in acute and recurrent depressive illness can lead to a rapid return to health and dramatically reduce the need for ECT.

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- ¹ Greenblat, M, Grosser, G H, and Wechsler, H, *American Journal of Psychiatry*, 1964, 120, 935.
² Royal College of Psychiatrists, *British Journal of Psychiatry*, 1977, 131, 261.
³ Bennie, E H, paper presented at First British Lithium Congress, 1977.
⁴ Bastrup, P C, et al, *Lancet*, 1970, 2, 326.

The cancer patient: communication and morale

SIR,—While agreeing with Dr Thurstan B Brewin's thoughtful paper (24-31 December, p 1623) we would like to draw attention to one distortion of communication which can arise when we tell patients they have a malignant disease.

There is an understandable tendency to convey an over-optimistic prognosis. We have found that instilling a false sense of optimism can be as destructive as the earlier tendency to conceal the diagnosis.

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Active immunotherapy in malignant melanoma

SIR,—About a year ago¹ you published the preliminary results of a controlled trial of active immunotherapy in the management of stage IIB malignant melanoma, in which we showed that a postoperative vaccination with a mixture of BCG and autologous irradiated tumour cells resulted in death from metastases in half the patients evaluated at one year. In contrast, recurrence in the non-vaccinated controls appeared later and all the patients followed up for one year were still alive.

The period of observation in this study is now at least two years and the accompanying table shows the updated recurrence and death rates in the two groups of patients. Three of the non-vaccinated patients died during the second year of follow-up, while only one further vaccinated patient died in this period.

Recurrence and death rates in vaccinated and unvaccinated patients with stage IIB malignant melanoma (total numbers in parentheses)

Follow-up period	Recurrences		Deaths	
	Vaccinated patients (8)	Controls (7)	Vaccinated patients (8)	Controls (7)
12 months	4	3	4	0
24 months	6	5	5	3

Thus the difference in death rates between the two groups that was so striking at one year is now less obvious. The two vaccinated patients who remain tumour-free have been followed up for 34 and 36 months and the two non-vaccinated patients who remain tumour-free for 40 and 24 months respectively.

These additional results do not deny our original claim that active immunotherapy given on the 14th postoperative day may

enhance tumour growth in some patients with stage IIB malignant melanoma. However, the observation that two vaccinated patients remain tumour-free 34 and 36 months later indicates that tumour enhancement is not an inevitable consequence of such treatment. The extent to which this is likely to happen may be determined by the tumour load (albeit clinically undetectable) at the time of vaccination, and a sensitive tumour marker, if available, might identify patients in whom active immunotherapy may still be of some benefit.

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¹ McIllmurray, M B, et al, *British Medical Journal*, 1977, 1, 540.

The NHS 5-ml spoon

SIR,—In the letter from Dr S W V Davies (11 February, p 365) attention is again drawn to the inadequacy of the 5-ml NHS issue measuring spoon. This form of measuring device has been the subject of adverse criticism from time to time in the pharmaceutical press. Experience suggests that medicines are prescribed with equal frequency in two 5-ml doses, thus resulting in further error when the 5-ml spoon is used. Perhaps, therefore, consideration might be given to the production of a measure somewhat similar to that suggested by Dr Davies but made to contain 10 ml and graduated at the 5- and 10-ml levels.

Such a measure, of course, would need to be made in transparent material and is, in fact, provided by some manufacturers in the carton containing their proprietary medicine. The cost of this type of measure would be greater than that of the 5-ml spoon currently provided, but in view of an increasingly aging population, who find difficulty in using the latter, a reasonable increase in cost would surely be justifiable.

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Cytomegalovirus infection in a physician

SIR,—Your readers may be interested in the following case.

Early in February 1972 a 38-year-old consultant physician developed a sore throat and pyrexia. Lymphadenopathy developed after 10 days and he felt extremely tired. In the succeeding months he developed severe occipital headaches with meningism, photophobia, generalised muscle pains, and ulceration of the fauces. On 28 April the patient's serum was found to fix complement in the presence of cytomegalovirus (CMV) to a titre of 1/756. CMV was repeatedly grown from the urine and saliva and a significant level of IgM antibody was demonstrated (1/64). All other investigations were negative.

The illness progressed with repeated episodes of fever, usually following even the mildest of exercise, associated variously with fleeting lymphadenopathy, mouth ulcers and oedema of the lips, conjunctival ulcers, severe muscle pains with girdle pain, fleeting rashes, and headache with

occasional meningism. A presumed viral osteomyelitis of the distal phalanx of a finger occurred, diagnosed with the help of thermography. The phalanx fractured without trauma but healed after six months in a plaster splint. Marked malaise was present in the febrile episodes and the impairment of exercise tolerance was so severe that the physician was unable to continue his consultant post. After five years, however, he is relatively well and has other medical employment. The patient's previous medical history seemed to indicate that the common viral illnesses of childhood had been unduly severe, and at the age of 25 he had had a particularly severe attack of glandular fever and was off work for 4½ months, the lymphadenopathy, fever, and malaise lasting for three years.

It must remain extremely unlikely that the CMV infection in this patient was secondary to an underlying reticulosis or other sinister disorder as this would almost certainly have become manifest after five years.¹ There were numerous episodes, however, during the course of the patient's work when he was extensively splashed with fresh blood from neonates with congenital heart lesions, possibly related to CMV infections, and from young adults who were probably shedding virus at the time. It is most likely that the initial infection dated from one of these episodes. Infection with CMV is well recognised in patients who have undergone cardiac surgery² but should also be considered when medical and nursing staff³ looking after such patients fall ill.

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¹ Duval, C P, et al, *Annals of Internal Medicine*, 1966, 64, 531.

² Smith, D R, *British Medical Journal*, 1964, 1, 945.

³ Muller-Stamon, A, et al, *British Medical Journal*, 1974, 3, 609.

Traumatic external rectus palsy in a child

SIR,—Sudden onset of an external rectus palsy in a child raises the suspicion of serious neurological disease—raised intracranial pressure, an infiltrating glioma of the pons, and tuberculous meningitis being possibilities.¹ However, benign external rectus palsy can occur and it is now 10 years since Knox et al² reported 10 children aged 18 months to 15 years in whom benign sixth nerve palsy occurred 7-21 days after a mild upper respiratory tract infection. In nine of the 10 children spontaneous complete recovery took place within 10 weeks. The development of external rectus palsy following an otherwise uncomplicated head injury in childhood appears to be rare. Yarzagaray,³ in a study of 246 children with head injury, reported only 15 with cranial nerve palsies and there is no record that any of these were isolated lesions. Of the 15 children, nine had sixth nerve involvement (six bilateral and three unilateral), four had seventh nerve palsies, and two had third nerve palsies. If the palsy is isolated and the evidence for intracranial trauma minimal there may be a strong indication to undertake complete investigation in order to exclude other serious underlying causes. The following case illustrates the diagnostic difficulty and also emphasises that spontaneous complete recovery after trauma can occur.

A previously healthy, intelligent, 9-year-old

girl collided with a schoolmate while playing and fell, hitting the right temporal region of her head on a piece of concrete. She did not lose consciousness but almost immediately noticed double vision on looking to the right. No other symptoms developed, but the diplopia persisted and she was admitted to hospital. Physical examination revealed no abnormality apart from an isolated right lateral rectus palsy which was confirmed by orthoptic testing using a Hess chart. In particular there was no superficial bruising, tenderness, or evidence of upper respiratory tract infection. Skull x-ray was normal, but in view of the unusual nature of the injury computerised axial tomography of the head was undertaken; this likewise showed no abnormality. She was kept in hospital for four days and after discharge was seen regularly as an outpatient; by 14 weeks after the injury recovery of right lateral rectus function was complete.

The course of events in this child leaves little doubt that the rectus palsy was the result of the trauma, but whether the injury was to nerve or muscle can only be speculative. The anxiety generated for both child and parents not only by the symptoms, which were distressing, but also by the investigations and the concern of the medical attendants was considerable. With hindsight or the knowledge of similar cases much of this might have been prevented.

I am grateful to Professor J K Lloyd for helpful criticism, advice, and permission to report this case.

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¹ *British Medical Journal*, 1968, 2, 190.

² Knox, D L, Clark, D B, and Schuster, F F, *Pediatrics*, 1967, 40, 560.

³ Yarzagaray, L, *Surgical Clinics of North America*, 1973, 53, 59.

Adultproof childproof containers

SIR,—For how much longer have patients to suffer their pills and tablets being dispensed in bottles that are difficult enough to open in a good light and infinitely more so in an artificial light and by the elderly with frail hands? All because, we understand, some parents are careless enough to leave screw-cap bottles within the reach of small children. Accidental poisoning in this way must be a minute fraction of the countless prescriptions dispensed and it is thought that the time has come to take a more balanced view of the matter, reverting to the old screw-on type with a warning from the doctor to parents with small children to act responsibly in the matter.

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Circumoral paraesthesiae and labetalol

SIR,—Tingling of the scalp has been described in three patients related to the use of oral labetalol.^{1,2} One of 22 patients I have treated with this drug has experienced persistent circumoral paraesthesiae reminiscent of that reported by some patients receiving parenteral streptomycin.

A 39-year-old West Indian has been treated with labetalol 600 mg twice daily for moderately severe essential hypertension since May 1977. Within two weeks of beginning the drug he developed a persistent perioral numbness "as if I had had a tooth removed under a local anaesthetic." The numbness gave way to circumoral tingling, which diminished after the dose of labetalol had been reduced to 400 mg twice daily. The

drug was stopped twice because of this symptom and on both occasions the paraesthesiae ceased. The discomfort was still present after eight months of treatment but ceased after sotalol hydrochloride was substituted. Placebo labetalol has not been used. There has been no scalp tingling or formication.³

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¹ Hua, A S P, Thomas, G W, and Kincaid-Smith, P, *Lancet*, 1977, 2, 295.

² Bailey, R R, *Lancet*, 1977, 2, 720.

³ Scowen, E, *Lancet*, 1978, 1, 98.

Fall in admission rate of old people to psychiatric wards

SIR,—The informative paper by Dr K Shulman and Professor Tom Arie (21 January, p 156) draws attention to the diminishing intake to psychogeriatric hospital beds in the face of lack of evidence of decreasing demand. Your correspondents Dr J Todd and Dr I M Pullen (4 February, p 299) relate this to the steady reduction of psychiatric beds in mental hospitals and the increased length of stay (mainly due to decreased mortality) of those admitted to psychogeriatric beds respectively. Dr Shulman and Professor Arie incline to the view that "scandals" in mental hospitals widely publicised in official reports and thence through the mass media have caused a growing reluctance on the part of psychiatrists to admit the demented. No doubt all these opinions are valid and simply indicate that psychogeriatric accommodation as a whole has been upgraded, that it is extremely unwise for any psychiatrist not to go along with the upgrading programme, but that with present financial stringency it has been found impossible, while improving quality of accommodation, to maintain quantity.

The burden of looking after the elderly demented unable to gain admission to a psychogeriatric ward inevitably falls to the lot of those unsuited and ill-equipped to deal with the problem. Thus the Annual Report of the Health Advisory Service for 1976¹ states: "The absence of a satisfactory service for the elderly severely mentally infirm means that general practitioners, physicians, and geriatricians frequently must carry the responsibility for problems which are not theirs." One might add to the list the hard-pressed staff of the social services' residential homes for the elderly. I regularly visit a dozen or so of these homes in my own catchment area and I am constantly appalled at the numbers of ambulant severely demented residents, whose behaviour may encompass anything from using flower pots as latrines to getting into the beds of residents of the opposite sex. In one of the homes residents have recently organised a petition of protest to the Department of Health and Social Security. In another with one of the much-praised but seldom provided elderly mentally infirm (EMI) wings I sympathised with the matron in not being allowed to lock the intervening door from the main block only to be told that it didn't really matter as many residents in the main block showed far more disturbed behaviour than those from the EMI wing.

If one can criticise the psychiatrists over the present state of affairs it would be for their complete failure to press a campaign for a substantial increase of long-stay beds for the

elderly alongside their compliance in the programme of upgrading of accommodation involving reduction of beds. The situation is not helped by the DHSS's adherence to a "norm" (2.5-3 psychogeriatric beds per 1000 population over 65), which is a considerable underestimate of demand and even of the actual existing provision in many areas of the country. It was therefore most refreshing to read² of the report published by the Scottish Division of the Royal College of Psychiatrists "firmly recommending that the NHS should provide... institutional care for elderly demented patients and that local authorities should be freed from this responsibility." No doubt it suits the Treasury admirably if financial responsibility is shifted in the reverse direction, but at what cost to the reputation of old people's homes, the comfort of their sensible residents, and the strain on their attendant staff?

We have just emerged from an era in which the stigma of the workhouse deterred potential residents from entering council homes for the elderly. There now seems a danger that these often excellent establishments will be branded by the general public, including the elderly, as places where only the feeble-minded are sent.

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¹ Department of Health and Social Security, *National Health Service: Annual Report of the Health Advisory Service*, 1976, London, HMSO, 1977.

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

Imbalanced ventricles and cardiac failure

SIR,—With reference to your leading article on cardiac failure (11 February, p 324) a method for causing a temporary shift of blood away from the pulmonary circulation in acute pulmonary oedema is the application of venous tourniquets to all four limbs. I have found this useful in general practice on several occasions. It acts rapidly and gives a "breathing space" for drugs to become effective.

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Serum IgE, lymphomas, and atopy

SIR,—I read with interest the paper by Dr P L Amlot and Mr L A Green on atopy and IgE concentrations in Hodgkin's disease and other lymphomas (11 February, p 327) and would like to make two points.

In the past three years three patients have presented to this department with generalised pruritus, and an underlying diagnosis of Hodgkin's disease was made. In two patients histological examination revealed nodular sclerosis (clinical stage II and IV) and in the third mixed cellularity (stage III). All three patients had had significant weight loss. None was atopic, but they all had markedly elevated serum IgE levels (the patient with stage IV nodular sclerosis having a level of 4675 U/ml). These limited data are thus in accordance with the authors' findings.

The authors state in their introduction that "with one exception, no valid study so far has shown any differences in serum IgE concentrations between people with cancer and those without." This is not true. In mycosis fungoides, a predominantly cutaneous