of vomiting does not distress the child as much as it does the mother, but its beneficial effect can be demonstrated to her by pointing out the sticky mucus it has produced.

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Beta-blockers and plasma triglycerides

SIR,—In a recent article by Dr A Helgeland and others (1 April, p 828) and in a letter from Mr J Shaw and others (15 April, p 986) attention is drawn to increased levels of serum triglycerides and serum uric acid caused by treatment with various beta-blocking drugs. The serum cholesterol values remained unaffected. The authors are concerned about the possible adverse effects from these elevated triglyceride levels during long-term treatment in hypertensive patients.

Caution is evidently necessary when treating patients with drugs for many years as in hypertension, especially in moderately severe hypertension in which the overall risk of hypertensive complications is not overwhelmingly high. Virtually all commonly used antihypertensive drugs cause subjective or objective side effects—diuretics causing increased serum uric acid and decreased serum potassium concentrations, methyl dopa mental changes and haemolytic anaemia, and beta-blockers bradycardia, cardiac decompensation, and elevated serum triglyceride concentrations, to mention but a few examples. Some consequences might be detectable only during long-term follow-up. Major end-points such as stroke, fatal or non-fatal myocardial infarction, cancer, and above all total mortality are of special importance.

Studies carried out so far have concerned only relatively short-term follow-up in relatively severe hypertension, but the balance has been in strong favour of antihypertensive therapy.^{1,2} The present concern seems to be due to the fear of high triglyceride levels being associated with an increased risk for coronary heart disease (CHD). There is no strong evidence for such a fear. In well-analysed prospective population studies high serum triglyceride levels have been associated with increased risk only in univariate analysis.³ In multivariate analysis including blood pressure, smoking, and serum cholesterol concentration the addition of triglycerides has not improved prediction at all.³ In one study⁴ triglycerides were considered of importance for predicting risk, but a proper multivariate analysis was never performed in that series. Nor have high serum triglyceride levels been found to be associated with an increased risk in patients who have suffered a myocardial infarction.⁵

In a recent study,⁶ though it was not double-blind with placebo versus active drug, we found a significantly lower total mortality and significantly lower rate of non-fatal plus fatal CHD during 4.3 years' follow-up in treated hypertensives as compared with non-treated men with somewhat lower blood pressures but comparable other risk factors. Seventy-eight per cent were treated with beta-blocking drugs. Thus the results of this study did not indicate any adverse effects of beta-blocking drugs on CHD—rather the opposite. These results might indicate some cardio-protective effect of the beta-blockers in hypertensive patients similar to those found in patients sustaining a myocardial infarction.⁷ The possible mechanisms behind this effect have been discussed recently.⁸

The most common complication during follow-up in most hypertensive patients will be CHD, whereas only a minor proportion will suffer strokes. Thus it is important not only to try to lower blood pressure but also to watch carefully any differences between antihypertensive drugs with respect to particular beneficial effects on CHD and total death rate. Two long-term multicentre trials aimed at disclosing whether such differences may exist between commonly used antihypertensive drugs are in progress. Our group started one such study in 1976 in which diuretic saluretics (and combinations) are compared with beta-blocking drugs (and combinations) in several thousand hypertensives with diastolic blood pressures of 100-130 mm Hg.

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¹ Veterans Administration Cooperative Study Group on Antihypertensive Agents, *Journal of the American Medical Association*, 1967, **202**, 1028.

² Veterans Administration Cooperative Study Group on Antihypertensive Agents, *Journal of the American Medical Association*, 1970, **213**, 1143.

³ Wilhelmsen, L., Wedel, H., and Tibblin, G., *Circulation*, 1973, **48**, 950.

⁴ Carlson, L. A., and Böttiger, L.-E., *Lancet*, 1972, **1**, 865.

⁵ Coronary Drug Project Research Group, *Journal of Chronic Diseases*, 1974, **27**, 267.

⁶ Berglund, G., et al., *Lancet*, 1978, **1**, 1.

⁷ Wilhelmsen, C., et al., *Lancet*, 1974, **2**, 1157.

⁸ Wilhelmsen, L., Vedin, A., and Wilhelmsen, C., *Cardiovascular Medicine*. In press.

Chronic bronchitis and emphysema

SIR,—I am a little disappointed that an author as competent as Dr Anne E Tattersfield (29 April, p 1123) does not know of a more effective mucolytic agent against tenacious sputum than steam inhalation or a hot drink. I have used potassium iodide 8%, which was recommended by Strümpell 100 years ago, in many hundreds of patients successfully (two tablespoons twice daily for four successive days, followed by a three-day interval). True, its taste is beastly, but tolerable in milk, orange juice, or beer and washed down with it. The effect lasts for 24-48 h after the last dose, so that the three-day interval permits one to judge the positive effect. If there is none the dose must be doubled or trebled. As some of the iodide is excreted in the saliva its taste may affect the appetite and, rarely, after long periods of medication, it may cause myxoedema.¹

And why has ephedrine been omitted as a remedy for breathlessness on exertion? It acts much longer than the new beta-agonists salbutamol and terbutaline, up to 8 h. If taken 1 h before rising in the morning and in the early afternoon no tolerance develops. The first dose to try is 30 mg, but this should be increased up to 60 mg if no palpitations or excitement occurs.

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¹ Bernecker, C., *Acta Allergologica*, 1969, **24**, 216.

Schumann's hand injury

SIR,—The operation which Mr J C Ballantyne mentions (29 April, p 1142) was described by Batty-Smith,¹ who had the procedure carried out twice on his own hand in order

to improve performance. Commenting on this work, a well-known surgeon wrote, "I personally regard this as an operation every hand surgeon does once and then regrets for ever after." Designed to improve ring-finger extension, the procedure would not have helped Schumann, whose second and third fingers were affected. Curiously enough, there is a completely unsubstantiated story that the composer carried out this operation on himself, an unlikely tale which Professor Ulrich and I (8 April, p 900) decided not to publicise.

The idea that Schumann's hand problem derived from his own technique shortcomings demands consideration, but we would find it hard to make a retrospective diagnosis of psychogenic finger paralysis to account for the medical findings in 1841-2. Recognition of psychogenic paralysis is difficult and dangerous enough in contemporary practice.

I am grateful to Professor Adrian Flatt, University of Iowa Medical School, who drew the reference to my attention.

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¹ Batty-Smith, C. G., *British Journal of Surgery*, 1942, **29**, 397.

Help for parents of the handicapped

SIR,—I am a member of a Wandsworth self-help group for families with handicapped children, "Make Children Happy." The letter from Professor R W Beard and others on "Help for parents after stillbirth" (21 January, p 172) has led me to the conclusion that there are many similarities in the needs of parents of the stillborn and of parents of handicapped children.

Parents in our group are very much in favour of having written information concerning their child's condition. The need for this stems from the difficulties of the situation in which the initial diagnosis is made known to the parents. In the period leading up to this point parents have very often built up a very strong suspicion that all is not well, a suspicion which may be based on their own observation of the child and of the unusual amount of attention given to it by medical and nursing staff. This feeling may develop into a state of anxiety heightened by frustrated attempts at obtaining information. When an explanation is actually given the resulting state of shock prevents comprehension. Parents may leave the consultation remembering very little, and if both parents were present they may later describe different versions of what the doctor said. Perhaps this is sometimes why parents claim that they have been misinformed. To have something in writing would allow time for consideration in a more relaxed frame of mind and discussion as to what further information was needed. Fathers, who are not always able to meet the doctor, would be put more fully into the picture.

Many of the questions in the proposed stillbirth leaflet relate very closely to those raised by parents of the handicapped. Others could be added: Is there any treatment? How long will he live? What will happen when he is older? To what services can I turn for help? These generalised questions require particular answers which could not be given in leaflet form.