and even then assortative mating may be involved.

None of this, of course, contradicts the recommendation to examine potential partners of PKU homozygotes for the carrier state in order to give genetic counselling.

JACK BAVIN

Twynver Unit,
Coney Hill Hospital,
Gloucester GL4 7QJ

*We sent a copy of this letter to Professor Kutter, whose reply is printed below.—ED, BMJ.

SIR,—Since the publication of my previous letter I have been able to complete the list of patients with phenylketonuria who have progeny. I have found reports on 75 patients (71 female and four male) of which 17 have one or more homozygous PKU offspring (14 mothers and three fathers). This would correspond to a carrier frequency of about 1:4. We have checked for the possible mechanisms proposed by Dr Bavin: so far as we can conclude from the different case reports there is no evidence for selective mating. In one of the cases incest is quite possible; in a second it cannot be excluded. In four cases there exists evidence of very remote consanguinity. Even if we exclude these six cases from our calculation we still find a carrier frequency which is very far from the 1:50 generally accepted.

I think that the carrier frequency is really much higher than we admit and that the 1:50 frequency, which is based on the homozygote detection in screening for PKU, is incorrect. There are several reports of increased reproductive casualties in PKU carrier women. This may mean that there is a higher quota of carrier marriages but that a large proportion of homozygous PKU pregnancies do not yield live births.

Carrier tests always compare parents of PKU children with a "normal" population. The possibility is not excluded that this "normal" sample contains a larger proportion of carriers and that the overlap between the two populations which is found by all the authors really does not exist.

I think at any rate that the problem is worth further investigation and I would welcome any suggestions.

D KUTTER

Luxembourg

Psychiatric symptoms and hallucinogenic compounds

SIR,—I was interested to read of the case of persistent panic attacks following the eating of psilocybin mushrooms described by Mr C Benjamin (19 May, p 1319). Like Dr D Jacobs (7 July, p 49), I have seen a number of cases in which persistent panic attacks followed the taking of cannabis and LSD. I would like to describe one such case and how it was treated.

The patient was a 23-year-old woman who had a three-year history of panic attacks which were precipitated by a particularly bad LSD "trip." During this trip what the patient experienced was horrific. Apart from the usual visual distortions associated with LSD she experienced herself being continuously raped by seven men. This sexual "assault" was truly brutal and over the period of six hours while the trip lasted she felt her body being continuously violated. The trip itself took place at home in the presence of her parents and sister. The experienced sexual

molestation could therefore have had no basis whatever in reality.

The panic attacks consisted of episodes of acute anxiety with palpitations, dryness of the mouth, hyperventilation, depersonalisation, derealisation, and a feeling of being about to go insane. Like those Dr Jacobs described, the attacks were unrelated to any particular situation and just seemed to come out of the blue. Treatment was based on the hypothesis that the patient had undergone what to her was a real traumatic experience, even though it was in fact a hallucinogenic one. Treatment consisted of sessions of abreactive psychotherapy. In these the patient was encouraged to relive her experience by talking about it in as much detail as possible. During such sessions she became extremely frightened and ended up screaming and crying. After only three such abreactions the panic attacks disappeared completely and they have not returned in the year and a half that she has been followed up since then.

Phobic anxiety with panic attacks has long been known to follow frightening real-life experiences.¹ Could it be that a frightening hallucinogenic experience may also produce this effect?

AIDAN MCGENNIS

St Brendan's Hospital,
Dublin 7

¹ Marks, I M, *Archives of General Psychiatry*, 1970, 23, 542.

SIR,—I read the short report on persistent psychiatric symptoms associated with the consumption of psilocybin mushrooms (19 May, p 1319) with interest as at the time I had under my care a patient with experience of eating "magic mushrooms" (as he referred to them), whose history may be of interest to some of your readers.

This patient, a 26-year-old bachelor, was admitted to hospital informally in February 1979. His parents, with whom he was living, had noticed a change in him over the previous month in that he had become vegetarian, had taken to staying up all night reading the Bible, and had become preoccupied with "the evil in the world." He told them that he found himself "in tune with nature" and was planning the world-wide conscription of an "environmental army" to sort out the problems of the world (for example, pollution, armed conflict).

On admission he showed no sign of self-neglect and was well orientated and co-operative, with no evidence of clouding of consciousness. He gave his history spontaneously, but with no marked pressure of speech, although his conversation was disjointed. He said that he felt ecstatically happy and felt able to solve all the problems of the world as he had been imbued with Messianic powers following a vision of "a crown of thorns coming down"—and that he was in telepathic communication with other people, felt possessed by a divine spirit, and had experienced a sensation of everyone being able to hear his thoughts. He seemed to have experienced hallucinatory voices talking about him in the third person. He was considered to show mild formal thought disorder and a diagnosis of schizoaffective psychosis was made.

He was described by his parents as being an extraverted, sociable, warm, generous, energetic, cheerful, and popular young man, if rather impulsive; and he appeared to have been making a success of his own business. He had, however, a past psychiatric history inasmuch as he had taken an overdose four years previously following a broken engagement, but this had not led to his receiving psychiatric treatment. There is no family history of psychiatric illness. It turned out that for some years he had experimented with a variety of illicit drugs, including cocaine, amphetamines, pot, and lysergic acid; but that over the two years prior to his admission he had taken only pot and occasional amphetamine tablets. He had taken neither of these, however, since the autumn of

1978, when he had for the first time on a number of occasions consumed dried "magic mushrooms," whose description left little room for doubt that they were *Psilocybe semilanceata*, which is found in profusion in the area. He told me that he understood they contained psilocybin and described the immediate effects as heightened awareness, perceptual distortion, and visual hallucinosis. He responded to treatment with haloperidol and was discharged five weeks after admission, since which he has had a few brief depressive bouts but no further psychotic experiences.

One cannot be sure what part, if any, the ingestion of mushrooms played in the aetiology of this illness, although he had previously consumed LSD without any long-lasting or delayed effects and had given that up about two years previously. He had, however, persisted with amphetamines in small quantity and pot until six months prior to the illness. However, it may be that his illness represents a delayed effect of the consumption of these "mushrooms" in a person possibly made more susceptible by the abuse of other drugs.

N S DAVIES

North Wales Hospital,
Denbigh, Clwyd LL16 5SS

The grumbling appendix

SIR,—Mr I Lewis (a September, p 552) says that acute appendicitis normally presents with midepigastriaic pain and not with umbilical pain. This is at variance with my experience, but I am also interested to know how he would explain this. The appendix lies distally in the alimentary tract to the point at which the small bowel attaches to the umbilicus by the vitelointestinal duct. Pain from Meckel's diverticulum must therefore on an embryological basis be referred to the umbilicus; the appendix, being distal, should not logically have pain any higher than this and might in fact be expected to have a very slightly lower distribution.

I hope that not all cases of chronic appendicitis will be dismissed. Although the diagnosis should be made with great reluctance there are nevertheless some patients with a stricture and a trapped faecalith who experience severe pain that is relieved by the operation; and there are certainly others with lesser signs whose pain goes—presumably owing to the subsidence of the swollen glands Mr Lewis describes to the patients.

GEORGE WATTS

General Hospital,
Birmingham B4 6NH

Disinfection with glutaraldehyde

SIR,—Dr R M G Boucher (18 August, p 444) describes advantages in the use of non-ionic potentiated acid formulations of glutaraldehyde. He dismisses many of the recent developments which have taken place with alkaline glutaraldehyde formulations. He neglects to point out that under normal conditions at room temperature the potentiated acid variety, unlike the alkaline solutions, is not recommended for use as a chemical sterilising solution.¹

The instability of glutaraldehyde solutions is known to be a consequence of aldehyde polymerisation, the rate of which has been shown to increase with both increasing pH and increasing temperature.² Studies with the original Cidex formulation have demonstrated an approximately 44% reduction in free glutaraldehyde content after storage at room

temperature for 14 days following activation.³ With the recently introduced alkaline glutaraldehyde formulations developments in activation techniques, using modified initial pH and buffer systems, have considerably reduced the extent of glutaraldehyde polymerisation after activation. This greatly diminishes the hazard of inactivation from in-use dilution with water carry-over during sterilisation and disinfection cycles.

It is recognised that in-use dilution and inactivation, rather than chemical instability, are now the major factors limiting the use life of many of the recently introduced alkaline glutaraldehyde preparations.³ Although certain manufacturers recommend a 28-day life in situations of low dilution and low-to-moderate throughput, authorities in cross-infection control in the United Kingdom have questioned the desirability of repeated use of disinfectant solutions. Despite improved chemical stability they are reluctant to recommend repeated use of a solution for more than 7-14 days.⁴

Freedom from corrosivity has always been a desirable feature of a glutaraldehyde-based steriliser and disinfectant formulation, and is a more essential prerequisite with the increasing application to decontamination, where the solution is confronted with a wide variety of metals in equipment.⁵

JOHN A KING

Galen Ltd,
Craigavon, Armagh

¹ Boucher, R M G, *American Journal of Hospital Pharmacy*, 1974, **31**, 546.

² Rasmussen, K E, and Albrechtsen, J, *Histochemistry*, 1974, **38**, 19.

³ Miner, N A, et al, *American Journal of Hospital Pharmacy*, 1977, **34**, 376.

⁴ Ayliffe, G, Collins, B J, and Babb, J R, *British Medical Journal*, 1979, **1**, 1019.

⁵ Expert Group on Hepatitis in Dentistry, *Report to the Chief Medical and Dental Officers of the Health Departments of Great Britain*. London, HMSO, 1979.

Health visitors and community midwives

SIR,—I should like to comment on the opening sentence of the review of *The Specialised Health Visitor for the Handicapped Baby, Young Child and School Child* (18 August, p 437)—namely, "The health visitor is the only person with an implicit obligation to visit the home of every newborn baby—thus she is in the best position to advise and support parents of handicapped children."

It is true that one of the duties of the health visitor is to make a visit to the home of every baby on or after the 11th day of life. There is, however, no legal requirement in this, nor is there any requirement on the part of the parents of the child to allow access to the baby.

The community midwife is in a very different position, in that she has a legal obligation to make daily visits to the newborn baby and his or her mother for a minimum of 10 days and a maximum of 28 days. More health districts are now requiring the community midwives to make these postnatal visits for the full 28 days. Where this is so, the health visitors' visits may overlap with those of the midwives, or they may defer the initial visit until after the 28th day.

It would appear that, should all mothers and babies have the midwife's continued care and supervision for the first 28 days following delivery, the health visitor would be available to provide the extra advice and

support required by those families with special problems associated with the handicapped child.

LILIAN BARTLETT

Central Midwives Board,
London SW7 4JY

The oesophageal airway

SIR,—Dr M G Harries in his excellent article (18 August, p 426) says that nobody in Britain has been trained in the use of the pharyngeal airway invented by Dr Don Michael.

In Brighton, cardiac ambulancemen are in their second year of using the oesophageal airway ("EOA") with great success. These cardiac men, who are also qualified to intubate the trachea, are free to use the EOA if they prefer, when they have been trained to do so. Of the last 100 intubations in Brighton, about 35% have been with the oesophageal airway—so far, fortunately, without complications.

J H WILLIAMS

Royal Sussex County Hospital,
Brighton BN2 5BE

Genetic association with bladder cancer

SIR,—In a recent leading article (1 September, p 514) you refer to a paper published by myself and my collaborators on the putative role which intrinsic variability might play in the pathogenesis of transitional cell carcinoma of the bladder.¹ You rightly drew attention to some of the difficulties inherent in such studies but made no mention of perhaps a more fundamental inconsistency. If there is a measurable genetic association with bladder cancer, as postulated in our paper, then more than one susceptible person should occur in some families and in turn more than one clinical case is likely. However, a search of the world literature revealed very few reports of such familial cases.¹ If our postulates were correct, familial bladder cancer should not be uncommon.

I am now able to report some preliminary results from a case-control study currently taking place in Yorkshire. Each of 1261 individuals, patients with bladder cancer together with age- and sex-matched controls, was asked about other cases of bladder cancer in first- or second-degree blood relatives. Overall 84 (7.6%) gave evidence that one or more family members also had the disease. Case-control analyses of these data by the method of Mantel and Haenszel² give an estimate of the odds ratio of the risk of familial bladder cancer of 1.345. This result is not statistically significant and shows that cases of bladder cancer are only slightly more frequent in the families of the cases.

These preliminary results show that a family history in cases of bladder cancer is not uncommon, and that this type of family history occurs also in the general population. It might have been expected that a stronger family history in the cases would support our genetic findings. This need not be the case if the genes in question are common, as we have suggested. My interpretation would be that certain quite common genes confer susceptibility to the disease but that only a fraction of such people ever get bladder cancer owing to their varying environmental exposures. Possibly the controls with a positive family history have the genes we described¹ and are

at a greater risk of bladder cancer. More analyses are required on the existing data, in particular to examine the genetics of the control group with a positive family history; but also a careful follow-up of both the controls and the families of the cases will be essential to see if the prediction about their susceptibility is true.

R A CARTWRIGHT

Yorkshire Regional Cancer Organisation,
Cookridge Hospital,
Leeds LS16 6QB

¹ Herring, D W, Cartwright, R A, and Williams, D R R, *British Journal of Urology*, 1979, **51**, 73.

² Mantel, N, and Haenszel, W, *Journal of the National Cancer Institute*, 1959, **22**, 719.

Photographing slides during scientific presentations

SIR,—At several conferences that I have recently attended I have been somewhat disturbed, both as a delegate and as a speaker, by the presence in the audience of other delegates photographing slides as they are being presented. I am uncertain of the legal or ethical principles involved, but feel that the practice at least constitutes gross impoliteness since generally no prior permission of speaker or chairman has been sought.

As a relative newcomer to the world of scientific presentations I am loth to interfere with the rules of the game. However, since I feel that this is also a relatively new practice, and one which will ultimately lead to devaluation of the forum good conferences provide, might I appeal to organisers and chairmen to make an appropriate ruling and to publicise and enforce it?

STEWART MANN

Northwick Park Hospital and
Clinical Research Centre,
Harrow, Middx HA1 3UJ

Treatment of reactions to hymenoptera stings

SIR,—Your experts advising on the prompt treatment of bee and wasp stings (17 March, p 726; 19 May, p 1334) recommend among other things the injection of 1/1000 adrenaline solution. This is not really very practical. When one is away from home it is cumbersome to carry on one's person, at all times during the season, the paraphernalia for injection treatment on the off-chance of being stung. The drawing up and injection by someone unaccustomed to this procedure, in what are likely to be inconvenient circumstances, probably out of doors, possibly with dirty hands (for example, when gardening), are bound to be difficult and fraught with the possibility of delay and error. Your first expert also suggests using a salbutamol aerosol, which is certainly handier in an emergency for the airways obstruction which causes 80% of deaths. This affords little protection for those who react to a sting with anaphylactic shock. Dr M A Ganderton (5 May, p 1216) recommends the inhalation of an adrenaline aerosol (Medihaler-Epi) in the belief that absorption would deal with general manifestations in addition to local relief of bronchospasm. How much would be absorbed by this route is questionable. Not all hymenoptera-sensitive patients are asthmatic, and those unaccustomed to the use of pressurised aerosols might experience difficulty in timing the discharge during inhalation—it needs practice.