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

ERNEST H BENNIE

Leverndale Hospital,
Glasgow

- 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.

C H COLLIS
M S LIPSEGE
PETER F M WRIGLEY

Departments of Medical Oncology
and Psychiatry,
St Bartholomew's Hospital,
London EC1

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.

M B McILLMURRAY
W G REEVES
M J S LANGMAN
MALCOLM DEANE

City Hospital,
Nottingham

M J EMBLETON

Cancer Research Campaign Laboratories,
University of Nottingham

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.

W C HODGES

London SW19

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.

J V S PETHER
D H ISAAC
P T PENNY

Public Health Laboratory,
Taunton and Somerset Hospital,
Taunton

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 al*² 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