differential metabolic mechanisms and production of pyrogenic metabolites.

Post-treatment fever has not been recorded in St Lucia, where the low-dose regimen (15 mg/kg in a single oral dose) gives satisfactory parasitological results and minimum side effects.

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Iatrogenic collapse

SIR,—I should like to comment on Dr Kathleen M Huntington's letter (20 October, p 1001) on her method of sedation for insertion of intrauterine contraceptive devices in nervous patients.

While vasovagal faints during this procedure are rare, profound respiratory depression following intravenous administration of pethidine 100 mg (perhaps more so with Phenergan (promethazine hydrochloride) 25 mg) is all too common.¹ It is certainly true that this is common practice in casualty departments and in wards for short procedures but these areas are better able to cope with the consequences. Intravenous pethidine must be considered in all cases to be a potential anaesthetic rather than an analgesic. As a minimum the patient must be starved and facilities for resuscitation, including effective suction and means for positive-pressure ventilation, should be readily to hand. Further, a narcotic antagonist such as naloxone (Narcan) should be instantly available.

The use of intravenous pethidine in ambulant patients is to be particularly deprecated, a large series² showing a 67% incidence of side effects (syncope, light-headedness, subjective vertigo) in ambulant patients compared with only 26% in hospitalised patients. Finally, the choice of healthy young subjects is not in itself an absolute safety factor with this dosage.³

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¹ Goodman, L. S. and Gilman, A. (editors), *The Pharmacological Basis of Therapeutics*, 2nd edn, p 264. New York, Macmillan, 1960.

² Batterman, R. C., *Archives of Internal Medicine*, 1943, **71**, 345.

³ Prescott, F., et al, *Lancet*, 1949, **1**, 340.

Hydrallazine as an aphrodisiac?

SIR,—Although antihypertensive drugs are known¹ to have deleterious effects on sexual function, as discussed in your recent leading article (13 October, p 883), data on the contrary effect are lacking. I wish to report an apparently beneficial effect on hydrallazine (1-hydrazinophthalazine) on sexual function.

A 55-year-old Englishman with essential hypertension of five years' duration had been treated for four years with oxprenolol 160 mg twice daily and hydrochlorothiazide 50 mg once daily without side effects. He developed podagra with a raised serum uric acid, which necessitated withdrawal of the thiazide. His blood pressure one month later was 160/110 mm Hg sitting and 170/114 mm Hg standing, and so hydrallazine 50 mg twice daily was added. This combination gave good blood pressure control and after three months the pressure was 132/92 mm Hg sitting and 132/100 mm Hg standing. He spontaneously volunteered that he had experienced a marked resurgence of sexual ability

and had successful intercourse at least three times weekly. This change coincided with the initiation of hydrallazine treatment. He had not had intercourse for 15 years, either because he had not felt the desire to do so or because he failed to maintain an erection. Clinical examination showed normal secondary sexual characteristics and there were no signs of peripheral vascular disease. Blood glucose and the results of routine tests of hepatic and renal function were all normal. Autonomic function was normal as assessed clinically by sweating, sinus arrhythmia, and increase in heart rate on standing. In view of the marked beneficial effect on the patient and his marital relationship, it was felt unethical to test the matter further by hydrallazine withdrawal or placebo substitution.

The cardiovascular changes resulting from hydrallazine treatment even in combination with a beta-blocker may produce a marked reflex increase in sympathetic nervous activity.² This, together with the arteriolar vasodilating action, may be implicated in the mechanism of the observed effect. Of interest in this respect are the reports of priapism caused by hydrallazine and more recently (27 October, p 1039) by prazosin, which is a vasodilator and an α -adrenoceptor blocker. The patient described above had experienced no effect on sexual function after treatment with prazosin alone for one month after the initial diagnosis of his hypertension. It would be interesting to hear of any other patients who experienced aphrodisiac effects from hydrallazine because impotence is difficult to treat and can also result in lack of patient compliance with antihypertensive treatment.

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¹ Bulpitt, C. J. and Dollery, C. T., *British Medical Journal*, 1973, **3**, 485.

² Davies, I. B., Sever, P. S., and Rosenthal, T., *British Journal of Clinical Pharmacology*, 1979, **8**, 49.

Long-term urethral catheter drainage

SIR,—The article by Mr B G Ferrie and others (20 October, p 1046) draws renewed attention to the best method of prolonged drainage of the bladder as a necessity or as a convenience. They state that long-term urethral catheterisation is always to be regarded as second best, a statement with which I am in complete agreement; yet they advocate the same method in treating incontinence whatever its cause. In the case of spinal cord injuries it was the method used by Guttman,¹ but it proved difficult to control the resulting urethral infection—which was inevitable even if the catheter was removed for 24 hours once a week.

A better alternative is a small, high suprapubic catheter (16 or 18 F), which I advocated in 1943^{2,3}; it is inserted when the bladder is distended and should be left in situ for 10 days or more. By that time a track is formed along which a new catheter can be passed; it can be self-retaining or held in place by a stitch tied round it. This catheter can be changed as often or as seldom as the degree of infection indicates. The small skin incision is half way between the umbilicus and the symphysis and the oblique track gives a watertight route for it.

During the first world war some men with wounds of the cord or cauda equina had to be left in no man's land for up to three weeks. In these men the bladder became distended, and in some of them automatic micturition had occurred by the time they were rescued; they were not catheterised.⁴

I am grateful to Mr Ferrie and his colleagues for their paper; I still believe that the small, high suprapubic catheter would be easier, pleasanter, and less costly for the patients and those who look after them than the urethral catheter.

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¹ Guttman, L., *Proceedings of the Royal Society of Medicine*, 1946, **40**, 225.

² Riches, E. W., *British Journal of Surgery*, 1943, **31**, 135.

³ Riches, E. W., *Lancet*, 1943, **2**, 128.

⁴ Vellacott, P. N., and Webb-Johnson, A. E., *Lancet*, 1919, **1**, 1733.

SIR,—I was interested to read the paper by Mr B G Ferrie and others on long-term urethral catheter drainage (27 October, p 1046). I applaud their assertion that the horrific bacteriological findings in the urine of those with long-term catheter drainage may normally be safely ignored. In my experience discontinuance of catheter drainage is required only in the following three problems: intolerable discomfort, including great difficulty and discomfort in passing the catheter; persistent leakage of urine around the catheter; and persistent haematuria.

I would, however, venture criticism regarding their remarks on the obsolescence of suprapubic catheters. A number of patients in the younger-chronic-sick ward attached to this hospital, mostly cases of multiple sclerosis, have been given suprapubic cystostomies for incontinence with conspicuous success. They were patients who for one reason or another had had problems with urethral catheters. Our urologist was at first reluctant to undertake the procedure, muttering something about putting the clock back 20 years. Now I believe, however, that he is reconciled, and the only obstruction to carrying out the operation on a much bigger scale and including geriatric patients would seem to be the work load it would impose on the urological units.

A De Pezza catheter is first inserted into the bladder, but after two or three weeks this is replaced by an ordinary Foley-type self-retaining catheter, size 28. The cystostomy opening closes tightly around the catheter and there is virtually no leakage. Replacement of catheters is much simpler and safer and for the patient less painful and less embarrassing than with urethral catheterisation. The first two patients to be so treated have had their catheters now for six and three years respectively; all patients have proved completely trouble free, with the exception of one man who has severe flexor spasms and gets occasional urethral leakage of urine.

If I were to suggest to any of these patients that they should return to the use of urethral catheter drainage I know what their response would be—"not Pygmalion likely."

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Blood donors and hepatitis

SIR,—The reply given to your questioner on the current regulations governing the acceptance of blood donors with a history of hepatitis (27 October, p 1047) is somewhat out of date.

Using sensitive techniques for the identification of the hepatitis B surface antigen,

transfusion centres screen all donations in a search for carriers before issuing blood to hospitals. We now simply reject donors known to be carriers and those with a history of hepatitis (jaundice) *within the previous 12 months*. Donors should not have been in close contact with a case of hepatitis during the previous six months. The decision whether to accept the donor is based on the history taken at the bedside during a donor session.

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Giving RSV vaccine intranasally

SIR,—I was interested in the reports of failure of immunisation to protect young children from respiratory syncytial virus (RSV) infections (leading article 25 August, p 457). In the studies quoted, a rise in serum antibody against RSV is often observed following systemic vaccine inoculation, but no mention is made of attempts at intranasal administration. The beneficial effects of local cellular and humoral immunity in the lung in response to local attenuated virus vaccines have been well documented.¹ Preliminary work suggests that immunity against rotavirus gastroenteritis may be related to local rather than systemic antibody and that the oral route of vaccine administration may be more protective than the systemic.² It would be interesting, therefore, to observe if intranasally administered RSV vaccine would be more protective than its systemic counterpart.

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¹ Newhouse, M, Sandins, J, and Bienenstock, J, *New England Journal of Medicine*, 1976, **295**, 1045.

² Chanock, R M, Wyatt, R G, and Kapikian, A Z, *Journal of the American Medical Veterinary Association*, 1978, **173**, 570.

Rubella vaccination

SIR,—While it is true that Dr Max Gringras (13 October, p 933) found high acceptance rates for rubella serotesting, he ignores the point that this was in general practice and not in area health authority family planning clinics. There are several reasons for the differences in acceptability—different client groups, the relationship with the doctor—all of which will effect compliance.

Under the present system, we are ethically prepared to risk causing terminations in seronegative women and ethically prepared to accept our impotence in preventing much larger numbers of terminations in unprotected women exposed to natural infection. Surely, by definition, our ethics should be consistent.

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Hypertension and general practice

SIR,—I am delighted to know that Dr D G Beevers (3 November, p 1137) is not responsible for the disgracefully low level of

diagnosis and treatment of hypertension in Great Britain, but that that old whipping boy the general practitioner can confidently be blamed for it.

If he were to spend one week in general practice he would realise that the average time available for a consultation is five minutes, give or take a few minutes. This is also the time it takes to measure the blood pressure properly. Which would he have? Although the number of doctors in hospital practice has increased enormously in recent years, there has been no parallel increase in the number of GPs.

What we need is more doctors in general practice to ease the very considerable burdens in that specialty, and perhaps this is the problem which Dr Beevers should take up in his next confrontation with the television cameras.

The considerable number of GPs currently running the Medical Research Council's mild-to-moderate hypertension trial, those in hypertension units all over the country, and the many others who are increasingly aware of the problem of hypertension must find the comments of Dr Beevers at the very least disheartening.

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Blood pressure measurements

SIR,—I, like Dr Eoin O'Brien and Professor Kevin O'Malley (3 November, p 1126), believe that selected hypertensive patients should be encouraged to measure their own blood pressures. However, I would suggest that for greater simplicity in self-recording the stethoscope should be discarded by the patient. With the aneroid or mercury manometer a satisfactory estimate can be made of the systolic blood pressure when the "knocking" sensation of the Korotkoff sound is felt in the brachial artery. The diastolic level can be reasonably accurately measured by the rather abrupt diminution or disappearance of the "knocking" sensation as the pressure in the cuff is reduced. The accuracy of measurement is certainly adequate for the efficient day-to-day management of high blood pressure.

Changes in the magnitude of oscillation of the aneroid stylus also occur at systolic and diastolic levels but they are more difficult to identify than the changing sensations in the brachial arteries.

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Pulmonary impairment and disability

SIR,—While it is always nice to be quoted by Minerva (29 September, p 801), it is nicer still to be quoted accurately. Only the neophyte would suggest that pulmonary function tests are an objective measurement of respiratory disability; in reality they measure pulmonary impairment, and the distinction between impairment and disability is crucial.¹

Minerva's second comment on my paper is also a trifle misleading. She implies that I said, "The effect of breathlessness on employment seems to depend most on the gap between earnings and sick pay and whether or not the work is interesting." While it is true that those

persons who are well paid and who have a job that they find interesting are more likely to continue working despite significant pulmonary impairment than those who have tedious, less well-paid jobs, I am not sure whether the decision to return to work depends all that much on whether the subject complains of shortness of breath. The same factors seem to operate in regard to the time off work following an acute illness or an operation, such as a myocardial infarction or lobectomy.

In questioning Minerva I trust I shall not suffer the fate of Arachne and be turned into a spider.

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¹ Morgan, K, *Chest*, 1979, **75**, 712.

George Gershwin

SIR,—Minerva's paragraph (20 October, p 1007) brings to mind information which came my way in America about 15 years ago, which throws light on at least the first referral of this neurosurgical case to a psychoanalyst.

The initial symptoms occurred when Gershwin, then 38, was performing his gorgeous piano concerto in one of the Californian cities. At one point he unaccountably seemed to pause and then jump four bars. The conductor pulled them together, and in conversation with the soloist afterwards it turned out that Gershwin had little recollection of the incident, but mentioned a momentary giddiness and a smell of burning rubber. The headaches began a day or two later.

At this time, George's brother, Ira, had been in touch with an analyst, in whom he had developed great confidence; so on hearing about the headaches he persuaded, or over-persuaded, his brother to consult this analyst. From then on Gershwin had no lack of well-wishers and their advice. As a result, he consulted at least three neurosurgeons or neuropsychiatrists in New York, Florida, and California, making tedious flights that in those presumably unpressurised conditions must have been hazardous for a brain tumour. In the outcome, neither localising nor even lateralising signs were elicited and the inference was that no surgeon, faced with such an illustrious patient, would take the risk of opening up first the wrong temporal lobe.

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Possible treatment for cold sores

SIR,—I have noted the letters on possible treatment for cold sores about using borates and the plea for ice (3 November, p 1150). If there is a helpful pharmaceutical service available Miller¹ describes how active herpes-virus infection could be treated using influenza virus vaccine intradermally as mentioned by Lee in 1961.

I have used the diluted vaccine on cases of mild herpes with healing of eruptions in a couple of days; I have not yet had any cases with severe symptoms to see if his report of symptoms clearing in 30 minutes holds for patients on this side of the Atlantic. But the