of his problem and its distressing symptoms.

Failures do occur, as in every other kind of therapy, but any success in this "difficult" group is surely worthwhile, when hypno-therapy does turn out to have been the treatment of choice.

GORDON D K FLINT

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¹ *British Medical Journal*, 1978, 2, 978.

² Waxman, W, *British Medical Journal*, 1978, 2, 571.

³ Hartland, J H, *Medical and Dental Hypnosis and its Clinical Applications*. London, Baillière Tindall, 1977.

Teratomas of the ovary

SIR,—We think there are several important points that were not included in your leading article (21 April, p 1034) on teratomas of the ovary. Although rare, malignant teratomas of the ovary have many features in common with their testicular counterpart. In testicular teratomas the prognosis has improved considerably for three main reasons. Firstly, the majority of malignant teratomas are now known to produce either or both of the tumour markers human chorionic gonadotrophin (HCG) and α -fetoprotein (AFP), which provide the most sensitive monitor of disease progression or regression. Secondly, new highly active cytotoxic drugs have been introduced, which are now used in combination. Thirdly, it has been recognised that bulky tumour deposits (greater than 5 cm diameter) may require surgical removal in order to obtain a complete clinical remission.

In our recent experience at Charing Cross Hospital we have treated eight ovarian teratomas with a cycling regimen of chemotherapy including platinum diamminochloride and etoposide (VP16-213), which is due to be reported shortly. The results were as follows. One patient died from malignant teratoma and one is still on treatment. Of the remaining six patients, five are off treatment (range 5-16 months), and one patient is well with a stable tumour, which has been biopsied on two occasions and both times showed differentiated teratoma. We would regard malignant ovarian teratomas as potentially curable tumours. The value of HCG and AFP in monitoring the treatment was confirmed and only one of the eight patients produced neither of these markers. Whole-body computerised tomography has also introduced a greater sensitivity in confirming complete clinical remissions.

Malignant ovarian tumours are rare and in order to combine the various treatment and diagnostic methods to get the optimum results these patients should be managed in a limited number of centres with a special interest in this tumour.

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Anaesthetic deaths and caesarean section

SIR,—I regret that use of the head-down lateral position as advocated by Dr B H Goodrich (21 April, p 1079) would not have prevented all the acid-aspiration syndromes that I have been asked to treat.

In two cases aspiration occurred during

recovery from anaesthesia and in one case this was undoubtedly preventable. This patient drank water about 1 hour before operation and after a straightforward D and C was returned to the recovery room unconscious lying on her back. The recovery nurses receiving her found the mouth full of clear fluid, which was being aspirated and subsequently induced a life-threatening aspiration syndrome.

I teach that all patients should be turned on their side and be in possession of protective reflexes before extubation. I also use a "therapeutic thump" to the lateral chest wall following extubation to clear any secretions, etc, from the upper airway where patients have had tonsillectomies, for instance.

Assuredly the hasty anaesthetist who extubates a half-paralysed patient while the houseman is still putting skin stitches in will find his enthusiasm tempered in the draughty corridors of the Queen's Bench.

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Treatment of onchocerciasis

SIR,—Your expert answering a query about the treatment of onchocerciasis in your Any Questions? column (31 March, p 877) advised trying metrifonate as an alternative to diethylcarbamazine in an attempt to reduce the severity of the reaction caused by treatment.

The "reaction" is due to the release of antigens from the dead microfilariae, and recent controlled trials in the Onchocerciasis Chemotherapy Research Centre in Tamale, Ghana, have shown no advantage of metrifonate over diethylcarbamazine. Furthermore, the dosage advocated in the answer by your expert is not sufficient to remove microfilariae from the skin: it is only because it is less effective that this dose has slightly fewer side reactions.

The only rational management avoiding the use of suramin is to give an initial intensive course of treatment with diethylcarbamazine to rid the patient of the microfilariae from the skin, followed by weekly doses. The initial course almost invariably causes a reaction, and there is no way in which it can be avoided. It is wise to start with a small dose such as 50 mg on the first day, 100 mg on the second day, 200 mg on the third day, 200 mg twice daily on the fourth day, then the full dose of 200 mg three times a day for three days. This regimen will kill almost all the microfilariae, and preliminary results suggest that an even shorter course may be equally effective. It is best to have the patient in hospital during this period because occasionally the reactions are severe, with fever, postural hypotension, and adenitis. Symptomatic relief can be obtained by using antihistamines, and the very severe reactions will occasionally require corticosteroids. If iritis develops, topical steroid drops should be used as well.

After ridding the patient of the microfilariae, the adult worms will remain alive, and if nothing further is done the skin will eventually be repopulated with microfilariae. In order to keep the microfilarial density in the skin low, without the need to give the potentially toxic drug suramin, diethylcarbamazine is given weekly. This drug is entirely without toxic effects and with such frequent administration the microfilariae never become sufficiently numerous to cause further reactions when the drug is taken. The initial cutaneous reaction to the dead microfilariae often takes

the form of a chronic papular dermatosis, which may take three to four months to subside. The patient should be reassured about this, and the continuation of weekly dosage will ensure that the patient escapes further skin irritation and that the eyes do not become involved. Normally, a weekly dose of 200 mg is quite sufficient; it should be continued for 10 years.

Incidentally, *Simulium*, the vector of onchocerciasis, is a black fly not a mosquito.

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Enuresis and tricyclic antidepressants

SIR,—Recent correspondence (7 April, p 951) on the subject of the use of tricyclic drugs in the treatment of enuresis illuminates one of the difficulties encountered by consultants and researchers when giving the benefit of their experiences to general practitioners—who are, in the main, the ones who have to contend with patients in their natural environment. I mean, of course, the difficulty of visualising the home conditions of the patient. At times the picture presented by some of your correspondents is idealised to the point of naivety.

In our group practice, which covers every type of family and home, the possession of adequate quantities of "easy care" linen and comprehensive laundry facilities is the exception: the family financial priorities put them rather low in the scale. Nor is the ability to produce hot water early in the morning for the necessary bathing all that common. The enuretic child may well share a bed; there may be siblings still at the napkin stage; there are often other enuretics in the family; and both parents may have to leave home early for work. The unfortunate child therefore goes to school with the faint but tell-tale smell around him and has to miss any social activities such as camps and visiting friends which entail spending a night away from home. Little wonder that there is great pressure for "something to be done" and that the practitioner, faced with waiting lists and bureaucracy when trying to arrange for a buzzer, prescribes the tricyclics that do help very many of the children.

The most splendid example of the unreality of our expectations lies in the advocacy of "childproof" containers, which are so difficult to open (except by children) that in most homes they are either left open or their contents decanted into another jar to form a marvellous pot-pourri of poisons.

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Poisoning with tricyclic antidepressants

SIR,—The report by Dr A J Cronin and others (17 March, p 722) rightly emphasises the danger of overdose, but some of its premises are debatable. It may be true that "tricyclic antidepressants are now the commonest cause of fatal poisoning in children under the age of 5 years," but the figures they quote for the UK as a whole show a gross increase in such deaths from 3.2 annually in 1962-71 to 3.4 annually in 1972-6—hardly a significant change. I agree that the buzzer "properly used" is

effective, but not all families are willing to tolerate the consequent nocturnal disruption. I disagree that children under 7 or 8 are indifferent to their wet beds; facts elicited by a more than superficial inquiry suggest otherwise.

To claim, as the authors do, that the use of these "dangerous drugs" for children under 8 "cannot be justified" is not correct. There is practically no danger with proper dosage, and proper dosage can easily be ensured if we prescribe unattractive tablets rather than tasty syrup.

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*.*This correspondence is now closed.—Ed,
BMJ.

Fats and atheroma

SIR,—May I reply to a number of comments which appeared in your correspondence columns following the publication of my contribution to the "Fats and atheroma" debate (17 March, p 732).

Dr D P St George (31 March, p 890) attributes to me the statement that "the decline in death rate from ischaemic heart disease in the USA, paralleled by changes in diet, at last gives us overwhelming evidence for a nutritional aetiology of ischaemic heart disease." I regard this phenomenon as only one of a substantial number of clues and this is made clear in my review. Sir John McMichael (p 890) once again criticises the published trials of primary prevention by dietary means. I pointed out that there were indeed a number of faults associated with each but that an impressive feature was that each pointed in the same beneficial direction. He now describes three further "negative" studies—one is published in a National Dairy Council publication, another in *Doctor*, and the third in a publication which thus far Blackwells have been unable to trace for me. Once these have been published in more accessible places it may be possible to evaluate them critically.

"Primary prevention trials of cholesterol reduction by clofibrate have failed to produce convincing evidence of benefit," claims McMichael. This may well be true if the benefit being sought was "community protection" against ischaemic heart disease. Probably the best conducted clinical trial of primary prevention to date, the WHO-sponsored clofibrate study,¹ provided convincing confirmation of the importance of cholesterol (or some other factor for which cholesterol is a fairly accurate marker in the aetiology of ischaemic heart disease). Cholesterol reduction was closely associated with a reduction in ischaemic events, the most striking changes being apparent in those at greatest risk (because of other risk factors or because of particularly high cholesterol levels). The fact that total mortality was not reduced in the overall analysis comparing clofibrate and control groups may raise questions concerning the precise clinical role of this drug, but with regard to the present debate the correlation between cholesterol reduction and reduction of ischaemic episodes is particularly important. (Final interpretation of the clinical relevance of this drug must await the publication of the analysis concerning benefits and risks in the high-risk group rather than the whole treated population, since it is among them that a beneficial effect is most likely to be seen.)

Sir John McMichael again offers the Blumgart report on induced myxoedema as "priority" evidence against the cholesterol hypothesis because after "many years of the induced hypercholesterolaemia there were no coronary occlusions." Can 1-13 years (in eight individuals) really be seriously regarded as a long period of time in the genesis of atheroma?

Dr H M Sinclair (7 April, p 952) implies that I

am actually recommending *trans* polyunsaturated fatty acids. I merely stated that the evidence suggesting that they were harmful was not strong—and indeed perhaps I might point out again that the dietary advice I offered would provide perhaps only 10% of energy from polyunsaturated fat, and consequently only a very small proportion of *trans* polyunsaturated fatty acids.

I agree entirely with Dr Sinclair, Professor M F Oliver (31 March, p 890), and Sir John McMichael that pursuit of Dr John Vane's approach (17 February, p 484) is a potentially exciting one. Certain fatty acids may well be shown to be precursors of antithrombotic substances. Nevertheless, until further information is available I continue to feel justified in making the recommendations I have offered and feel confident that no major recantation of faith will be necessary in the light of future discoveries.

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¹ Committee of Principal Investigators, *British Heart Journal*, 1978, 40, 1069.

Nutritional intake, adiposity, and diabetes

SIR,—May I be allowed, please, to comment on the letter by Dr D P Burkitt and the Revd H C Trowell (21 April, p 1083). Speaking of Africa in my book *The Saccharine Disease*,¹ I comment on the fatal effect of removing fibre from foods, especially from carbohydrate foods, as in those containing sugar, which I corrected in HMS *King George V* in the last war by bringing in raw unprocessed bran by the sackful straight from the mills, which was very popular with the ship's company—a project that was carefully recorded in the *BMJ*.²

In the same book I try to show that Dr G D Campbell and Dr E L Batchelor showed an almost unparalleled increase in diabetes in large numbers of the 400 000 Natal Indians in South Africa, working in the sugar plantations, who were also given a ration of refined sugar. This incidence of diabetes in these people is, still, I believe about the highest in the world, and obesity is also common in them. Dr Campbell also showed that the increase of coronary disease in the Natal Indians is almost as great as the incidence of diabetes, and indeed coronary disease in diabetes generally is well known to be so high that it is often the commonest cause of death in this disease.

More important than any medical opinion, I submit, is Nature herself, which is what my book seeks to establish, especially in its diet sheet, and I hope that the book will have a prophylactic effect in both diseases.

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¹ Cleave, T L, *The Saccharine Disease*. Bristol, Wright, 1974.

² Cleave, T L, *British Medical Journal*, 1941, 1, 461.

One man's schizophrenic illness

SIR,—I was much impressed by the article "One man's schizophrenic illness" by Peter Wescott (14 April, p 989). In particular, I value the opportunity such an article gives one to hear criticism of doctors by a long-suffering patient. Perhaps the excellent "If I had . . ." series could be followed by a series entitled "When I had . . ." written by real patients (preferably non-doctors) about their

own experiences within the NHS. It is not always comfortable to hear just criticism of oneself and one's fellows, but it is good.

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Another personal view of cardiac arrhythmia

SIR,—I always read with interest the articles that appear from time to time in the *British Medical Journal* under the heading of Personal View. In these articles some of our colleagues tell of their experience with illness in themselves. The article by Dr I W B Grant (14 April, p 1012) prompts me to write of my own experience with cardiac arrhythmia (extrasystoles). It may help to reassure him and his attitude to irregular heart beats.

I am a retired orthopaedic surgeon, now aged 77 years. I know precious little about cardiac disorders, and have never managed to read and understand electrocardiographic recordings. At the end of the war I noticed that after drinking coffee I started having irregular heart beats. I consulted a friend who was a cardiologist at a London hospital and had ECG No 1. I was told that I had an "irritable heart," with extrasystoles. He showed my wife the technique of carotid compression. We did this periodically, but she was afraid of killing me, so we stopped doing it when I had a bad attack of palpitations. However, I took a quinidine tablet, which stopped the extrasystoles. Having been reassured, I no longer worried about them, even if I got them when operating. Some years later, when the attacks occurred more often, I saw my own hospital's cardiologist (ECG No 2). He told me not to worry if I developed an attack when operating. His advice—"Take a quinidine tablet." So it continued, and I did not bother to feel my pulse, as I suffered no inconvenience beyond knowing that I was palpitating; but I declined a cup of coffee after operating.

Shortly after retiring when I was about 70, having had about three days of very irregular pulse, normal rhythm resumed of its own accord. Some days later I suddenly found that my right arm appeared paralysed. Panicking, I considered that I had had a stroke, but after some five minutes or so full mobility of the arm returned. Thinking that I might have had an infarct, I consulted my general practitioner, who had another ECG (No 3) carried out. He confirmed that I had arrhythmia, and sent me to see a third cardiologist, who again took an ECG (No 4), and suggested that I should take lanoxin. When I reported back to my general practitioner for a prescription he gave me the opinion that I should take lanoxin to the end of my days, and suggested that I should "live from day to day."

That was probably six years ago, and in the interval I managed to nurse my paralysed late wife, having to get her up on to her feet whenever she fell, which she did several times a day. I never bothered about my own heart misbeating. Now occasionally, if I remember it, I do take once a day a lanoxin tablet 0.25 mg if palpitations disturb me more than usual. I think that it steadies the rhythm for some hours, then once again I start irregular cardiac beating. I no longer worry about my heart's function. I have had long anaesthetics for a prostatectomy and three retinal welding operations. I do gardening, home decorating, and smoke heavily.

So cheer up, Dr Grant. Don't worry too much over your pulse rhythm misbeating. Maybe you will live 30 years with it irregular as I have done since first my heart started misbeating—the exact pathology of which, as a surgeon, I never remember. Extrasystoles, fibrillation, or other conditions with