis occurs, diving must be forbidden until the skin has returned to normal," could lead many people being denied their recreation. It is hard to see how this is reconciled with your state-
ment that the first priority is the application of water can hardly cause any harm even when an active eczematous process is present, or the statement by Wright and Alexander,1 whose work you quoted in length. They write: "Swimmers with otitis externa were able to continue swimming with only a limited interruption in their daily routine," and of their divers, all of whom developed external otitis, none ceased their 14 to 16 daily (8-12 hours) ex-
cursions into the water and only in a few instances did treatment fail to obtain a sterile ear canal.

For the swimmer whose recreation is scuba diving, none expose themselves to the extent that the above divers did, and far from prophy-
laxis being difficult in divers, as you claim, it is in practice very simple and effective. It is more competitive to suffer more from external otitis than scuba divers2 because they spend much more time in the water, and in temperate zones the majority of scuba divers wear a hood, which prevents the flow of water and of the external ear canal. Prophylaxis in the susceptible person begins with the use of 5% acetic acid in rectified spirit3 after im-
merition, to dry the skin and maintain its normal acidity and also for its bactericidal and fungicidal properties.


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