the same as those of the older agents, although the incidence of such effects is undoubtedly less. This relatively low frequency of toxic effects may lead to a feeling that modern agents are safe; however, cases of paraplegia¹ and renal failure² have occurred after translumbar aortography with modern contrast media.

I believe with Mr Imrie and his colleagues and with Gammill and Craighead³ that where possible the high translumbar route should be abandoned. It is now not recommended for renal angiography and so a low puncture well below the renal arteries may be used which gives better anatomical details and fewer serious complications.³ The complications of high translumbar puncture include, as a result of direct toxicity with injection of a single vessel, renal, pancreatic, and intestinal necrosis.⁴ The complications of dissection of a major vessel include paraplegia⁵ and renal infarction.⁶ Major dissections can be avoided by the use of a test injection, but compromise of the major anterior radicular artery supplying the spinal cord does not require a major dissection⁷ and can occur with punctures as low as the third lumbar vertebra.⁷

By making a low puncture one may also avoid accidental puncture of the heart, lung, and thoracic duct, although the inferior mesenteric artery is at risk.³ A particular disadvantage of high puncture is loss of contrast medium into the great vessels of the aorta; this leads to the use of more concentrated and so more toxic contrast media which then necessarily perfuse the sensitive abdominal viscera at high concentrations. The complications of translumbar aortography reported today are much the same as 20 years ago and the lessons learnt during that era of aortography should not be forgotten.

I would have welcomed more details of the technical aspects of the aortograms in the report by Mr Imrie and his colleagues as these might have allowed an assessment of the relative contribution of contrast medium toxicity or technical factors to the development of pancreatitis in their cases to be made.

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¹ *Lancet*, 1973, 2, 1067.

² Older, R A, et al, *American Journal of Roentgenology*, 1976, 126, 1039.

³ Gammill, S, and Craighead, C, *Surgery, Gynecology and Obstetrics*, 1975, 140, 59.

⁴ Gaylis, H, and Laws, J W, *British Medical Journal*, 1956, 2, 1141.

⁵ Hare, W S C, *Journal of the Faculty of Radiologists*, 1956, 8, 258.

⁶ Boblitt, D E, et al, *American Journal of Roentgenology*, 1959, 81, 826.

⁷ McAfee, J G, *Radiology*, 1957, 68, 825.

Sodium cromoglycate and Hodgkin's pruritus

SIR,—Pruritus in untreated Hodgkin's disease can be severe and is frequently resistant to antipruritic therapy. Following the report by Dr S A Haider (18 June, p 1570) of the successful use of sodium cromoglycate (SCG) for pruritus in atopic eczema we have used SCG in two cases of severe pruritus secondary to Hodgkin's disease.

The first patient was a man aged 20 years with stage IIB Hodgkin's disease who presented with intractable generalised pruritus. Treatment with calamine lotion, oral chlorpheniramine maleate, and clioquinol cream was ineffective. Ointments of

varying concentrations of SCG in soft paraffin wax (1%, 2%, 5%, and 10%) were applied twice daily and all provided relief, though this was maximal with the 5% preparation. The 10% preparation tended to produce a mild burning sensation which partially negated the antipruritic effect. In a comparison of 5% SCG in soft paraffin with 5% SCG in propylene glycol the propylene glycol suspension was preferred. The second patient was a man aged 42 years with stage IIIB Hodgkin's disease and long-standing pruritus which had failed to respond to local and systemic antipruritic treatment. Immediate relief of symptoms was achieved with a single application of 5% SCG in soft paraffin, and with twice daily application he remained symptom-free until given chemotherapy. Pruritus in both patients resolved with chemotherapy.

As pruritus in patients with lymphoma can be a distressing and intractable complaint until relieved by treatment of the underlying condition topical SCG may be of benefit in this situation, though further controlled studies are required.

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Poisoning with antidepressants

SIR,—In recent issues the attention of readers has again been drawn to the potential toxicity of antidepressant drugs and the apparent differences between drugs (23 July, p 260; 20 August, p 523). In this context we would like to make a preliminary report on a case of attempted suicide with the antidepressant mianserin.

A 53-year-old woman took a deliberate overdose of at least 60 tablets of mianserin (more than 600 mg) together with 20 sleeping tablets (totalling 10 g of carbromal-like monoureides) and 250 ml of ethanol 40% w/v. Three hours after the event she was found unconscious by her husband. On admission the patient was in deep coma. Gastric lavage showed that no tablets were left in the stomach. Systolic blood pressure was initially down to 80 mm Hg but returned to normal values later. Heart rate ranged from 100 to 110/min. Repeated electrocardiograms showed no abnormalities apart from left axis deviation. In an attempt to lower the plasma mianserin level haemodialysis was performed for 6 h. Seventeen hours after ingestion the patient woke up and her subsequent course in hospital was uneventful apart from an aspiration pneumonia which did not cause further problems.

Pharmacokinetic analysis of mianserin concentrations obtained from multiple plasma samples showed first-order kinetics which were not influenced by haemodialysis. The half life of the elimination phase was comparable to the value calculated for therapeutic mianserin dosages. The first blood sample, taken approximately 5 h after ingestion, showed a peak level of 780 µg/l; the therapeutic concentration varies from 30 to 120 µg/l.

The message from this overdose case seems to be that haemodialysis is not useful in the management of mianserin overdose. It gives further support to the conclusion of previous correspondents that mianserin in overdose does not produce cardiotoxicity.

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Doctors and the global population crisis

SIR,—I read Dr John A Loraine's Edward Holme lecture on the global population crisis (10 September, p 691) with a growing sense of amazement that any man of his standing could be so certain that his views were completely right and those opposed to him so completely wrong. He regrets that when a "liberal" abortion law was introduced in India the number of terminations was "disappointingly small"—he does not seem to consider the possibility that perhaps the Indian people are wiser than he. He condemns the Society for the Unborn Child as "emotive," yet his own views seem dehumanised and amoral. The only surprise is that when he mentions the increasing proportion of elderly people in the population he does not continue to the "logical" conclusion of recommending compulsory euthanasia at a fixed age—perhaps, however, this would be coming too close to home.

It was because of the very attitudes that such an article expresses that I, who had been born and educated in Britain, left the country, and I would seriously question whether history will not look back in horror on the "liberal" attitude adopted by the British medical profession, among others, in the second half of the twentieth century.

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A record?

SIR,—The ability of breast carcinomas to produce local recurrences many years after apparently successful primary treatment is well recognised. However, a particularly extreme example of this problem has recently presented to us, and may be of interest.

A woman born in 1895 presented elsewhere in 1929 with a short history of a lump in the left breast, with nipple indrawing. Left radical mastectomy was performed, but unfortunately further details are not available. She was not irradiated. She was well until 48 years later in July 1977, when she developed a lump in the scar. On examination there was an ulcerated lesion 4 × 2.5 cm at the lateral end of the mastectomy scar. There was no clinical evidence of nodal or other metastases or of a new primary. Chest x-ray was clear. Biopsy confirmed recurrent mammary carcinoma. She has started a course of irradiation to the lesion.

Danckers *et al*¹ reported a local recurrence after a latent interval of 32 years and referred to a further histologically proved case at 40 years. We have been unable to find a published case of histologically proved recurrence with a longer latent interval. Is this case a record?

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¹ Danckers, U F, Hamann, A, and Savage, J L, *Surgery*, 1960, 47, 656.

Status of general practitioners

SIR,—I note the Secretary's comment after Dr C D Garratt's letter (17 September, p 775) and I welcome it.

The present system of payment for late night visits presupposes that the normal