with angina pectoris, especially for patients unable to tolerate beta-blockers. Even if the occasional patient does develop side effects such as those described, the fact that these are easily recognised and, in our experience to date, have always been reversible should provide reassurance to those who have doubts about prescribing this drug because of the development of neuropathy.

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¹ Fraser, D M, Campbell, I W, and Miller, H C, *British Medical Journal*, 1977, 2, 675.

Treatment of arthritis associated with psoriasis

SIR,—As a dermatologist, may I comment on several points in your leading article on this subject (4 February, p 262)? It is true that chloroquine can occasionally convert localised psoriasis into a generalised exfoliative state, but a better reason for not using this drug is the hazard of irreversible retinopathy with long-term treatment. Prednisolone, even in the 2.5-5.0 mg daily dose mentioned, can destabilise psoriasis too, so that in my view the indication for this drug needs to be stronger in the psoriatic with polyarthritis.

Regarding the hazard of joint infection after steroid injection through psoriatic skin, it should be recognised that psoriasis, unlike eczema, is rarely secondarily infected. Occasionally psoriatic scale carries pathogenic cocci, but if a bacteriological swab is negative the risk of joint infection should be negligible.

Turning to gold, I agree that documentary proof of its efficacy in psoriatic arthritis is lacking, but it is my own strong impression that the drug is as effective as in rheumatoid arthritis. Certainly psoriatics are not more prone to gold toxicity, dermatological or otherwise.

Lastly, I believe the statements on the toxicity of methotrexate are somewhat misleading. Such statements are meaningless unless they distinguish between mild and severe and acute and long-term toxicity. In fact, in the dosage used generally for severe psoriasis or arthritis (0.2-0.4 mg/kg body weight given once weekly) nausea for 24-48 h following the weekly administration of the drug is much the commonest problem. Bone marrow depression is very uncommon and the cited acute gout, gastrointestinal haemorrhage, and perforation are all very rare. The real problem with long-term treatment is the hazard of the development of hepatic fibrosis and then cirrhosis.

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Choosing an antidepressant

SIR,—We were somewhat surprised to find that your recent leading article on this subject (21 January, p 128) contained no mention of their adverse effects in overdose. Tricyclic antidepressants account for about 20% of overdose admissions to our intensive care unit and about 10% of deaths from drug poisoning.¹ Concerned at this increasing problem, we have been monitoring the effects of the

newer antidepressants reported as overdoses to us. Maprotiline, like the tricyclic antidepressants, causes coma, convulsions, and cardiac arrhythmias.² Our observations on mianserin have now been extended to 44 patients and these confirm our original findings² that mianserin when taken in overdose does not cause the severe complications seen with tricyclic antidepressants. Similarly, follow-up of 28 cases of flupenthixol poisoning has failed to show any serious toxicity. The number of reported cases with the other new antidepressants has been too small for any definite conclusions to be drawn.

The incidence of self-poisoning in depressed patients cannot be ignored. In those with suicidal thoughts or with a history of a previous suicidal attempt it would seem more prudent to prescribe an antidepressant with lower toxicity than one of the well-tried antidepressants you recommend.

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¹ Office of Population Censuses and Surveys, *Mortality Statistics*. London, HMSO, 1977.

² Crome, P, and Newman, B, *British Medical Journal*, 1977, 2, 260.

Predictive tests in Huntington's chorea

SIR,—I am sure that many practitioners as well as myself are interested in and grateful for your updating of this important subject in your leading article (4 March, p 528). As you conclude, "There remains the difficult problem of the ethics of such testing. When a definitive test is eventually introduced—as will surely happen—its application will cause controversy."

Some of the main difficulties were described in a contribution "Huntington's chorea and pregnancy" you kindly published about a decade ago,¹ when I commented on the suggestion that Huntington's families "would have done all they could to avoid having children... had they been aware of the hereditary nature of the illness." Perhaps a quotation from that communication might be salutary and pertinent, particularly as very recently I had a case in which the particular strain of Huntington's chorea made itself evident later than usual—that is, at 44 years rather than some 34 years—further emphasising the appalling time factors in this "potential time-bomb" disease."

"The main problems here are those of prediction at as early a stage as possible, and then consideration of what recommendations can or should be made in the individual case before the damage may be done.... Considering the possible mental anguish and the exceptionally high incidence of suicide in Huntington's families, the dilemma is whether it is humane and ethical to direct a young person's thoughts to the, at best (or worst), fifty-fifty chance that he or she might deteriorate into the condition witnessed in a relative, and should govern life accordingly. Thus an individual who might never have consciously or otherwise contemplated the possibility of personal involvement might have life and hope blighted, and survival without development of the disease might be little compensation for a lifetime of anxiety, dread, and single status."

"The essential differences from the more usual decision, whether or not to tell a patient of his malignancy, are the inevitability and limited

duration in those cases, compared with the fifty-fifty uncertainty and possibly several decades of waiting involved in Huntington's chorea, with both the individual and his potential progeny possibly being involved. I wonder how others manage these problems. Who is actually to tell the individual (possibly a genetic counselling clinic), and, apart from the sympathetic factual approach, does one attempt to gradually orientate the patient and hope for more peaceful acceptance, including the possibility of sterilisation, or could guidance be effectively given discreetly through other relatives or through friends? I have used various of these methods, each case being considered and tackled individually, but I feel that there must be very careful thought for the actual present as well as for future possible generations."

Rightly do you suggest that "the time has come when we should debate possible guidelines for handling the results before the [predictive] test is introduced."

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¹ Segal, M, *British Medical Journal*, 1968, 2, 48.

Vitamin E in treatment of Huntington's chorea

SIR,—Mrs Margery Hall's comment (18 February, p 446) on our report (21 January, p 153) of a trial of vitamin E in Huntington's chorea calls for a reply.

We were not attempting a comparison of a dietary alteration but merely the comparison of large doses (80 times the recommended daily intake) of tocopheryl acetate with placebo on the symptoms of the disease. Hoffer's observation¹ was of a single, open, uncontrolled case; our trial was an attempt to investigate the claim that large doses of vitamin E have an effect and this we did by a recognised controlled, double-blind, cross-over technique which, whatever its shortcomings, is of potentially more scientific value than a clinical impression gained on one patient.

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¹ Hoffer, A, *Journal of Orthomolecular Psychiatry*, 1976, 5, 169.

Blood pressure and kilopascals

SIR,—We were disturbed to read the article by Dr John Price (4 March, p 554) supporting the measurement of blood pressure in kilopascals.

We have had several examples of confusion in clinical practice since the International System of Units was introduced into clinical chemistry here, despite comprehensive instruction of staff and issue of nomograms and conversion tables. However, it is an accepted fact that the change has taken place and it would probably cause more confusion to change back than to continue as at present.

There is a certain logic in the use of the mole, but we fail to see any logic in the practical use of the kilopascal. This is a theoretical physical concept and as such may be useful to physicists, but in clinical practice we measure blood pressure by the height of a column of mercury which is measured in