Hazards of diconal

SIR,—I and the other consultants in charge of the London drug dependence treatment clinics are concerned about the frequent prescription of diconal (Calmic) (dipipanone hydrochloride, 10 mg; cyclizine hydrochloride, 30 mg) to addicts. This drug is prescribed frequently by general practitioners and others to opiate addicts, sometimes knowingly and sometimes unwittingly. The dipipanone hydrochloride which is contained in diconal is a substance controlled as a class A drug by the Misuse of Drugs Act 1971 and is subject to the full restriction of the Drugs Regulations 1973. It is also a part 1 poison included in the first Schedule of Poisons. In any case such prescribing should lead to notification of the addict to the chief medical officer at the Home Office (Drugs Branch, Queen Anne's Gate, London SW1; tel 01-213 3403).

Unfortunately many patients do not take diconal by mouth but rather inject a number of crushed tablets intravenously. There have been cases of death and there have been some acute reactions reported which have not led to death in people who injected crushed tablets. Apart from damage to the vascular bed of the lung which may result from these crushed tablets and other more general effects, the local effects can be severe. There may be thrombosis and inflammation of the veins used, with a subsequent sclerosis and local sepsis. As the compound leaks from the veins into surrounding tissues it in some cases appears to interfere with lymphatic drainage and leads to lymphoedema. It is therefore felt that these facts should be brought to the attention of all prescribing doctors and that they should exercise due caution.

It has been pointed out in the *British National Formulary* that a prescribing doctor has a responsibility to see that he is not being used as an unwitting source of supply for addicts, who may be skilled, plausible, and persistent in attaining their ends. They may visit more than one doctor, fabricating stories to substantiate demands. A doctor should be wary of prescribing for strangers, particularly young patients under temporary care, unless unequivocal information has been obtained from their own doctor.

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Whooping cough

SIR,—The leading article (22 April, p 1007) represents somewhat of a challenge to any general practitioner in the firing line of primary care, being a supreme example of an article written from an academic rather than a practical point of view and as such misses the target by a wide margin as far as the complete, broad readership which I hope was intended.

Perhaps you could comment on the following:

How does he reconcile "The clinical features of established whooping cough are distinctive" with, same paragraph, "Without a history of exposure early diagnosis is impossible"? Hodgkin¹ could only make a firm diagnosis in half the suspected cases. I remember being taught by a wise paediatrician in Newcastle, "All that whoops is not whooping cough."—certainly sixteen years in general practice has shown me nothing to change

that view. The fact remains that it is an extraordinarily difficult, almost impossible, infection to diagnose confidently.

It may be of interest to know that there are blood and other changes, but of what real practical use is this to we family doctors? Some useful advice to us as to whether we should or should not be carrying out procedures like femoral punctures would have been most helpful.

I really am at a loss as to the implications of the paragraph dealing with antibiotics and their use, particularly prophylactically. "May be beneficial" is not good enough. Surely we are entitled to expect less fence-sitting; do we or do we not use antibiotics? If it is important enough to mention them and the use of them for contact siblings, we cannot be left without an answer to this question. The implications of actually doing something positive, such as treating all siblings prophylactically, are immense for doctor, parent, and siblings alike.

At what clinical point are general practitioners supposed to be thinking in terms of admission to hospital for those that we think are suffering from pertussis? There is absolutely no guidance along these lines.

Have you ever tried promethazine hydrochloride (Phenergan syrup) or related drugs for the socially and physically wearing night cough? In an age-and-weight-related dose, it is my experience that it does seem to help in some cases.

When do we general practitioners decide to keep a child away from school or other group activities? It is certainly my own impression that we tend in practice to be influenced more by the severity of the constitutional illness in the child rather than the cough, whooping or not.

How many humidity tents are there in general practice? Perhaps each group practice should have one; certainly I advise the use of steam in suspected whooping cough, and the other respiratory viral infections.

From questions to some observations. During the past few months there has been quite an extraordinary number, almost of epidemic proportions, of children of school age with what appears to have been a respiratory viral infection. Little if anything that has been prescribed appears to have influenced the duration of the illness; some have been helped by relief of night cough and "simple" advice, such as making sure the air temperature in the child's bedroom does not fall below 16-18°C. Concurrently with this epidemic there have also been some undoubted cases of pertussis. However, the children in the first illness appear to be clinically very different from those suffering from pertussis; the latter invariably appeared to be constitutionally ill and the pertussis group includes a much younger child, from six months onwards. We have certainly learned in these last few months not to take the parental diagnosis of hearing the whoop as anything but as dubious evidence and have persuaded some parents to tape record the so-called whoop—this has proved of considerable help, both to doctor and patient. Incidentally, the figures related to notifiable diseases are notoriously suspect in terms of actual numbers: what they probably do reflect are trends, and undoubtedly there has been an increase in general practice in the number of cases of pertussis during the past few months.

I have read with interest the comments, both editorial and correspondence, about signing leading articles. This leader on whooping cough needs no signature. It was written by a hospital doctor, for hospital doctors, but it could have been of help to general practitioners if the author had given any thought at all about the role of the general practitioner in the management of the vast majority of both upper and lower respiratory tract infections.

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¹ Hodgkin, K, *Towards Early Diagnosis*, 3rd edn, p 38. Edinburgh, Livingstone, 1973.

Management of self-poisoning

SIR,—The paper by Dr D R Blake and Professor J R A Mitchell (22 April, p 1032) on the management of self-poisoning is valuable in showing that many of these patients do not require inpatient care. This observation is particularly timely in view of the growing anxiety over the length of waiting lists for admission to hospital.

Accident and emergency departments, with the provision of short-stay beds under the supervision of a full-time consultant, can manage a patient who has taken a minor overdose as adequately as a general physician with inpatient beds. Provided one can be sure that the substance and the dosage taken have not and will not produce any serious physiological disturbance, then the patient should be managed in one of three ways. The accident and emergency physician may refer the patient to his general practitioner or to a psychiatric outpatient clinic, or, if the situation requires it, the patient can be admitted to an accident and emergency short-stay bed for an acute psychiatric consultation. The paper from Nottingham indicates that this policy is being followed already for some patients. If this system of management could be adopted officially throughout the country there would be a saving of thousands of bed days without any harm to the patients concerned.

Another progressive step which is highlighted by this paper is the value of having a consultant physician appointed to the staff of the emergency department. Over recent years there has been a considerable increase in the medical content of emergency work. In the large urban emergency departments a consultant physician who can specialise in the care of overdose patients and instruct the department's staff in their management will fulfil a valuable role for the community and the hospital. The Nottingham department is to be congratulated for having already made such an appointment.

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SIR,—I would agree with Dr D R Blake and Professor J R A Mitchell (22 April, p 1032) that the recommendations of the Hill Committee should be critically re-examined. Present work is showing that psychiatrists are not the only discipline capable of evaluating these patients. A study we have carried out at Charing Cross Hospital (unpublished) has shown that social workers are equally effective as duty psychiatrists in making initial assessment of overdose patients. The importance of initial evaluation must not be overlooked, but other disciplines may do it—for example, physicians, social workers, community nurses. They do, however, need some special training, and this is an important role for psychiatrists. The actual discipline of the interviewer is not the important factor.

It is necessary to consider the reasons for this first interview. The main ones are prevention of repetition and suicide, detection of serious mental illness, and a response to the cry for help. The therapeutic value of this interview is often ignored. It may supply the help the patient needs at a time of crisis when defences for talking are lowered. Follow-up may not be needed; this does not mean the patient has not received valuable psychological help.