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Cyanosis attributable to right to left shunt in the carcinoid syndrome

SIR,—Dr G W Stewart and colleagues (1 March, p 589) described an interesting case of pronounced arterial hypoxaemia in a patient with the carcinoid syndrome. In the absence of pulmonary metastases they attributed the hypoxaemia to intrapulmonary shunting through microscopic arteriovenous fistulas. The data presented, however, do not exclude an alternative explanation—right to left shunting through a patent foramen ovale.

Although right to left shunting through the foramen ovale is well recognised in patients with pulmonary hypertension,^{1,2} it may also occur in the presence of normal pulmonary artery and right heart pressures, apparently as a result of reduced right atrial compliance.³ Thus though mean left atrial pressure may exceed mean right atrial pressure, during atrial filling right atrial pressure rises disproportionately, causing phasic shunting across the interatrial septum. Right atrial compliance tends to diminish with age,⁴ but it is conceivable that in Dr Stewart and others' patient the typical endocardial thickening, seen in carcinoid heart disease, may have contributed.

The distinction between intracardiac and intrapulmonary shunting could have been made quite easily by contrast angiography or injecting microspheres through a pulmonary artery catheter. Although this distinction may not have influenced management in Dr Stewart and others' patient, it may be important in other patients in whom severe, symptomatic arterial hypoxaemia may be abolished by surgical closure of the atrial septum.^{3,4}

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Totally implantable vascular access for long term chemotherapy

SIR,—Drs P J Woll and R D Rubens (15 March, p 761) draw attention to the complication of deep vein thrombosis of the arm after insertion of the Port-A-Cath system. Lokich *et al* have also found this to be a major complication, with subclavian or jugular thrombosis occurring in 15 of 92 patients.¹

We have not encountered this problem with 37 Port-A-Caths implanted to date, although migration of the catheter requiring reinsertion

occurred in three patients. We believe the cause of subclavian vein thrombosis to be movement of the catheter within the vein, seen particularly in active patients with cephalic vein cannulation, in whom vigorous shoulder movements may cause gradual displacement of the catheter. To prevent this we now secure the catheter firmly within the cephalic vein using a non-absorbable suture or use in preference the external jugular vein, where little movement of the cannulation site in relation to the chest wall portal occurs. Since adopting this practice we have had no further cases of catheter migration. Interestingly, a recent series in which the external jugular route was mainly used reported only one case of vein thrombosis among 42 patients.²

Drs Woll and Rubens advise critical evaluation before implantable drug delivery systems are adopted for general use. We maintain that the indications for their use are different from those for Hickman catheters.³ We now use Port-A-Caths when chemotherapy is likely to be needed for longer than three months, particularly in younger patients and those with an active lifestyle, for whom the convenience of an implantable system is a major advantage. We do not use the Port-A-Cath system in patients with marrow failure (patients with leukaemia and those undergoing high dose chemotherapy) or in those for whom the prospect of remission is poor.

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Impotence: science and sciencibility

SIR,—The leading article by Dr W J Jeffcoate (22 March, p 783) comes fast on another major article on the same topic printed in your pages.¹ The more recent article summarises some fairly complicated and not very practical procedures for the management of erectile dysfunction and concludes that they should be more widely available. All psychological treatments are grouped together under the term "counselling." Neither of the articles pays any attention to specific procedures for the management of anxiety, although anxiety about sexual function, performance anxiety, is probably the largest single cause of sexual dysfunction in both men and women. Perusal of five recent British textbooks on sexual dysfunction²⁻⁶ shows that in all but one² the management of anxiety is scarcely considered and given only passing mention usually in the setting of the Masters and Johnson approach, which is time consuming and probably beyond the resources of time allocation for most psychiatrists, general practitioners, and others who work in hard pressed health service establishments.

In our psychosexual clinic we also do not have much time—just one session a week for one new patient and five or six patients receiving continuing treatment. We have therefore adapted the technique of anxiety control training⁷ to sexual anxiety. This procedure is practical in such a setting, requiring no more than six or seven weekly sessions of 10 minutes as the patient is taught to control his anxiety with practice at home and, in

effect, becomes his own therapist. Although we have not had the opportunity to publish the results of this approach, we would like to point out that it is not only brief but, given good motivation on the part of the patient, very successful. It may also be used in those common cases in which the patient cannot bring along a cooperative partner for joint counselling.

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SIR,—Dr W J Jeffcoate's leading article is well timed and relevant. He describes the use of a sleep laboratory to determine nocturnal penile tumescence associated with rapid eye movement sleep and outlines the problems of staff, space, and interest, which are limiting factors. For a short period we investigated nocturnal penile tumescence fairly cheaply and easily and reported our results.¹ We used a very cheap strain gauge and manufactured our own loops with mercury and Silastic rubber, attaching the whole to an ordinary chart recorder run at a very slow speed. Patients were admitted to a hospital side ward overnight and studied without any recording of rapid eye movement sleep. The equipment we used is thus available to anybody at minimal cost. Indeed, it is also portable and could therefore be used in the patient's own home, which might well be a better reflection of his performance than in a noisy and strange hospital side ward.

I am unaware of any patients sleeping without rapid eye movement sleep apart from those with profound brain damage, which most people presenting with this complaint clearly will not have, and hence, as an interested amateur, I would question the need for expensive equipment to monitor periods of rapid eye movement sleep. As long as patients slept for a short while it seemed that they had nocturnal erections which were easily measurable using our system. I believe that the construction of such apparatus is possible for anyone who has the most basic equipment and can find a quiet single room in which to study the patients.

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Diminution in energy expenditure during lactation

SIR,—Dr P J Illingworth and colleagues have shown very elegantly that an increase in energy expenditure after a standard meal is reduced during lactation (15 February, p 437). Whether or not this is an adequate explanation for the observed similar weight losses of breast and bottle feeding women despite similar dietary intake and similar resting metabolic expenditure is debatable. Clearly