grey and breathless in her cot. A tachycardia of 240/min was noted which settled over the following four hours. Examination showed no evidence of cardiac failure. A chest x-ray was normal. An ECG the next morning revealed a sinus tachycardia of 180/min. Her subsequent progress was uneventful and she was discharged home on her 65th day weighing 2.42 kg.

She failed to keep her follow-up appointment and we later learnt that she had been found dead in her cot unexpectedly at home at the age of 10 weeks. Post-mortem examination revealed no abnormalities.

One feels after reading the article by Dr Keeton and his colleagues, that a more detailed investigation by means of a 24-h ECG tape would have been helpful and perhaps life-saving.

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ECT in underdeveloped countries

SIR,—The guidelines by the Royal College of Psychiatrists on the use of electric convulsion therapy (ECT)¹ (10 September, p 713) have implications for psychiatric practice not only in the UK but also in those underdeveloped countries which depend upon Britain for expatriate staff and for training local students. Since the use of a double standard in the administration of such a controversial treatment is clearly unacceptable, attention needs to be drawn to the problems of applying the recommended standards of administration of ECT in underdeveloped countries and the possible consequences of not applying them.

The memorandum states without qualification that "every patient having ECT should be anaesthetised and given a muscle relaxant by an anaesthetist." This has become standard practice in the UK following recognition that it reduces the risk of bone injury and lessens the patient's distress. In underdeveloped countries, however, shortage of anaesthetists and resuscitative equipment means that ECT is usually given "straight"—that is without anaesthetic and muscle relaxant. A study² of complications associated with straight ECT administered to 1105 patients at Butabika Hospital, Kampala, during 1972 and 1973 recorded two cases of serious bone fracture. A related study³ in 1972 confirmed that observers of straight ECT find it an unpleasant and frightening spectacle. Recognition of the disturbing effect of even modified ECT upon a patient who happens to see or hear another being treated⁴ presumably underlies the recommendation that patients should be treated singly and if possible in a single room. This need for privacy is not always observed in the crowded psychiatric institutions of underdeveloped countries.

When anaesthetists and resuscitative equipment are not available it becomes especially important to "weigh any possible disadvantages of ECT against the probable benefits." The problems facing doctors in underdeveloped countries who have to make such decisions have been discussed by Orley⁵: "Doctors in a hospital admitting over 60 patients a week and who usually do not speak the patients' language find it almost impossible to do more than give rough symptomatic treatment with medication and ECT, and sometimes do not bother with the niceties of diagnosis."

The evidence which is available^{6, 7} suggests that the incidence of severe depressive illness at Butabika Hospital at the time of the above

investigations was relatively low. One might therefore expect, in view of the evidence presented in the memorandum, that ECT would have been prescribed relatively infrequently. However, comparison of the number of patients receiving ECT (1105 for 1972 and 1973 combined)² with the annual admission rate (2900²) suggests that this was not the case. Hays⁸ has cautioned against "a tendency, in overcrowded and under-doctored institutions, to use it [ECT] too frequently on incompletely assessed patients." It is also recognised that under such conditions there is an increased risk of ECT being used as a method of control rather than as a therapeutic intervention. The RCPsych guidelines, if followed, should help to safeguard against such abuse. However, given the problems which Orley refers to and the high rate of illiteracy in the Third World, it is hard to see how the important recommendations concerning written informed consent could be implemented in underdeveloped countries. In the UK some protection against the misuse of ECT is provided by pressures such as the court hearing in the 1950s (*Bolam v Friern Hospital Management Committee*), which stimulated a series of inquiries into the risks associated with straight ECT, and the recent public pressures which precipitated the publication of the RCPsych guidelines. Such pressures will normally be absent in underdeveloped countries, where the social distance between patients and doctors is far greater than in the UK and where patients are less likely to be aware of their limited legal rights. This is another factor indicating a need for a critical appraisal of the use of ECT in the Third World.

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¹ Royal College of Psychiatrists, *British Journal of Psychiatry*, 1977, **131**, 261.

² Revill, M G, and Cox, J L. Unpublished observations.

³ Farrant, W, Cox, J L, and Farrhounumund, N. Unpublished observations.

⁴ Slater, E, and Roth, M, *Clinical Psychiatry*, p 234. London, Balliere, Tindall, and Cassell, 1969.

⁵ Orley, J, *East African Medical Journal*, 1972, **49**, 18.

⁶ Wood, J F, in *Uganda Atlas of Disease Distribution*. Kampala, Makerere University, 1968.

⁷ German, G A, *British Journal of Psychiatry*, 1972, **121**, 461.

⁸ Hays, P, *New Horizons in Psychiatry*, p 100. Harmondsworth, Penguin Books, 1964.

Thrombophlebitis with intravenous naftidrofuryl oxalate

SIR,—We wish to add our comments to the several letters regarding the paper by Mr C R J Woodhouse and Mr D G A Eadie (21 May, p 1320) concerning thrombophlebitis associated with naftidrofuryl (Praxilene) infusion as we feel that neither the pH nor the drug itself is responsible for the observed complication.

In hospitals where a pharmacy cannot provide a comprehensive additive service it is well known that drugs added to an infusion at ward level can result in particulate and bacterial contamination of the delivery system. The contamination has been associated with a number of complications, which include infusion phlebitis.^{1, 2} Where five ampoules of Praxilene must be opened to prepare an infusion the risk of contamination at ward level must be assumed to be high.

The pharmacy at this hospital has overcome the problem in the following manner. Naftidrofuryl 200 mg is dissolved in 225 ml 0.8%

sodium chloride, and the solution is filtered through a 1.2- μ m membrane filter which has a diameter of 47 mm. The filtrate is autoclaved at 121°C for 35 min. The content of naftidrofuryl is assayed using the technique of Cawood and Marshall³ and the solution was found to be stable for one year at room temperature. Over a one-year period starting in July 1976 over 500 doses of the drug prepared in this manner have been infused intravenously and no instances of infusion phlebitis or complications from contamination have been recorded by vigilant observers.

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¹ De Luca, P P, et al, *American Journal of Hospital Pharmacy*, 1975, **32**, 1001.

² Phillips, I, et al, *Proceedings of International Symposium, University of Sussex, March 1976*. Lancaster, MTP, 1976.

³ Cawood, A, and Marshall, I W, *Journal of Hospital Pharmacy*, 1975, **33**, 149.

Cerebral vascular disease and cortical function

SIR,—With reference to the article by Dr J C Murdoch and others (23 July, p 226) and the letter from Dr W Hughes (10 September, p 702) it might be of interest to your readers to hear of the surprising results of the neuro-pathological investigations carried out on the brains of two individuals who were of great significance to twentieth century history, President von Hindenburg and V I Lenin. The former died in old age after a period of progressive dementia with a few episodes of sudden loss of consciousness towards the end. His brain showed no trace of vascular disease. Lenin died at 54 after recurrent attacks of cerebral vascular accident, in between which he invariably regained his usual extreme intellectual ability and efficiency. His brain was riddled with necrotic areas in all stages and the little amount of apparently unaffected parenchyma aroused great amazement as to the patient's mental performance immediately before his death. Unfortunately I have not been able to trace the reference to the publication in which these two post-mortems are compared—a not entirely anecdotal contribution to the discrepancy between clinical assessment of cortical function and morphological evidence occasionally encountered.

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Complications of high translumbar aortography

SIR,—Mr C W Imrie and his colleagues, in their short report on cases of pancreatitis following translumbar aortography (10 September, p 681), assume that this was induced by direct damage to the pancreas although puncture was at the appropriate level in only two of the cases. I suspect that this complication is more likely to be due to direct toxicity of the contrast medium. Iothalamate and diatrizoate compounds are less toxic than acetrizoate, diodone, or sodium iodide. They are, however, more toxic than normal saline and it seems likely that the toxic effects are

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