cage usually reveals the true cause of the pain. The syndrome is not always self-limiting and may incapacitate the patient for months. The best treatment is a local injection of a corticosteroid plus an anaesthetic like lignocaine. Often one injection is enough to relieve the symptoms. Sometimes the injection must be repeated. Oral anti-inflammatory drugs have a very limited value in the treatment of Tietze's syndrome.

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Teaching first aid to children

SIR,—Dr D D'Auria (24 September, p 835) asks about educating children in first aid and he cites the splendid example of Norway, where this teaching has been done for many years. Safety and accident prevention should also be taught as part of the same package.

Unfortunately no national plan in the UK is yet forthcoming from any official source to require the teaching of safety and first aid in all schools, in spite of the obvious humanitarian and other reasons for doing so. However, an editorial and an article in *Burns*^{1,2} on teaching safety, accident prevention, and first aid in schools shows what can and could be achieved.

Do the hours devoted to literature, mathematics, languages, physical education, and the arts show that these subjects are, to the official mind, more important than the preservation of the lives and limbs of our children? It would seem imperative that all children should be enabled to survive free from injury so that they may enjoy the benefits of these other subjects. Or is the absence of interest and teaching simply a matter of lethargy and lack of compassion in our society?

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¹ Gardner, A W, and Foster, S, *Burns*, 1976, 2, 203.
² Gardner, A W, and Foster, S, *Burns*, 1976, 2, 204.

Place of chlormethiazole in treatment of alcoholics

SIR,—The risks of indiscriminate use of chlormethiazole should be widely known and, as stressed by Dr J J Bradley (17 September, p 774), Dr Joan M Horder's warning (3 September, p 614) is very timely. However, in contrast to Dr Horder's opening statement, chlormethiazole is not an antidepressant "widely used in the treatment of depression" and her concluding sentence, "In the depressed alcoholic it would seem wiser to avoid the drug altogether," misses the point.

Chlormethiazole is held in Sweden and Germany to be the best drug for the treatment of severe alcohol withdrawal syndromes, including delirium tremens. Experience in the routine use of this drug at the Alcoholism Unit at St Bernard's Hospital¹ over the past 13 years have fully confirmed that for such purposes it is an extremely valuable and safe drug. It is, however, not a "treatment for alcoholism"; as a rule it should not be used except under hospital conditions or (except in delirium tremens) for longer than about six to seven days because of the risks of psychological and, more rarely, physical dependence.^{1,2} Prolonged use in alcoholic patients outside hospital of course also carries the risks of

potentiation and of overdose, as rightly described by Dr Horder. Reactive depression in alcoholics during the alcohol withdrawal phase is very common (being present to a severe or moderate degree, for example, in 53% of over 100 patients in our 1965 controlled trial of chlormethiazole¹); under hospital conditions the drug can certainly be used for depressed alcoholics in the withdrawal phase.

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¹ Glatt, M M, George, H R, and Frisch, E P, *British Medical Journal*, 1965, 2, 401.

² Glatt, M M, "Alcoholism—A Social Disease," Teach Yourself Books. London, English University Press, 1976.

Surgical treatment of trigeminal neuralgia

SIR,—We are surprised that your leading article (17 September, p 718) makes no mention of peripheral branch injection or division as part of the surgical treatment of trigeminal neuralgia.

For several years now we have adopted this method as the first line of surgical management in those patients whose pain is no longer controlled by medical means and is essentially confined to one division of the trigeminal. In accepting the ultimate inevitability of pain recurrence we have nevertheless found that prolonged periods of remission are obtainable by injection, either with local anaesthetic or alcohol, or subsequent neurectomy. The success of the method depends firstly upon meticulous mapping of the distribution of the patient's pain so that, secondly, an anatomically accurate injection may be made. In the face of recurrent pain the injection can be repeated, often in the privacy and comfort of the patient's home, or appropriate neurectomy performed of one or more peripheral branches.

Before recourse is made to the destructive procedures on the ganglion or sensory root, with their inherent morbidity and mortality, we suggest that the simpler and safer peripheral procedures be tried.

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Intravenous diazepam and Cyclimorph

SIR,—Dr A S Gardiner (10 September, p 701) attributes amateur status and inferior results to those who use intravenous diazepam and Cyclimorph as a substitute for general anaesthesia. I invite him to consider the example of the patient with a dislocated shoulder admitted to the casualty department after a recent meal who is presented with the alternatives of waiting several hours for general anaesthesia or having an immediate injection of diazepam and Cyclimorph followed by painless reduction of the dislocation. I also invite him to visit my fracture clinic and see fractures remanipulated immediately during the course of the clinic rather than enduring anxious waiting for the next anaesthetic session.

I am delighted to read the letter from Mr P

Sykes (24 September, p 832) and to learn that he can perform the most complicated dental extractions under intravenous diazepam and pentazocine. This confirms my expectations that the use of intravenous diazepam with or without intravenous analgesics will obviate the need for general anaesthesia in dentistry and thus eliminate the recurring tragedies of deaths in the dental chair. Mr Sykes claims that intravenous pentazocine is virtually non-nauseating. This is rather surprising in view of the reports which suggest that the emetic side effects of pentazocine are about half those of pethidine and plain morphine.^{1,2} Moreover, pentazocine is known to have a higher incidence of other side effects such as dizziness and light-headedness. When I started using Cyclimorph I thought that it was virtually non-emetic until I made careful follow-up inquiries as to what happened after the patient got home. I then discovered that in some cases the emetic effects of morphine outlasted the antiemetic effects of cyclizine. A comparative trial of intravenous diazepam with Cyclimorph and with pentazocine is clearly indicated.

I am surprised that Mr Sykes has not found much increase in tolerance to intravenous diazepam in patients taking long-term benzodiazepine medication. Last week, for example, I injected 80 mg of diazepam before getting adequate sedation in such a patient who required remanipulation of relapsed Colles fractures. However, I agree that adequate sedation can usually be obtained and there appears to be no danger in larger doses providing these are carefully titrated.

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¹ Mowat, J, *British Medical Journal*, 1970, 2, 757.

² Morrison, J D, et al, *British Journal of Anaesthesia*, 1969, 41, 987.

Barbiturates and fractures

SIR,—Drs J B and Elspeth T MacDonald (1 October, p 891) have not fully taken up the main point I was making in my letter (10 September, p 699), perhaps because I expressed myself badly.

It is to be expected that any hypnotic would increase the risk of falls and hence of femoral fractures in the elderly, especially in those whose balance is already impaired. The figures in their paper (20 August, p 483) support this, though the authors drew attention particularly to the association of barbiturate hypnotics and nocturnal fractures. Their figures, however, suggest that non-barbiturates are more prone to cause fractures than barbiturates and show an altogether unexpected difference in the two groups between night and day fractures.

Time distribution of fractures

	10 pm-6 am	Daytime	Total
Barbiturate hypnotic fractures ..	91	12	103
Non-barbiturate hypnotic fractures ..	5	216	221
Non-hypnotic fractures ..	2	64	66

I agree that hypnotics will not be prescribed as often in the elderly generally as in those referred to a geriatric clinic, but when they are prescribed it would be reasonable to expect the prescribing pattern to be similar to that in the geriatric clinic referrals in the same locality.