hospital pharmaceutical departments and general practice pharmacies.

A study by one of us (BCD)¹ showed that a significant number of patients wanted further information regarding their drug treatment. We have decided to provide this by means of a new system of labelling (see figure). We are at present investigating whether this has a significant effect on patient compliance.

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¹ Das, B C, *Modern Geriatrics*, 1977, 7, 22.

Otosclerosis

SIR,—May I comment on your interesting leading article on otosclerosis (14 January, p 63), in which you express the view that “experienced stapedectomists can expect initial success rates of over 95%, and the complication of early sensorineural hearing loss should occur in under 2% of cases”?

In the 1960s the enthusiasm among otologists for stapedectomy was very great. Here was the almost complete answer to otosclerotic deafness. Now, in the 1970s, the optimism of many experienced surgeons is distinctly less and one would wish that the failure rate could be given more prominence. In a letter dated 31 March 1976, in reply to mine, Mr Andrew Morrison, senior consultant otolaryngologist at the London Hospital, wrote: “I think the failure rate from this operation is much higher than is generally realised and I know that I for one am always very careful now before advising surgery.” A skilled and experienced surgeon at another London teaching hospital expressed the view at a conference in July 1975 that perilymph fistula after stapedectomy is a “major problem.”

With reference to another point made in the leading article, that the recurrence of conductive deafness may be dealt with by further surgery and the results should be comparable to those of primary operations, may I again quote from a statement made by the same surgeon at the July 1975 conference? “With a recurrent conductive loss it must be made clear to the patient that there is a greater risk of damaging the residual hearing than was involved in the original procedure.”

General practitioners in the main seem not

to be aware of the shift of opinion since the 1960s. Also, in view of the fact that as late as 1976 an article appeared in a paramedical journal written by a young ENT surgeon in which the success rate was given as “about 98%,” it might be appropriate to lay further emphasis on the considerable risks involved in stapes surgery, the results of which are sometimes quite disastrous.

Now that the ear-level hearing aid is being issued free of charge to patients for whom it is suitable many surely would choose this alternative if, through their family doctor, they were made aware of these risks.

FLORA JACOBS
Retired social worker

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Bromocriptine-induced mania?

SIR,—We were most interested to read the letter from Dr D Vlissides and others (25 February, p 510), and we would like to report a very similar case.

Our patient was 29 years old and two weeks post partum. She too had received bromocriptine twice daily for eight days post partum for suppression of lactation. On the fourth day she started becoming overactive, elated, and aggressive. These symptoms became progressively worse and she was admitted informally to the psychiatric unit on the 14th day post partum. Initially she was treated with haloperidol 20 mg four times daily and she settled quickly. Medication was then reduced slowly over a period of seven days. At the end of this period all her psychotic signs and symptoms had disappeared.

Bromocriptine may have been an aetiological factor in this patient's puerperal mania.

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Typhoid and its serology

SIR,—We read with interest your leading article (18 February, p 389) and fully support your conclusions—namely, that laboratory confirmation of a clinical diagnosis of typhoid depends essentially on bacterial culture.

We wrote to you four years ago (13 April 1974, p 121) querying the validity of the Widal test when used for screening for enteric fever in water board employees. We believe that Brodie's findings provide the sort of evidence needed to remove many of the misconceptions associated with the serology of the enteric fevers and of the carrier state and suggest that legislation regarding routine Widal testing of water board employees should be revised.

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M E COWAN

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Hazard of chemical sympathectomy

SIR,—We were interested to read the report of paraplegia occurring as a complication of chemical lumbar sympathectomy (4 March, p 552). This possible danger has been recognised since the earliest accounts of the technique¹ and is due to some of the neurolytic agent, usually phenol, being deposited in the

subarachnoid space. This may happen if a needle passes through the intervertebral foramen or pierces a dural sleeve which may surround the somatic nerves in the paravertebral spaces.

This complication is entirely preventable. Reid's excellent method² has been improved further by the use of radiological control with a swinging-arm image intensifier which allows visualisation of the exact position of the tips of the needles.^{3,4} A further refinement is to inject radio-opaque material such as meglumine iohalamate 60% (Conray 280) to see the exact spread of the solution.⁵

We have performed over 200 chemical lumbar sympathectomies in the past four years and do not believe that this technique should be performed without radiological control. In the absence of an image intensifier a check anteroposterior and lateral x-ray should be taken before the injection of the neurolytic solution. In this way serious complications will not be produced, and a simple and effective technique will not fall into disrepute.

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¹ Haxton, H A, *British Medical Journal*, 1949, 1, 1026.

² Reid, W, Watt, J K, and Gray, T G, *British Journal of Surgery*, 1970, 57, 45.

³ Rubin, A P, Film—“Chemical lumbar sympathectomy.” ITT in conjunction with the Royal College of Surgeons of England, 1976.

⁴ Hughes-Davies, D I, and Redman, L R, *Anaesthesia*, 1976, 31, 1068.

⁵ Keane, F B V, *British Journal of Surgery*, 1977, 64, 519.

“The Way Forward”

SIR,—I am astonished that the Government's reiteration of its policy to finance improvements in the geriatric services by cutting acute services¹ has not provoked a more vigorous response. Few would deny that there is an urgent need to improve services for the elderly, but the proposed means of achieving this aim reveals a monumental ignorance of what is going on in acute units all over the country.

Last week I was on duty in a small provincial hospital; in a 24-h period there were nine emergency surgical admissions, two of them under 65, four over 80. A spot check showed a total of 67 surgical patients, of whom only 23 were under 65, while 21 were over 80. All in acute beds. I have no doubt that similar figures could be obtained in many places.

Can someone please explain how cuts in the acute services are going to help the elderly?

J A GIRLING

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¹ Department of Health and Social Security, *Priorities in the Health and Social Services, The Way Forward*, London, HMSO, 1977.

New consultant contract

SIR,—I have been a consultant for three years and in that time I have witnessed a decline in my living standards despite annual incremental increases in pay. Private practice does not offer a viable alternative to my whole-time contract and therefore I am totally dependent on an improvement in our contract. I have been particularly dismayed by the quiet and lame manner in which the BMA