histamines, which were significantly associated with motorcycle accidents (although not with road accidents of all types).

Dr Wheatley repeats his previous assertion¹ that general practitioners usually warn patients about possible effects of tranquillisers on driving skills, but he does not cite any evidence to support it. Unfortunately, the type of warning that he describes could not be relied on to prevent accidents, because it is postulated that tranquillisers "produce subtle effects undetected by the patient." In tests of low-speed vehicle handling, Betts and his colleagues² showed that drivers whose performance was affected by tranquillisers did not experience subjective effects.

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¹ Wheatley, D, *British Medical Journal*, 1977, 2, 126.

² Betts, T A, Clayton, A B, and Mackay, G M, *British Medical Journal*, 1972, 4, 580.

Use of car headlamps

SIR,—Dr D F Martin (21 April, p 1086) seems to think that my unwillingness to dazzle other road users (not just car drivers) typifies a selfish attitude, yet I think exactly the reverse is the case (31 March, p 891). As long as such diametrically opposed views can be honestly held and justified there is no hope that laws, regulations, or even codes, will be adhered to.

Just because a car may be seen more easily by having extra lights, and headlamps are extra to sidelamps, this does not unfortunately mean that accidents will be reduced. The other person, blinded by dazzle, may run into a ditch, a pedestrian, or even the first person's car. One cannot expect the other person to take safe avoiding action if one has made him temporarily unable to see to do so. There are snags even when dipped headlights are properly aligned (this is by no means 100%)—they still dazzle coming over the brow of a hill and by reflection from wet or snowy roads.

Apart from these points, which apply to everyone, I listed in my letter some common ophthalmic conditions where patients are more susceptible to dazzle and complain to me about car headlamps. These are things which medical people should consider to a greater degree, and not advocate anything which will only increase the already alarming dazzle.

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Obstetrics in general practice

SIR,—I would like to congratulate Dr W J Reilly on his Personal View (21 April, p 1077). The doctor, who is an old friend of mine, loves to be controversial and he has therefore succeeded in making me put pen to paper. I am not prepared to debate the question of general practitioner obstetricians, but I am prepared to debate the preparation made by the patient, midwife, and doctor for the home confinement in the early 1960s.

Many of our young general practitioners and your consultant obstetricians will have gained a false impression if they regard Dr Reilly as typical of the era. I worked with six first-class district (that is, community) midwives, who

before they would permit a home confinement made sure that everything was to their satisfaction. This included the preparation of the confinement bedroom down to the smallest detail. The bed had to be raised to the required height, the lighting improved, and help made available.

When I or one of my partners received a request for help from the midwife I loaded my car with my portable anaesthetic machine, several spare cylinders, a portable transfusion stand, a transfusion-giving set, artificial plasma, a cutting-down set in case the veins in the arms had collapsed, my obstetric bag containing all my instruments (which had already been sterilised); gowns, gloves, etc, were in a sterile drum. I also included a portable light in my equipment but usually the midwife had arranged this. I asked my second on call, who was a skilled general practitioner anaesthetist, to meet me at the patient's home. In other words, I brought everything that a flying squad would bring except blood. I already had a container labelled in order to take blood for cross matching. I always received excellent support from the ambulance service in transporting the patient and ferrying blood.

Very often the midwife had alerted a colleague and I had the help of two midwives. I agree with Dr Reilly that we did not have a flying squad, but our three consultant obstetricians in Shrewsbury stated that it was impossible for them to give this cover for various reasons. However, they did urgent domiciliary visits as soon as they were available, supported by a member of their midwifery staff.

I appreciate that Dr Reilly was describing personal experiences in home confinements in the early 1960s and these may have been applicable to some of his general practitioner obstetric colleagues, but I hope his readers will understand that there were many of us who were attempting to do something better.

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Yaws or syphilis?

SIR,—In your leading article (7 April, p 912) entitled "Yaws or syphilis?" you state that "The most common mode of presentation is a latent infection brought to light by routine serological tests for syphilis." I wonder whether the word "latent" is the right description of these cases as it suggests that there is still dormant active disease present. These serological tests show that the patient has had a treponemal disease in the past, but they do not suggest activity.

When immigrant West Indians began to attend the clinics in the mid-1950s, many were found to have weakly positive serological tests for syphilis or yaws and were treated as for syphilis. During the next 20 years many of them were retreated and retreated, some for multiple pregnancies and some for attacks of gonorrhoea, receiving up to 60-70 million units of penicillin—despite which their serological test results remained the same. If there had been any activity present which caused the serological changes perhaps it is reasonable to suggest that treatment would have caused some reversal. Also, none of these patients with weakly positive serological reactions, whether treated or not, have ever developed any signs of a relapse of yaws or have produced children infected with yaws or any sign which might indicate active disease.

Perhaps a better description of these cases would be "past yaws" or "past treponemal disease."

However, as your leader writer says, these cases should be treated in case syphilis has been missed. In the treatment of syphilis to ensure the highest possible penicillin blood level, many years ago we raised the dosage of procaine penicillin from 600 000 to 1.2 million units daily for 10 days as this was the largest volume of the drug generally acceptable to the patient for daily injection. The results have been so good that it now seems doubtful to me that serological follow up in treated early syphilis is of value. Certainly such delicate tests as the *Treponema pallidum* immobilisation and haemagglutination tests and the fluorescent treponemal antibody test are more trouble than they are worth in treated early syphilis; their persisting positive results, which mean only that the patient has had a treponemal disease, often mislead the inexperienced physician and cause unnecessary anxiety to the patient.

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SIR,—It was very interesting to read your leading article "Yaws or syphilis?" (7 April, p 912). This dealt mainly with the clinical features. I would like to add that the pathological diagnosis of yaws is equally difficult, having worked myself in pathology. Moreover, other pathological states can be misdiagnosed as yaws, and plasmacytoma is an example.^{1 2} The following case illustrates this.

A 30-year-old Jamaican presented with complaints of left nasal obstruction and swelling of the left cheek. Six months earlier he had had two upper teeth extracted in view of complaints of toothache, and on two occasions the specimens of the swelling were reported histologically as yaws; but serological tests were negative. There was an initial response to penicillin and later to tetracycline, but this tumour continued to grow. It was decided on clinical grounds to start radiotherapy and further pathological opinions suggested a plasmacytoma later. A maxillectomy was performed and the histology was confirmed as that of a plasmacytoma. Thus tumours can be misdiagnosed as yaws.

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¹ Pahor, A L, *Journal of Laryngology and Otology*, 1977, 91, 241.

² Pahor, A L, *Journal of Laryngology and Otology*, 1978, 92, 223.

Male sexual dysfunction during treatment with cimetidine

SIR,—We have read with interest the recent report by Dr N R Peden and his associates (10 March, p 659) on male sexual dysfunction in three patients with duodenal ulcer during treatment with the histamine H_2 receptor antagonist cimetidine. Hormonal imbalance as a possible cause of loss of libido and impotence has been suggested but such a relationship has not been proved. An alternative or additional mechanism for the sexual dysfunction reported after cimetidine therapy may involve an antagonism of the effects of endogenous histamine on the smooth muscle of the penis.

Stimulation of sacral parasympathetic nerve

results in vasodilatation and relaxation of the mammalian penis leading to erection.¹⁻³ However, there is no evidence to suggest that the transmitter responsible for this inhibitory effect is cholinergic in nature. Indeed the identity of the transmitter has so far not been established. We have previously suggested the possibility that the inhibitory transmitter leading to erection may be histamine.⁴ The smooth muscle of the erectile corpus cavernosa of the human penis in vitro is either contracted or relaxed by histamine. The former effect is abolished by mepyramine (a histamine H₁-receptor antagonist), which also potentiates the relaxant effect of histamine on this tissue. The relaxant effect of histamine on the human penis is abolished by burimamide,⁴ which is chemically related to cimetidine and is known to antagonise actions of histamine mediated through H₂ receptors.

Thus cimetidine, by blocking H₂ receptors on the body of the penis, may prevent erection. However, definite proof that histamine is the neurotransmitter at the sacral parasympathetic nerve is lacking.

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¹ Langley, J N, and Anderson, H K, *Journal of Physiology*, 1895, 19, 85.

² Henderson, V E, and Roepke, M H, *American Journal of Physiology*, 1933, 106, 441.

³ Baço, Z M, *Archives of International Physiology*, 1935, 40, 311.

⁴ Adaikan, P G, and Karim, S M M, *European Journal of Pharmacology*, 1977, 45, 261.

A case of compulsory admission

SIR,—Your correspondent JSP (7 April, p 949) may have found the *Man Alive* programme of 27 March entertaining, but if he considers that it was a "responsible piece of journalism" he was not paying attention. He describes it as an excellent programme; it was a slanted, misleading distortion.

Four doctors at the time (two psychiatrists, a consultant physician, and the GP who had been more concerned with the patient recently than any other) agreed that admission was appropriate. Only one, Dr Whitehead, the NHS psychiatrist involved, disagreed; he had not seen the patient for several days, and my attempt to make contact with him at the time was unsuccessful. The social worker saw the patient for a few minutes only and could not be expected to consider the differential diagnosis; the patient's "housekeeper" had been with him for just about three weeks, and "his" solicitor first became involved a fortnight before (the solicitor who had looked after the patient's affairs for 30 years and who, I am informed, is now doing so again was temporarily displaced—perhaps by reason of the patient's disordered mental state at the time).

On admission he was seen by a consultant physician, who noted, "On arrival here he was thin, unfit, and moderately dehydrated. . . . With adequate feeding, nursing care, etc, his condition improved steadily without specific therapy other than for his anaemia, and his weight rose steadily from 8 stones to 8 stones 8 pounds."

He remained on as an informal patient for five months after expiry of the Section 25 order, so presumably even the patient considered his admission was not misplaced. He then left to live with one of the daughters pilloried in the programme. He has been with her for a year. All strange behaviour indeed for one who has been "Put Away," as the programme was emotively entitled.

Dr Whitehead's opinions are not shared by the Royal College of Psychiatrists: "The

College feels that, as far as possible, relatives themselves should be encouraged to take responsibility and continue to be involved in admission and discharge procedures rather than to relegate this entirely to a professional group (social workers)."¹

Why was this propaganda exercise allowed to be presented as a serious documentary programme? One can but speculate on this; surely, however, it is time that measures were taken by the BBC to improve their standards of reporting.

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¹ *Bulletin of the Royal College of Psychiatrists*, April 1979.

New approach to treatment of recent stroke?

SIR,—Dr A K Admani's report (16 December, p 1678) of a double-blind trial of naftidrofuryl (Praxilene) in acute stroke has prompted the manufacturers, Lipha Pharmaceuticals Limited, to produce a brochure extolling the virtues of the drug in stroke patients.

The brochure includes descriptions of two patients admitted to the stroke unit of the Northern General Hospital, Sheffield, presumably under Dr Admani's care, in September 1978. The first was admitted following the sudden onset of loss of consciousness and a left-sided weakness. A distinction between cerebral haemorrhage and infarction was not attempted. The paper itself indicates that strokes due to recent ischaemic cerebral infarction were studied, whereas the manufacturers' literature gives as the definition of stroke used for the purposes of the trial a deficit produced by an ischaemic lesion in the cerebral hemisphere (thromboembolic or haemorrhagic insult). The second case description refers to a patient with a left hemiplegia and a carcinoma of the bronchus. Treatment included dexamethasone. The paper on the trial indicated that only strokes due to vascular causes were included.

Both patients made good recoveries, with the implication that naftidrofuryl had been at least partly responsible. The assumption is unsatisfactory in the first case, where the distinction of haemorrhage from infarction was never attempted, and in the second case, where adequate measures to exclude a cerebral metastasis were not taken.

A criticism of the trial paper has already been published (10 February, p 412). The unwarranted assumption by the manufacturers about the efficacy of the drug in two patients who would not have qualified for the trial in the first place and their description in their literature of "a major development in acute stroke therapy" seem to indicate that they have not understood or considered the merits of that criticism.

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Shortening hospital stay for psychiatric care

SIR,—In his letter (17 March, p 751), Dr Peter F Kennedy has misinterpreted the study we reported earlier (17 February, p 442), in which we carried out a randomised experiment to examine the effect of an across-the-board administrative policy to shorten hospital stay for acute psychiatric patients.

The success of the experimental variable, random assignment to brief care, in reducing length of stay is reflected by the fall in the mean length of stay of 33 days for all admissions during the year before the study (1974) to a length of stay of 22 days for patients randomly assigned to brief care during the year of the study. This was an overall saving of 33%; but from the point of view of number of patients affected the saving is even greater in that the median length of stay fell from 24 days to 9, a reduction of 63%. The difference in length of stay between the brief and standard care patients fell during the experimental year owing to a halo effect. However, the potential administrative saving which can result by arbitrarily deciding that inpatient care should be as short as possible must be judged by comparing the length of stay of the experimental group to that of all patients during the year before the study.

We have data to show that the standard care patients received, if anything, higher doses of medication, and that there was no difference in the amount of social work or outside support given to the two groups. This was possible because brief and standard care patients were treated in the same facility spread between five consultants, so that heterogeneity of approach was more likely.

Unfortunately, the approach which Dr Kennedy mentions, in which all brief-care patients are sent to a separate experimental ward, does not throw light on the effects of brief care as such, for their therapeutic approach was different. This, Dr Kennedy states, "involved staff having to learn new skills and deploy their time quite differently." I will be interested to see if Dr Kennedy is able to identify whether his results are due to one experimental variable or the other.

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Drug-induced neurological disease

SIR,—Dr E M R Critchley in his article on drug-induced neurological disease (31 March, p 862) listed a wide range of drugs capable of causing convulsions. Recently, with the increasing number of inquiries we have received regarding solvent inhalation, it has come to our attention that convulsions may result from the acute intoxicant effects of glue sniffing.

Case 1—While sniffing Evostik glue, a 14-year-old boy became suddenly unconscious and was observed to have a generalised convulsion involving all four limbs. He remained unrousable over the following ten minutes, during which time he had a further convulsion. On arrival at hospital he was drowsy and complained of being unable to see clearly. Apart from widely dilated pupils, examination revealed no abnormality and after 24 hours of observation he was discharged home. The patient had a two-year history of glue sniffing, of which his family were unaware.

Case 2—A 15-year-old boy collapsed after sniffing Evostik glue continuously for four hours. While he was unconscious his companions reported several episodes of violent shaking of his arms and legs. By the time he was admitted to hospital he was fully conscious and very aggressive. Physical examination was normal and he was discharged home the following day. The patient had a two-year history of intermittent glue sniffing and had previously experienced five similar episodes of collapse while inhaling solvents.

Case 3—The patient, a boy of 12 years, was