As far as the case report of Dr Lewis and others is concerned, it would be useful to know if the patient had acute or fulminant changes of exophthalmos, for without these changes their patient would be similar to one of our own who did not respond. The lack of response in such patients is probably due to permanent fibrotic changes in extraocular muscles. In this regard it would be extremely useful to have a simply measured biochemical marker which would predict potential responders. For the moment, however, it appears that one would have to depend on the clinical indications such as those described above; this is not necessarily a compromise since it is mostly in association with these features that the threat to visual acuity occurs. Plasmapheresis is not a treatment for cosmetic discomfort but a possible alternative to orbital decompression. We agree that this procedure needs further assessment.

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Autonomic neuropathy in the Guillain-Barré syndrome

SIR,—Further to your correspondence regarding heart rate variation in diabetes mellitus and in tetraplegic patients (19 May, p 1353) we would like to report a case of Guillain-Barré syndrome in which serial tests showed the presence and then resolution of an autonomic neuropathy.

A 30-year-old man presented to the casualty department with a seven-day history of numbness paraesthesiae of both legs and hands and a left facial weakness which had been present for two days. On examination, his temperature was 37.2°C; pulse rate 124 beats/min, regular; and blood pressure 120/80 mm Hg lying down, 110/80 mm Hg standing. There was a left lower motor neurone facial palsy, a proximal weakness of all four limbs, and sensory loss of a glove and stocking distribution with absent deep tendon reflexes. Investigations: haemoglobin concentration 15.9 g/dl, white blood cells (WBC) $10.5 \times 10^9/l$; cerebrospinal fluid WBC $< 1 \times 10^6/l$; protein 2.3 g/l. Electromyography showed slowing of sensory and motor conduction.

A diagnosis of Guillain-Barré syndrome was made and corticosteroid therapy started. In view of the marked resting tachycardia serial tests for autonomic neuropathy were performed. The heart rate response to standing was conducted as described by Ewing *et al*¹ and the "30:15 ratio" derived. The variation in heart rate during respiration was recorded by continuous electrocardiographic monitoring during deep breathing (six deep breathing manoeuvres in one minute) and the E:I ratio of the mean of the longest R-R interval during maximal expiration to the mean of the shortest during maximal inspiration was calculated as described by Sundkvist *et al*.² For the first three days of his admission there was a persistent tachycardia and both the "30:15" and the E:I ratios were compatible with vagal neuropathy and autonomic dysfunction. His neurological signs were unchanged. On the fourth day, however, these ratios returned to within the normal range. This was followed by a gradual resolution of the neurological deficit.

The Guillain-Barré syndrome has been associated with a variety of circulatory abnormalities³ and vasomotor disturbances have been accepted as a sudden cause of death.⁴ Thus autonomic function should be

monitored closely in this syndrome, both to assess progress and to provide objective parameters with which to assess therapy.

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- ¹ Ewing, D J, *et al*, *British Medical Journal*, 1978, **1**, 145.
² Sundkvist, G, *et al*, *British Medical Journal*, 1979, **1**, 924.
³ Birchfield, R I, and Shaw, C-M, *Archives of Neurology*, 1964, **10**, 149.
⁴ Appenzeller, O, and Marshall, J, *Archives of Neurology*, 1963, **9**, 368.

Diving and hypothermia

SIR,—Another two divers in the North Sea have died from hypothermia and I should like to add to the recent contributions on this subject (5 May, p 1182; 9 June, p 1566; 25 August, p 494).

Divers under water lose heat from the body surface and through respiration, the latter in two parts—(a) the humidification of dry inspired gas and (b) absolute warming of the cold inspired gas. With a helium-oxygen respiratory mixture the absolute warming part of the respiratory heat loss becomes much more important than in air. Under normal circumstances heat supplied from the support ship to the diving bell via the umbilical cord counteracts the heat loss; but in any accident normal sources of power and heat will almost certainly be lost, as happened in the Thistle field, or at best reduced. When this happens the men are in trouble and emergency equipment should therefore be effective without requiring any outside source of power.

Respiratory heat loss could be reduced by means of a heat exchanger which also acts as a condenser humidifier. A soda-lime-filled canister, as used in anaesthetics but with the addition of insulation, could fulfil this need. The soda-lime granules would initially act as a passive-condenser humidifier and heat exchanger, but as the expired carbon dioxide reacted with the soda lime to produce heat and moisture the system would gradually change to one providing a positive heating effect. Of course, as the soda-lime became exhausted the canister would revert to a passive heat and moisture conserver. A single canister should nevertheless provide about six hours of positive heating and CO₂ absorption.

The provision of the insulated canisters would encroach on the space in the diving bell but a space of 30 × 15 cm diameter per man might not seem excessive for an emergency. The other problems would be (a) fitting the canister into the diver's breathing system; (b) a slight increase in resistance to breathing; and (c) a gradual increase in dead space as the soda lime became exhausted.

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"Herbal" medicines and rheumatoid arthritis

SIR,—Dr P G J Forster and others (4 August, p 308) rightly warn against the use of Chuei-Fong-Tou-Geu-Wan pills apparently imported from Holland, for the treatment of

rheumatoid disorders. However, they did not need to refer to a newspaper as a source of reference, since the matter has received wide publicity in the Dutch medical press.

After the first warning that analysis of such pills had shown the presence of indomethacin and dexamethasone, and that cases of Cushing's syndrome and withdrawal symptoms after stopping treatment had been reported,¹ a case similar to Dr Forster's was published,² involving a patient who had been using 12 pills daily containing an average of 75 mg indomethacin, 112 µg dexamethasone, and small quantities of diazepam and hydrochlorothiazide. These pills had been manufactured by the Nan Lien Pharmaceutical Co Ltd in Hong Kong. Similar pills from the Singapore subsidiary of the same firm were shown to be composed of prednisone 0.4 mg, hydrochlorothiazide 4 mg, chlorthalidone 0.5 mg, chlorpheniramine maleate 1.3 mg, and thiamine disulphide 5 mg; whereas the pills marketed by the Shou Sing Pharmaceutical Co Ltd in Taiwan contain varying (0.6–6 mg) amounts of phenylbutazone, about 8 mg of aminopyrine, and some thiamine. Moreover, the Yi Chung Tai Medical Manufacturing Co Ltd in Taiwan markets Chi-Shi-Ton pills containing 8.1 mg paracetamol, 0.26 mg ethaverine hydrochloride, 2 mg chlorzoxazone, 0.55 mg diazepam, 1.9 mg caffeine, and some thiamine.³ In none of these cases was the presence of these drugs mentioned on the package or the directions folder. Obviously patients suffering from rheumatoid arthritis run great risks in the unauthorised use of such adulterated pills.

Though marketing—mostly by small Chinese dealers—of these pills in the Netherlands is alleged, and since October 1978 has been officially condemned, a total embargo on this dangerous practice seems almost impossible to enforce. Patients should therefore be clearly warned against the use of any Chinese so-called herbal pills. This is not the only example of its type; similar instances (Amborum Spezial F, Tsai-Tsao-Wan, "nose pills," and Swasahar) have been reported from Germany, Australia, and the United States.⁴

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¹ Offerhaus, L, *Nederlandsch Tijdschrift voor Geneeskunde*, 1978, **122**, 1633.

² Uitdehaag, C M J, *Nederlandsch Tijdschrift voor Geneeskunde*, 1979, **123**, 1009.

³ Central Drug Inspectorate, *Nederlandsch Tijdschrift voor Geneeskunde*, 1979, **123**, 1347.

⁴ Dukes, N M G, (editor), *Side Effects of Drugs Annual* 3, Amsterdam, Excerpta Medica, 1979.

SIR,—It might be of interest to your readers that in addition to the Chinese herbal medicine Chuei-Fong-Tou-Geu-Wan, on which Dr P J G Forster and others report (4 August, p 308), four more exotic drugs—Amborum spesial F, Tsaitsoan, Nose Pill, and Swasahar—claimed to be pure herbal remedies, were found by the German Medicines Inspection Institute (Deutsches Arzneiprüfungsinstitut, DAPI), an independent laboratory of the pharmaceutical profession, to contain dexamethasone or prednisolone or both. The

doctors and pharmacists in the Federal Republic of Germany were informed accordingly by their Medicines Commission.

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SIR,—I was most interested to read the article by Dr P J G Forster and his colleagues (4 August, p 308) as I have recently seen a patient who obtained the same dramatic remission of symptoms in rheumatoid arthritis after taking Chuei-Fong-Tou-Geu-Wan. The samples of these pills have not yet been analysed but it would seem from the speed of the remission that these also contain steroid drugs.

It appears from discussion with my patient that quite a number of people in Britain are taking these pills, as the dramatic relief afforded by them caused the patient to recommend them to all his friends. As far as I can ascertain, all these pills have been obtained by individual patients from Hong Kong by post, therefore avoiding distributors and the need for a product licence. I feel that through your columns the widest possible publicity should be given to the dangers of these pills, and, indeed, perhaps attempts should be made through the Hong Kong authorities to ban their manufacture.

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Epidemic hysteria—divide and conquer

SIR,—Your leading article (18 August, p 408) brings to mind my single experience of epidemic hysteria. This occurred in a double-decker-busload of morris dancing girls on their way home at night from a long day's competition. They were laid out on the verge of a main road, and a fleet of ambulances ferried them to our casualty department. Already slightly sheepish, they were split again into small packets in cubicles and some were admitted. These were redivided and slipped into a bed wherever one could be found.

The episode started about 10 pm; by 2 am it had completely evaporated. The girls were from many different schools and did not meet again next day. There was no recurrence by the group or by any individual. Divided they were conquered. It was lucky that it was only a busload and not a whole school.

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Gout and port

SIR,—In his article on gout Sir Richard Bayliss (23 June, p 1695) states that "port probably has its reputation for inducing gout because in the past it was drunk in large quantities, and today is drunk at the end of a meal, before and during which other alcoholic drinks have been served." Having been a martyr to gout for just over 50 years, and having consumed port on and off for as many years, I have had ample opportunity of studying this famous factor in the causation of gout. While agreeing with Sir Richard that quantity

is very important, I think that there is more to it than that.

I have observed that the longer the bottle of port has been opened, the greater is its goutogenic properties, dose for dose. I can safely consume up to half a bottle of freshly uncorked port without suffering later but if I were to drink even one glass of the same wine after it had stood in a decanter on the sideboard for three or four days, especially in warm weather, I would have gout within a day. Keeping the decanter in a refrigerator will reduce this effect, though not eliminate it entirely. I am therefore convinced that it is the oxidation of the wine that is the cause of the trouble. In the homes of both my grandfathers wide-based decanters of port were kept in readiness on the sideboard. I believe that this custom was prevalent in many middle and upper class homes in England and that it was due to this practice that port has got its reputation.

Port is not alone among wines in causing a gout attack. Indeed, most wines can do it, especially when they have been exposed to the air for an appreciable length of time. The sweeter wines and those which have been fortified with brandy such as sherry are more likely to cause trouble than the light dry wines, the exception being the cheaper wines made from second pressings (the grape juice of these will have been exposed to the air already during the waiting time between the first and second pressing). Even brandy, when the bottle has been left half empty for a week or two in warm weather, can precipitate an attack.

Perhaps some interested biochemist will discover which oxidation product of port is the one that cannot easily be tolerated by the inheritors of gouty genes. If it were to be found that "broken up" fructose was the cause of the trouble, this would fall into line with my observation that over-ripe fruit can also act as a precipitating factor, as can stale maltose-containing products. I am sure that a reawakening of interest into the dietetic aspects of gout is long overdue.

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AID for lesbians

SIR,—I was extremely surprised to read Dr M J G Thomas's statement (25 August, p 495) that artificial insemination by donor is "treatment." Treatment for what, I asked myself. Infertility? No, it can't be that or it would not work. Treatment for lesbian tendencies? No, because the women are still lesbians after conception has occurred. Treatment for the psychological strain of having "married" someone of the same sex and so being unable to conceive naturally? This seems to me to be the only possible way in which the process can be regarded as "treatment."

If this is so, then it would appear that the chairman of the Central Ethical Committee is approving the action of a doctor who helps in the creation of a child as a means of psychotherapy. I personally would consider this to be unethical.

To use an unnatural method of conception to bolster up an unnatural relationship is unlikely to produce a satisfactory result. For a child to grow up and discover that both its "parents" are female will surely impose on it even greater psychological strains than its

conception was supposed to resolve. Quite apart from any ethical consideration, this must be bad medical practice and should not receive the support of the British Medical Association.

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SIR,—Your leading article "Artificial insemination for all?" (25 August, p 458) states that there is no centre in the south providing artificial insemination by donor.

I wish to correct this mis-statement. A limited AID service has been provided by the professorial department of human reproduction and obstetrics at the Southampton General Hospital for some time. In addition, the service has now been accepted as a regional service by the Wessex Regional Health Authority, which will contribute to its future development.

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SIR,—I am astonished that the ethical issues of artificial insemination by donor are dismissed so lightly in your leading article "Artificial insemination for all?" (25 August, p 458). It is perfectly right and proper for parents to have children to satisfy their own needs—but surely the hallmark of responsible parenthood must be the asking of the question "Am I providing the best possible environment, accepting my own limitations, for the child I wish to parent?" I suggest that AID does not measure up to this test. Either the child must be told a deliberate lie about his father, and the family has to live with a guilty secret which may well come out one day, or the child must be told that his biological father can never be known. Both situations are detrimental to the child's emotional development. How well he copes with the disability will, of course, depend on many factors, not the least of which is his genetic make-up.

I take Dr Michael Thomas's point that decisions on medical treatment cannot be taken on moral grounds—but is AID a treatment? It is only a "treatment" if we confine our attentions to the emotional demands of the mother. As a treatment for the baby this procedure is at least questionable. This is an excellent example of the extension of the medical model to avoid emotional issues.

In my view it is ethically wrong deliberately to inflict a handicap of this sort on a child.

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Gutter treatment for ingrowing toenails

SIR,—I read with interest the article "Gutter treatment for ingrowing toenails" by Mr W A Wallace and others (21 July, p 168). My interest in this subject stems from a bizarre nightmare I frequently had as a child, in which I saw a somewhat bulbous hallux growing suddenly large. I always woke with a feeling of incongruity and horror. These feelings, however, are as nothing to those evoked by the mutilated toes I see in young people when bathing, which result from the radical surgical procedure of nail fold advancement and hemiphalangectomy. One thing