hypnotised and trained in autohypnosis to avert an attack. This can be perfected so that it is effective in a fraction of the time for chemotherapy, without any side effects, without any need for "sleeping away" the illness, and without the incapacity.

Hypnosis is more time consuming than writing a prescription, but far less so than most physicians realise; and it has the added merit of permanent remission in appreciable numbers of sufferers.

M BASKER

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¹ Harding, C H, in *Proceedings of the International Congress of Hypnosis and Psychosomatic Medicine, Paris 1956*, ed J Lassner. Berlin, Springer-Verlag, 1967.

² Cedercreutz, C, in *Hypnosis at its Bicentenary. Papers from the Seventh International Congress of Hypnosis and Psychosomatic Medicine*, ed F Frankel and H Zamansky. New York, Plenum, 1978.

³ Perkins, J, *British Journal of Clinical Hypnosis*, 1975, 5, 2.

⁴ Anderson, J A, Basker, M S, and Dalton, R, *International Journal of Clinical and Experimental Hypnosis*, 1975, 5, 2.

Intermittent ophthalmoplegia

SIR,—We note the constructive comments of Dr J F Falconer Smith (13 January, p 124) and we welcome the chance to provide further details of our patient (2 December, p 1534).

In a short report we were indeed unable to give all the data supporting the statement that our patient was clinically euthyroid; before treatment she was examined many times by us, and once by the members of the section of endocrinology of the Royal Society of Medicine.

We had already considered using L-thyroxine and in June 1978 treatment was commenced with 0.2 mg/day; we have observations for six months on this dose. Serum thyroid-stimulating hormone (TSH) became 1.3 mU/l (normal < 1.4 mU/l) and serum thyroxine and T₃ rose slightly, towards the upper limit of our normal range. The patient remained clinically euthyroid, but there was weight loss of 4 kg to 67 kg. While she was taking thyroxine, there were two mild attacks of ophthalmoplegia, in August and October 1978 (when she was on prednisone 10 mg/day), and a severe attack in December 1978 (when she was on prednisone 7.5 mg/day).

Thus, despite treatment with thyroxine, intermittent attacks of ophthalmoplegia continue to occur, and appear to be more severe when the dose of prednisone is reduced. The frequency of attacks appears to have diminished. However, a further period of observation is necessary to be sure of this, and to find the optimum dosage of medicines.

After we wrote the original report, the serum level of TSH antibody was kindly measured by Professor R Hall and Dr B Smith, and the result was normal. Other assays were kindly done by Dr K Mashiter.

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ABC of Ophthalmology

SIR,—Mr P A Gardiner in "ABC of Ophthalmology" is to be congratulated on the very helpful current articles on eye conditions which interest general practitioners. His work is just

what many GPs want, and deserves much praise.

I would like to point out, however, that in his reference to the physiology of accommodation (2 December, p 1555) he has been misleading in saying that "the lens can be squeezed by its controlling muscle. . . . This is known as accommodation." This is the opposite of what happens, as the lens becomes more spherical when the suspensory ligament is relaxed by contraction of the ciliary muscle: no squeezing at all is involved. Mr Gardiner also makes a reference to a connection between refractive errors and colour vision, which is largely misleading.

Your editorial staff is not, in my opinion, to be congratulated on its publishing a contentious letter on myopia (20 January, p 198). Its most unsuitable title is "Myopia or juvenile expansile glaucoma" and it does little to help readers of the *BMJ*. Its author, Mr T S-B Kelly is an experienced consultant in ophthalmology, but his views are expressed as if they are facts, rather than theories, and are supposed to be substantiated by his sweeping statements and curious explanations, which appear to me to be largely fallacious and would be rejected by the great majority of ophthalmologists everywhere. It is strange to suggest that too much accommodation is the cause of myopia, a condition in which there is reduced accommodation; in hypermetropia there is increased accommodation but it seldom progresses into myopia. "Anterior chamber anomalies and other causes not yet found" in relation to nearly 10% of myopes is a reference, clearly, to figments of Mr Kelly's imagination. It is probable that bifocal spectacles (with or without special contact lenses) are as valuable in preventing pathological myopia as bee stings are in arresting so-called retinitis pigmentosa, in spite of Mr Kelly's overbearing enthusiasm for his recommended regimen. Is it not rather pathetic to hear that Mr Kelly admires the implantation of electrodes or transducers into the vitreous cavity to seek confirmation of his theory? (Would he submit his own eyes to such procedures?)

I and my colleagues will continue to serve our myopic patients with orthodox spectacles as in the past without feeling guilty of neglecting their best interests.

K DEAN FOGGITT

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Bleeding massive gastric ulcer on diflunisal (Dolobid)

SIR,—Dolobid is hailed as a major advance in analgesic therapy having, unlike aspirin, no significant effect on gastrointestinal blood loss. A perforated duodenal ulcer was recently reported by Drs R W Talbot and Helen Rees (28 October, p 1229) in a patient on diflunisal (Dolobid) and they ask, "Will it continue to be as trouble-free as predicted?" The following is a case report of a patient with major bleeding from a gastric ulcer while taking diflunisal for only 10 days.

This very active 78-year-old woman had no previous history suggestive of peptic ulceration. She regularly took slow oxprenolol 160 mg and digoxin 0.0625 mg daily and she took sorbitrate occasionally. She was afflicted by herpes zoster in the distribution of left D9. For the severe pain she took diflunisal. After 10 days' treatment with this drug she lost her appetite and vomited. The next day she had melaena. Three days later (during which time she continued to take diflunisal)

she vomited a small amount of blood. She was admitted to hospital, where the haemoglobin was found to be 6.6 g/dl. At gastroscopy the next day a very extensive superficial ulcer was seen extending from the cardia to the angulus on the lesser curve. There were patches of clot in the ulcer indicating recent bleeding. There was a small ulcer 1 cm away. The duodenum was normal. Biopsies of the ulcer margin showed no evidence of malignancy. She was transfused with 4 units of blood and given cimetidine 200 mg three times a day and 400 mg at night. The diflunisal was stopped, and the other drugs were continued. Her gastrointestinal symptoms disappeared and at gastroscopy six weeks later there was only a linear scar along the lesser curve where the ulcer had been. There was no ulceration.

The temporal relationship between administration of diflunisal and the bleeding, the absence of prior gastrointestinal symptoms, and the healing of the ulcer when diflunisal was stopped (albeit she was also given cimetidine) suggests that the diflunisal caused the gastric ulcer and the bleeding.

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Miniature peak-flow meters

SIR,—I was most interested to see Dr B J Freedman's letter (27 January, p 268) about the Pneumometer Minimus. Owing to editorial condensation it was not made quite clear in my paper (9 December, p 1627) that this instrument was a precursor of the Peak-Flow Meter. It uses a fixed orifice and a pressure gauge as originally described by Hadorn.¹ For various reasons, fully discussed by McKerrrow and myself,² we did not regard this as a satisfactory method.

Although the Pneumometer is much the same size as the mini-meter it is nearly four times as heavy and its price is similar to that of the standard model. In addition, the standard meter's correlation coefficient of 0.902, compared with 0.990 for the mini-meter, means that it is only about one-third as precise. The instrument is still available and is, I believe, quite widely used on the Continent but has little sale in this country.

B M WRIGHT

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¹ Hadorn, W, *Schweizer medizinische Wochenschrift*, 1942, 23, 946.

² Wright, B M, and McKerrrow, C B, *British Medical Journal*, 1959, 2, 1041.

Seat-belt legislation

SIR,—In the Parliament section of News and Notes (27 January, p 276) it is noted that the chairman of the BMA Council has written to all members of Parliament telling them of the BMA's policy in regard to seat belts. The 1976 Private Member's Road Traffic (Seat Belts) Bill had the support of the Government and after successful passage through the Commons was defeated in the House of Lords on 26 April 1977 by 55 votes to 53—a majority of 2.

Careful analysis of the Lords' debate, as fully reported in *Hansard*, showed that most of the opponents were prepared to concede that compulsion would save lives and reduce serious injuries; but they argued that (a) some people would be injured as a result of wearing seat belts who would have escaped if they had not been wearing them; (b) it would impose a

lot of extra work on the police; (c) they did not have enough statistical knowledge; and (d) compulsion represented an infringement of individual rights.

Through the London Ambassadors and High Commissioners of the sixteen countries where seat-belt wearing is mandatory an imposing amount of data has been assembled; and at Mr William Rodgers's request has been sent to the appropriate quarter in the Department of Transport.

With regard to (a) I could quote, for example, the Soviet reply: "It has been confirmed that safety belts are effective in reducing the gravity of injuries in accidents at speeds below 90 km/h provided they were used properly—that is, when there was the necessary minimum gap between the belt and the body. If the gap is increased the effectiveness of safety belts is sharply reduced. The belts also prove ineffective in the accidents occurring at speeds higher than 90 km/h. Practically all fatal accidents involving persons using safety belts occurred at speeds of 90-140 km/h. There is no record of cases when safety belts were causing injuries." The other countries agree that seat belt injury is too uncommon to be of statistical significance.

In regard to (b), none of the police forces in these countries find that their work has become more onerous. To quote the Swiss Embassy, "An inquiry among competent cantonal police organisations reveals that the compulsory wearing of seat belts causes no appreciable extra work"; and Sweden says, "As to the police co-operation, the central police authorities have been much in favour of the compulsory legislation." Objection (c) can be countered by the mass of reports now at the Ministry of Transport. France's extensive official survey of its results had to be translated into English—as had the Israeli one.

It was understandable that the Lords should have viewed objection (d)—infringement of individual rights—with some misgiving; for like their legal counterparts they desire to uphold the principle of freedom wherever possible. And none can deny that this is something very valuable. But Dr James Cameron in his letter to Parliament brings to our attention that more than half of all male deaths in the age group 15 to 19 are due to road traffic accidents. This sombre fact must surely make the Lords think again.

We, as GPs and surgeons, are more acutely aware than any others in our community of the deep and lasting distress caused by the tragic deaths of these young people; and it is to be earnestly hoped that Parliament will take our advice.

R S ROSS

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Use of car headlamps

SIR,—Your special correspondent (9 December, p 1619) does not, I feel, stress sufficiently the need for the use of headlamps in conditions of poor visibility. We are told that the use of the "fog code" described in the latest Highway Code could "much reduce accidents," but the point needs to be made that drivers are required by law to use headlamps or fog lamps with rear lamps when driving under conditions of seriously impaired visibility, whether due to fog, snow, rain, or smoke. This has been of particular relevance recently when drivers, in extremely poor

conditions, can be fleetingly seen speeding along motorways in daytime with only sidelights lit. Similarly, drivers in urban areas seem to care little whether or not they can be clearly seen by other road users, including pedestrians.

Although headlamp dazzle worries some drivers, the possible reduction in accidents, particularly those occurring at hazardous road junctions, would surely be considerable if cars were more easily visible. This argument, of course, not only applies to conditions of poor visibility due to fog or snow, but also extends to the routine use of dipped headlamps in urban areas at night. Motorcyclists obviously appreciate the advantages of being clearly seen. Many now regularly use headlamps in all driving conditions and well-known motorcyclists have endorsed this practice.

The police are obviously at a disadvantage in enforcing any law dealing with the compulsory use of headlamps, simply because of the work involved. Publicity explaining the advantages, both to drivers and to pedestrians, of properly aligned headlamps under specific conditions in the daytime and more generally at night could be life saving.

A similar argument could be applied to publicity in favour of wearing seat belts, but if a driver chooses not to wear his seat belt then it is he who is thrown through his windscreen in the event of an accident. If he does not use his headlamps in conditions of poor visibility then other road users, possibly children, may be injured as a consequence of their lack of awareness of his approach.

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Shingles: a belt of roses from Hell

SIR,—The last paragraph of the leading article on shingles (6 January, p 5) has moved me to write this letter because I have never seen real improvement in patients referred to me by neurologists or other physicians for postherpetic pain. I am quite certain, however, that patients starting treatment on the first or second day of the formation of blisters given three to five doses of 50 rads on successive days at the root ganglion or ganglia concerned do not develop postherpetic pain. Moreover, the skin condition may heal more rapidly than usual, although of this I am not certain. The field size to be used and the estimate of the position and depth for the dose to be delivered depend on the anatomy. The doses given are so small, and to such a small volume, that unwanted early or late clinical radiation effects are absent. No radiation is given to the affected skin. The important point is to give the treatment early. In many cases even without treatment of any kind no pain would develop, but to wait to see if there is postherpetic pain is to leave any treatment too late.

The reason for the effect is not established. My working hypothesis (right or wrong) was that there was an acute small round cell inflammatory reaction of the root ganglion and that the radiation caused disintegration of the lymphocytes, setting free gammaglobulins in large concentration at the site of the virus activity. If the inflammatory process is allowed to follow its natural course, scarring in the ganglion provides a permanent pathology which produces the pain.

In some way a failure of immune response seems to be the precipitating cause of shingles,

as shown by its development in patients with grossly disturbed immune mechanisms mentioned in the sixth paragraph of the leading article. I have seen a patient die with purpura fulminans complicating extensive shingles due to cytotoxic drug treatment of Hodgkin's disease. Radiation in large doses to large volumes can be followed after a latent period by shingles not necessarily in the irradiated region.¹ I have always been puzzled by the apparently capricious affection of one rather than another nerve, although the development of more extensive disease when the immune damage is greater suggests that the virus might be widespread even when the shingles is not.

F ELLIS

Oxford

¹ Ellis, F, and Stoll, B A, *British Medical Journal*, 1949, 2, 1323.

SIR,—I enjoyed reading your leading article on herpes zoster (6 January, p 5), and I would like to express the following points of view as an otolaryngologist.

Herpes laryngis may be associated with facial herpes, as was first noticed by McKenzie,¹ and examination of the larynx is recommended in cases of head and neck zoster.² Also, in cases of idiopathic cord palsy, especially if of recent onset, serological tests for herpes zoster may give a clue to the cause. As your article indicated, pain during the attack may be very severe and in this case carbamazepine (Tegretol) may be of help if the pains are along the trigeminal nerve.²

Although your article indicated that zoster affecting the facial nerve appears to have a good prognosis, some authorities believe that the prognosis in cases of herpes zoster is worse than in cases of Bell's palsy³; however, this point is questioned by others.

A L PAHOR

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¹ McKenzie, D, *Journal of Laryngology and Otolaryngology*, 1915, 30, 339.

² Pahor, A L, *Journal of Laryngology and Otolaryngology*, 1979, 93, 93.

³ Dalton, G A, *British Medical Journal*, 1960, 1, 1765.

Effect of once-daily atenolol on ambulatory blood pressure

SIR,—Dr M W Millar Craig and his colleagues (27 January, p 237) provide interesting information on circadian variations of blood pressure in six patients on once-daily dosing of atenolol, obtained using intra-arterial recording. After a paper about untreated hypertensive patients¹ several letters²⁻⁴ drew attention to earlier observations obtained using non-invasive methods of recording blood pressure. These results were notable for their similarity to those reported with the intra-arterial ambulatory method,¹ and suggest that information obtained by non-invasive methods may contribute to understanding circadian variations.

Dr A M J Woolfson and I used non-invasive automatic blood pressure recording equipment and reported measurements of blood pressure over 24-hour periods in patients before and during hypotensive therapy with atenolol.⁵ An effect was seen on nocturnal and early morning blood pressure, suggesting that once-daily atenolol can control nocturnal and early morning blood pressure. Only one of five