postpone the emergence of drug resistance. The cosmetic unacceptability of B663 and the emergence of resistance to rifampicin complicate the matter.

A daily dosage of 100 mg of dapsone from the onset of treatment, combined with good health education and alternative methods of supervised administration, especially for lepromatous patients, as suggested by Allard,¹ Pearson *et al.*,² and Warren,³ may be our best defences against the emergence of dapsone resistance for some time to come.

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¹ Elland, G. A. *Leprosy Review*, 1975, **46**, 149.

² Pearson, J. M. H., *et al.*, *Leprosy Review*, 1977, **48**, 83.

³ Warren, G., *Leprosy Review*, 1977, **48**, 113.

Indomethacin, prostaglandins, and schizophrenia

SIR,—Dr M W P Carney (15 October, p 994) reported an apparently drug-induced paranoid psychosis with hallucinations in a woman receiving indomethacin. Turner¹ reported a similar episode, this time acute, in a normal volunteer receiving both indomethacin and aspirin in a drug metabolism study.

I have suggested that schizophrenia may be a prostaglandin (PG) deficiency disease.² Natural schizophrenia seems to be related to a specific deficiency in PGE₁ since prolactin, whose secretion is stimulated by antischizophrenic drugs, specifically stimulates PGE₁ synthesis,³ and since platelets from schizophrenics off drug treatment fail to increase their PGE₁ synthesis normally in response to adenosine diphosphate.⁴ Since indomethacin inhibits synthesis of all the prostaglandins and related substances it is not to be expected that it will be able to cause a syndrome which imitates exactly the natural disease. However, the schizophrenia-like features reported by Dr Carney and by Turner support the concept that a prostaglandin deficiency may be playing a causal role in the natural syndrome.

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¹ Turner, P., *Lancet*, 1977, **1**, 1058.

² Horrobin, D. F., *Lancet*, 1977, **1**, 936.

³ Horrobin, D. F., *et al.*, *Psychological Medicine*. In press.

⁴ Abdullah, Y. H., and Hamadah, K., *British Journal of Psychiatry*, 1975, **127**, 591.

Alpha-fetoprotein in antenatal diagnosis of neural tube defects

SIR,—It was with interest and awe that I read the case reports in the article by Drs D J H Brock and Christine Gosden on "Early antenatal diagnosis of small open spina bifida lesions" (8 October, p 934). The advent of α -fetoprotein as the diagnostic tool to detect spina bifida early in pregnancy has certainly raised a number of false hopes, especially with those who are directly concerned with the management of these babies. The decrease in the numbers of babies born with spina bifida is still not evident in those centres that have to manage these deformities. A number of open spina bifida lesions are missed because screening is not advised to the pregnant patient or because they fail to go to antenatal clinics. However, the majority of closed

myelomeningoceles go undetected and α -fetoprotein is of no practical help.

What should be questioned at this stage in view of the second case in this article is the real danger of the false-positive elevated α -fetoprotein concentration which was the reason for the abortion of a perfectly normal fetus. Can any of the centres in Britain provide the information that many would like to have: how many false-positive levels are recorded and has the reason for these false-positives been investigated? Clearly the whole value of the screening is at stake on this issue. This argument extends also to the elevated levels found in cases with exomphalos and gastroschisis, which are treatable conditions, and it would be disastrous if one had to practise eugenics on a raised α -fetoprotein level.

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Asymptomatic gonorrhoea in men

SIR,—In their interesting report (29 October, p 1155) on the detection of antibodies in gonorrhoea Professor A A Glynn and Miss Catherine Ison state that as many as 68% of infected men may be asymptomatic. They cite a point prevalence study¹ of urethral gonorrhoea in US Army enlisted men, many of whom could have been in the incubation and presymptomatic phase of the disease while others may have had ignored or suppressed symptoms. Most men with urethral gonorrhoea develop symptoms within two weeks of contracting infection, and a US cohort study² showed that only 3% of men who became newly infected in South-east Asia did not develop symptoms within two weeks. The combination of effective and rapid contact-tracing and accurate diagnostic techniques in the UK is resulting in more infected males being seen with no symptoms, particularly in genitourinary and venereology clinics. In view of this and to facilitate monitoring of the extent of asymptomatic gonorrhoea in infected males it might be wise to confine the term "asymptomatic urethral gonorrhoea" in men to those cases which are seen two weeks or more after first contact with infection. Confusion with presymptomatic cases still incubating disease would then be excluded.

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¹ Handsfield, H. H., *et al.*, *New England Journal of Medicine*, 1974, **290**, 117.

² Harrison, W. O., *et al.*, Paper presented at the 13th Interscience Conference on Antimicrobial Agents and Chemotherapy, Washington, DC, 1974.

SI units

SIR,—I am glad Dr J S Law and Dr J M Stansfeld have raised this matter again (5 November, p 1224). We are fed up with SI units too.

It would seem to me that there are three problems. Firstly, it is difficult to acclimatise to the *significance* of these new units. This is true in general but is particularly a problem with measurements that one only uses

occasionally. Secondly, certain of the changes have resulted in contraction of the range: calcium and blood gas measurements are a good example. As a result, changes which were only small in the old units, but which were clinically significant, are now almost imperceptible and, particularly in the case of blood gases, the management of patients is much more complicated. Thirdly, we have the additional problem that the Americans are apparently not changing to SI units and therefore in reading the literature one is going to require double knowledge for a long time to come. This will be relatively easy for some of us who have grown up with the old units, but for the new generation it will be very hard indeed.

I am glad to say that we have persuaded our own biochemistry department to give way on their principles of purity and present us with figures which are clinically meaningful, which is after all their prime function. We are now receiving our blood gases both in SI units and in mm Hg.

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Cancer of the lung and bladder

SIR,—Dr S Dische and others (13 November 1976, p 1174) and Dr T A W Edwards (5 March, p 637) have reported cases of the development of primary carcinoma of the bladder subsequent to carcinoma of the lung and vice versa in patients with a long history of cigarette smoking.

To assess whether routine urological follow-up is indicated in patients treated for squamous-cell carcinoma of the lung, we studied a series of 99 consecutive patients treated over the two-year period 1960-1 for squamous-cell carcinoma of the lung. Information was obtained about necropsy findings in 92 out of 94 patients. None of these had bladder cancer. The remaining five patients, who were alive, had no symptoms of bladder tumour according to their family doctor. The interval from the detection of the squamous-cell carcinoma of the lung to death or follow-up was less than two years in 78 cases, 2-5 years in six, 6-10 years in seven, and more than 11 years in eight.

Hence in this 2-year series of consecutive patients with squamous-cell carcinoma of the lung an incidence of bladder malignancy of zero was found (95% confidence limits, 0-4). In our opinion, this does not justify routine urological follow-up of patients treated for squamous-cell carcinoma of the lung.

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Long-term Althesin infusion and hyperlipidaemia

SIR,—The intravenous anaesthetic Althesin may be used for the long-term sedation of patients in intensive care units.¹ Its active components, alphaxalone and alphadolone, are presented for injection as an aqueous solution containing 20% of the surface-active agent Cremophor EL (polyethoxylated castor