1 in 10 (or greater) chance of diagnosing a brain tumour is not to be missed, then referral of all stroke patients with the appropriate evolution would completely swamp the available CAT scanning resources. Stroke evolution is only one factor determining the attitude of a general physician towards the management of a stroke patient.

Considering the scarcity and the costliness of the new diagnostic machinery, information is required concerning the incidence of tumour or subdural haematoma in stroke patients as they present on the general medical ward.

G D SUMMERS

Bury General Hospital,
Bury, Lancs

¹ Weisburg, L A, and Nice, C N, *American Journal of Medicine*, 1977, **63**, 517.

² Carter, A B, *Quarterly Journal of Medicine*, 1960, **29**, 611.

³ Bull, J D, Marshall, J, and Shaw, D A, *Lancet*, 1960, **1**, 562.

⁴ Symonds, C P, *Quarterly Journal of Medicine*, 1924, **18**, 93.

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Chlormethiazole addiction: unusual presentation

SIR,—The existence of chlormethiazole addiction has long been recognised,¹ although detailed recordings are rare.² We would like to report such a case with an unusual presentation which recently came to our attention.

A 58-year-old Englishman presented himself at the casualty department of the hospital where two of us (D I B-T and P K) work. He complained of seeing red ants and spiders crawling around him and said that he had recently had a number of convulsions. All his symptoms had apparently begun after he had stopped drinking two days before. He said he had regularly consumed two bottles of whisky a day for the past seven years following the death of his wife and described several other symptoms suggestive of alcohol addiction.

He was a crew's cook with a passenger shipping line and stated that he had come ashore eight days before presentation but had stopped drinking two days previously because he had weakness in his right foot. He gave a past psychiatric history of an overdose of drugs after the death of his wife and of being treated for his alcohol addiction by the ship's doctor shortly before coming ashore this time. He made a point of saying that all sorts of drugs were used but that only the "yellow pigeon's eggs" were of benefit. In his past medical history he said he had had a number of abdominal operations in the 1940s for shrapnel wounds and a thoracotomy for empyema in 1950.

On examination he was a tall, thin man with thick white hair and a moustache. There were multiple scars on the abdomen that were suggestive of elective surgery rather than trauma and scars on the arms and legs at cut-down sites. He had a weakness of dorsiflexion of the right foot. In his mental state he was fully orientated in time and space but appeared alarmed at his hallucinations. Despite some doubt as to the genuineness of his symptoms he was admitted and started on a regimen of chlormethiazole and parentroviolate. The next day he became angry when he overheard a staff member say that his chlormethiazole dosage should be reduced and a couple of hours later he discharged himself from hospital when an increase in medication was refused.

He was next seen by one of us (J C) two days later at another, unconnected, hospital some miles away. He presented similarly at their casualty department a few hours after discharging himself from the first hospital. He complained of identical symptoms and gave the same history but made

no mention of treatment at the previous hospital. He was once again treated with chlormethiazole and parentroviolate plus diazepam. When he was recognised (because of a chance discussion between two of us) as being the patient described above he was questioned about this but claimed amnesia for the previous few days. He discharged himself soon after this confrontation. Attempts to confirm his social history were unsuccessful, for he always gave false addresses and his putative employers denied knowledge of him, though they said another London hospital had recently inquired about him.

The presentation and clinical picture of this man's symptoms made a diagnosis of delirium tremens unlikely and any uncertainty was resolved when, after requests for information to a large number of London hospitals, it was revealed that in the weeks before the admissions described above he had been admitted twice elsewhere with an identical story and had received identical treatment. He took his own discharge from these hospitals too. It must be concluded, then, from these four descriptions that he presented himself to the hospitals in order to obtain chlormethiazole, though his fluency implied that he had at one time been an alcoholic and treated legitimately with the drug. It would seem to us that this case underlines the dangers that have recently been reported³ of the long-term use of chlormethiazole in alcoholics.

J M CUSHNIE

Epsom District Hospital,
Epsom, Surrey

D I BEN-TOVIM
PETER KOPELMAN

St George's Hospital,
London SW17

¹ Glatt, M M, George, H R, and Frisch, E P, *British Medical Journal*, 1965, **2**, 201.

² Reilly, T N, *British Journal of Psychiatry*, 1976, **128**, 375.

³ Horder, J M, *British Medical Journal*, 1978, **1**, 693.

Immunisation and eczema

SIR,—We are concerned about the immunisation status of children with atopic eczema.

While reviewing the vaccination history of such children we noted that more than half of those admitted to this hospital with eczema did not have their full vaccination or their boosters because of their skin condition. We feel that children with eczema should be immunised in the same way as other children: only smallpox vaccination is contraindicated. The vaccinations are best done when the skin disease is not active. Although allergy was thought to be a contraindication for whooping-cough immunisation in the past, this is no longer considered to be so.

Some children with eczema give a specific history of allergy to egg protein and these children should not be given the following vaccinations: measles, influenza (live or killed vaccines), and yellow fever. Rabies human diploid cell vaccine is not contraindicated.

S LINGAM
R S WELLS

Hospital for Sick Children,
London WC1

Back pain

SIR,—I would like to supplement Mr A H G Murley's letter (8 July, p 125) on positive advice and common sense in back pain. Why

not attempt to displace the dreadfully misleading popular phrase "slipped disc"? I suggest "spinal compression disorder." The key word is compression. It is easily accepted and understood by the public, particularly if demonstrated on a simple model or diagram of the spine. Once understood it is an aid to both cure and prevention.

Formerly people were told "not to bend" and "to lift and carry properly and with care." May I suggest that one should preferably say "don't lift and carry at all, but you may bend as much as your spine will allow"? Explaining the avoidance of spinal compression is easy and logical. Sustained carrying is the most to be avoided and, depending on the severity of the disorder, weight-bearing advice can be precisely advised such as "not more than 30 lb for the next six months." The message is that so long as you don't concertina or compress your spine you will get better slowly. Toe-touching, back-bending exercises done in a standing position, gently and patiently, are beneficial.

Surely compression is the logical cause of most back pain. Simple avoidance therefore allows natural recovery. Having used this explanation over the past few years, I find my patients understand it and adapt and apply it to daily living and I believe they recover in better morale and relapse less frequently.

J K WATERLOW

Hinckley, Leics

Organ transplantation and the fetal allograft

SIR,—The monograph¹ cited by Drs Ronald Finn and C A St Hill (24 June, p 1671) as an example of development of the concept of the fetus as an allograft takes this idea farther. It collates evidence supporting a form of adaptive immunity, the immunological inertia of viviparity, as the specific phenomenon involved in the paradoxical coexistence of mother and fetus and in the survival of mutual skin grafts.² The studies of the two-way mixed leucocyte reaction by Drs Finn and St Hill have helped to elucidate one important facet of this multifactorial phenomenon, and they wisely emphasise other putative factors such as humoral immunosuppressants and suppressor lymphocytes of the fetus.³ The concentration of one circulating macro-globulin, pregnancy-associated α_2 -glycoprotein, of apparent relevance in cancers of the breast⁴ rises tenfold during pregnancy⁵ and appears to possess immunosuppressive properties justifying its inclusion in a list of candidate suppressants.

Raised pregnancy-associated α_2 -glycoprotein concentration, depressed two-way mixed leucocyte reaction, and fetal suppressor T lymphocytes have been observed during well-established pregnancy and are probably inappropriate to earlier events when the fetus first challenges the maternal lymphoreticular system and is itself unlikely to have developed a system capable of responding to challenge by maternal histoincompatibility. Earlier immunoprotection, of spermatozoa at the time of fertilisation, of the blastocyst at implantation, and of the young embryo, requires elucidation of the functions of locally concentrated hormones, of possible protective substances upon the surfaces of cells, and of any traffic in transplantation antigens between mother and embryo. Once

the embryonic circulatory system has developed interchange of transplantation antigens is possible; before this some traffic of trophoblastic cells or of subcellular material from the fetal complex to the mother may occur, while the passage of immunopotent substances into the embryo from the maternal circulation is also a possibility. Antigen thus transferred could be not only non-sensitising in form and amount but also capable of defunctioning rejection mechanisms in ways previously reviewed¹ and artificially explored.⁶

Whichever of these hypothetical mechanisms may be shared with the cancer-host and the surgical transplant-recipient systems, it seems clear that the immunological equilibrium existing throughout pregnancy is a dynamic multifactorial system with a steady interchange of immune information and a concomitant ever-changing series of reactions. Knowledge of the kinetics of humoral and cellular responses to the two-way traffic in transplantation antigens is the central need of further understanding.

JOHN MAXWELL ANDERSON

Royal Infirmary,
Glasgow

¹ Anderson, J. M., *Nature's Transplant*. London, Butterworths, 1972.

² Anderson, J. M., *Proceedings of the Royal Society B*, 1970, **176**, 115.

³ Oldstone, M. B. A., et al., *Nature*, 1977, **269**, 333.

⁴ Anderson, J. M., Stimson, W. H., and Kelly, F., *British Journal of Surgery*, 1976, **63**, 819.

⁵ Stimson, W. H., *Journal of Reproduction and Fertility*, 1975, **43**, 579.

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Confusion about New Zealand abortion

SIR,—Professor H. C. McLaren (24 June, p. 1697) criticises Dr Richard Smith for his article about abortion in New Zealand (10 June, p. 1533) and suggests that “he offers no support” for his opinion that “most doctors were against the [new] law” and proceeds to throw doubt on the survey he quoted. He follows this with his own opinion about New Zealand abortion politics, which from my three-year experience of working there is pure fantasy (and tells us more about Professor McLaren than about the majority of people in New Zealand).

Dr Smith's article is amply supported by the evidence gathered in two surveys conducted in November 1977 before the new law was passed.¹ Professor R. McD. Chapman, of Auckland University, surveyed all the 4200 doctors currently registered in New Zealand with New Zealand addresses; 51% replied and only 20% of these supported the Bill, which was ultimately passed. The General Practitioner Society conducted a similar survey among 1400 general practitioners; 72.9% replied, and 79% of these doctors, who cannot escape from the problem of unwanted pregnancy in the way that hospital doctors can, agreed with the statement that “a new abortion law should be so formulated as to leave the question of termination during the first three months of pregnancy to the woman and her medical advisers and that the fetus should be afforded the protection of the law in the last six months of pregnancy.” Public opinion polls have consistently shown a majority of people in favour of liberalising the law, and the latest of these, in October 1977, given to a random sample of 1000, showed 88% in favour of a more liberal law

than existed then, which was less restrictive than the law which was subsequently enacted. In 1974, with the help of the National Organisation of Women (Gisborne branch) I conducted a survey of opinion about abortion among the 62 doctors practising in the east coast area. Apart from the two doctors who tore the form up (who probably would see things in the same way as Professor McLaren), replies were obtained from 57. Just over 50% agreed with the statement that “abortion should be a personal decision between the woman and her physician” and subsequent referral practice confirmed the validity of these responses.²

In the three years I worked in Gisborne the need for termination was apparent and attitudes were very similar to those in England. The effect of the restricted abortion law now passed will be to prevent the older, more parous, poor woman from obtaining an abortion as the younger, nulliparous woman with no responsibilities and the rich will fly to Australia, where large series have already been reported.³

Professor McLaren may have been influenced by the attitudes of some members of the Royal New Zealand College of Obstetricians and Gynaecologists, some 50% of whom, when surveyed for the Royal Commission on Sterilisation in 1975, disapproved of abortion on either ethical or “other” grounds⁴; but I doubt that even Mr Muldoon's supporters would say that “tolerance and compassion” were his strong points and the passage of the new Act through the New Zealand Parliament was considered by many observers to be an abuse of the democratic system.

WENDY SAVAGE

London Hospital,
London E1

¹ Facer, W., *New Zealand Nursing Forum*, 1978, **6**, 13.

² Savage, W., *Proceedings of Royal Commission on Contraception, Sterilisation, and Abortion*. Wellington, Government Printer, 1976.

³ Rogers, A. F. C., and Lenthall, J. F., *New Zealand Medical Journal*, 1975, **81**, 282.

⁴ Royal New Zealand College of Obstetricians and Gynaecologists, *Proceedings of Royal Commission on Contraception, Sterilisation, and Abortion*. Wellington, Government Printer, 1976.

Phenistix urine test-strip and desferrioxamine

SIR,—Twins aged 16 months were admitted to our unit on 21 April 1978 having ingested an unknown number of ferrous gluconate 300 mg tablets about 25 min before admission. Immediate treatment was instituted, including the administration of desferrioxamine mesylate. Samples of venous blood taken 3 h 50 min after the iron ingestion gave serum iron readings of 51.5 $\mu\text{mol/l}$ (288 $\mu\text{g}/100\text{ ml}$) and 56 $\mu\text{mol/l}$ (313 $\mu\text{g}/100\text{ ml}$) respectively.

Specimens of urine from all children admitted to this hospital have for several years been tested with a Phenistix strip, partly as a screening procedure for unsuspected salicylate poisoning. When a Phenistix test was carried out on a urine specimen obtained from each twin after the desferrioxamine had been administered a very deep red-brown colour resulted. A repeat venous blood sample from each of the twins at 23 h after the iron ingestion showed no demonstrable salicylate content, while the serum iron readings were 12.5 $\mu\text{mol/l}$ (70 $\mu\text{g}/100\text{ ml}$) and 10.5 $\mu\text{mol/l}$ (59 $\mu\text{g}/100\text{ ml}$) respectively. The urinary Phenistix test was

entirely negative in both children 25 h 30 min after the iron ingestion.

Two urine specimens from a patient with thalassaemia, one taken before and the other after the administration of desferrioxamine, have been tested with Phenistix, and the same change was seen in the second specimen. Desferrioxamine mesylate solution taken from an ampoule and then well diluted will produce a similarly striking change when applied to a Phenistix strip.

Although the urine of patients receiving desferrioxamine can have a characteristic reddish discoloration, the Phenistix test-strip is at manufacture impregnated with ferric ammonium sulphate along with other substances.

I wish to thank student nurse Sonia C. Archibald, who drew attention to the abnormal Phenistix reaction in the twins.

HARRY V. L. FINLAY

Paediatric Unit,
Hillingdon Hospital,
Uxbridge, Middx

Platelet MAO activity in epilepsy

SIR,—Your leading article on serotonin, platelets, and autism (24 June, p. 1651) was of considerable interest to us because we have been studying the platelet monoamine oxidase (MAO) activity in patients with epilepsy, a disorder which may accompany infantile autism and mental illness. Our results from earlier investigations showed that tyramine, a substrate for MAO, activated the electroencephalogram of epileptic patients,¹ and preliminary analysis of our present results shows that the platelet MAO activity is significantly raised in epileptic patients when compared with neurological controls and normals. There are also some sex differences. All the epileptic patients were taking anti-convulsant medication, and it may be that this is important.

It is possible that our observations relate directly to a biochemical substrate for epilepsy at a cellular level, and it is hoped to publish full results shortly.

Z. L. KRUK
A. MOFFETT
D. F. SCOTT

Department of Pharmacology and
Therapeutics and Electroencephalography,
London Hospital Medical College,
London E1

¹ Swash, M., Moffat, A., and Scott, D. F., *Nature*, 1975, **258**, 749.

Management of intracranial metastases

SIR,—We noted with regret that the article by Mr M. M. Sharr and Mr J. S. Garfield (10 June, p. 1535) failed to mention the place of palliative radiotherapy in the management of patients with intracranial metastases.

The neurosurgeon deals with a small and highly selected group of these patients. They are often those presenting with undiagnosed cerebral metastases or with a solitary intracranial deposit. Even in this group of patients the results of surgical intervention either with or without postoperative radiotherapy are acknowledged to be poor.^{1,2} The operative mortality alone in some series is as high as 20%.²

By contrast the value of radiotherapy alone in the management of patients with multiple