known that patients, tense and anxious in the average six minutes given by doctors, can forget what was said to them. This pamphlet is also to be distributed to pharmacists at their point of contact, to reinforce further the message to the patient.

A poster is by definition for public display and the intention is that this poster should be viewed by patients while waiting to see the doctor. It is subjective because the reviewer seems to think that a left-to-right slant is somehow "unnatural." This surely must be a personal view with which many others will disagree. It is also merely a matter of opinion whether the colours are "visually discordant." It would seem a truism of advertising that bland colours and messages that glide over the eye may never pierce the eyeball. The poster is meant for the small confines of waiting rooms, where the information can be assimilated. It was never meant to be read "on the run." A preliminary test on around 150 people indicated that the majority saw that in the whole context of the poster the diseases mentioned were to be read as "Drugs prescribed for these diseases." This approach was purposely adopted, because patients may not understand the technical names of some groups of drugs but will better understand the name of the disease for which these are given.

In a pamphlet regretfully there is time only for a thumbnail sketch. It is not an academic textbook. A pamphlet can state the obvious again and again. This pamphlet did, however, highlight a relatively unknown dangerous interaction between alcohol and Distalgesic (dextropropoxyphene). This interaction was noted in Northern Ireland and had already caused the death of over 57 people. This is certainly worthwhile knowledge to publicise, as it may not be as widely known as the effects of benzodiazepines.

The pamphlet and poster have already had a wide distribution, and the response to both productions has been extremely gratifying—so much so that a reprint of 3000 has been necessary. It is to be hoped that this negative review will not detract from the object of our publications, which is to make medication safer. Other journals have reviewed the poster with considerable acclaim, and we are grateful for the many complimentary letters which have been sent to us.

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Confusion associated with cimetidine

SIR,—We would like to report an instance of a confusional state in an elderly patient which could well have resulted from the use of cimetidine. While this subject has already been well aired,¹⁻⁴ we cite the present case as a further warning against using this powerful drug in the elderly unless it is considered not merely adjunctive but really essential to therapy. Mental confusion may indeed be the single most troublesome adverse effect of this widely used agent.⁵

A 76-year-old widow with no previous psychiatric history was admitted with a gastric bleed following treatment with phenylbutazone for arthritis of the knees. She had also been treated with diuretics for cardiac insufficiency for some time. She required four units of blood over the first 48 hours. By the fourth day her blood count had returned to normal. Tests of renal and hepatic function were also within normal limits. Because

of bed shortages the patient had several changes of ward and bed position within a few days. Treatment with cimetidine in a dose of 1 g daily was instituted shortly after admission to facilitate healing of the erosions.

On the fifth day, though her physical state was by now quite satisfactory, she suddenly developed an acute paranoid psychosis which necessitated her transfer to the hospital psychiatric unit. She was disoriented as to place (but not time), believing that she was being kept in the house of a religious sect against her will, the doctors and nurses on the medical ward being in league against her and "putting her through the third degree"; they were, for instance, interfering with her home life and stealing flowers brought by her visitors. Cimetidine was stopped and chlorpromazine 25 mg thrice daily started because of her extreme agitation. Within 36 hours she was settled enough for chlorpromazine to be discontinued.

This woman's paranoia and confusion disappeared so quickly that it was felt that the H₂ antagonist with which she had been treated must have been a potent factor in her psychiatric condition.

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¹ Cumming, W J K, and Foster, J B, *Lancet*, 1978, 1, 1096.

² Schentag, J J, et al, *Lancet*, 1979, 1, 177.

³ Agarwal, S K, and Paramus, N J, *Journal of the American Medical Association*, 1978, 240, 214.

⁴ Wood, D C A, *Journal of the American Medical Association*, 1978, 239, 2551.

⁵ *Medical Letter*, 1978, 20 (18), 77.

Neutropenia associated with metronidazole

SIR,—Dr T Bergan suggests (10 November, p 1219) that our case report of neutropenia associated with metronidazole is not valid as the patient was also receiving azathioprine. We would like to emphasise the point made in our letter (29 September, p 795)—that azathioprine had been given continuously for three months before metronidazole and was prescribed for a further three months after metronidazole was stopped with no fall in the white cell count. The temporal relationship between metronidazole and the observed neutropenia makes the association probable. We fully accept that there may well be a combined suppression effect on the marrow, as suggested in our letter, but reject the suggestion that metronidazole was entirely innocent.

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Fatal carbon monoxide poisoning—a new circumstance

SIR,—A 17-year-old boy was admitted deeply unconscious, pulseless, with no respirations, and with widely dilated pupils. Further examination revealed that his periphery was still warm and that his mucous membranes were cherry red. External cardiac massage and ventilation via an endotracheal tube were started immediately but without success. Acute pulmonary oedema was confirmed by radiology.

An initial clinical impression of possible carbon monoxide poisoning was made and

soon the following history emerged. The patient was a street trader of some three days' experience who sold roasted chestnuts. On the night before his death he had slept in his van with four coke stoves alight, presumably to keep warm, and was found deeply unconscious on the following morning. This occurred despite warnings from a colleague, who had awoken nauseated, dizzy, and light headed after a similar night spent in his van.

It is therefore evident that, despite the arrival of North Sea gas, carbon monoxide poisoning is not only of historical interest, and that the public should be made aware of the dangers of sleeping in confined spaces in the presence of solid fuel fires.

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Mefenamic acid poisoning and epilepsy

SIR,—Dr R J Young has drawn attention to the possibility of convulsions following mefenamic acid (Ponstan) poisoning (15 September, p 672). We have encountered this complication in a number of patients over the years and we recently measured plasma mefenamic acid concentrations by high-performance liquid chromatography¹ in 23 consecutive patients who claimed to have taken mefenamic acid in overdosage.

Single convulsions occurred in two. A 14-year-old girl allegedly took 100 mefenamic acid tablets (50 g) and six aspirin tablets. A grand mal fit occurred one hour after ingestion of the mefenamic acid and on admission three hours later the plasma mefenamic acid concentration was 72 µg/ml. The other patient was an 18-year-old girl who said that she had taken 50 tablets of mefenamic acid (25 g). On admission three hours later she had a generalised convulsion and the plasma mefenamic acid concentration was 110 µg/ml. Both patients recovered uneventfully.

The plasma concentrations of mefenamic acid on admission were much lower in all but one of the other patients (mean 36, range 0-108 µg/ml). All patients were admitted within four hours of ingestion. The concentrations expected after a maximum therapeutic dose are less than 10 µg/ml² and our preliminary studies show that mefenamic acid normally has a very short half-life (about two hours). There is no doubt that convulsions may occur following mefenamic acid overdosage, and they may be associated with high plasma concentrations of the drug.

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¹ Prescott, L F, et al, *Proceedings of the Analytical Division of the Chemical Society*, 1979, 16, 300.

² Glazko, A J, *Annals of Physical Medicine*, 1967, suppl, p 23.

Penis captivus

SIR,—Readers of the article "Penis captivus—did it occur?" by Dr F Kräupl Taylor (20 October, p 977) will be interested in the