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

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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 parentroviite. 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 parentroviite 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.

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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