which is also effective in folate-responsive neurological disorders.³

(4) Drs Manzoor and Runcie were aware of the posterolateral involvement of the spinal cord in their patients; however, they considered their patients as exhibiting folate-responsive neuropathies. It is difficult to accept such diagnoses when: (a) no evidence was given about the neurophysiological condition of muscles and nerves and (b) a bilateral extensor plantar response was one of the main clinical findings. I believe that the reported cases should be regarded as having folate-responsive subacute degeneration of the spinal cord.

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¹ Botez, M I, *Annals of the Royal College of Physicians and Surgeons of Canada*, 1976, 1, 71.

² Botez, M I, *Medical Hypotheses*, 1976, 2, 135.

³ Botez, M I, et al, *Canadian Medical Association Journal*, 1976, 115, 217.

⁴ Hunter, R, Barnes, J, and Matthews, D M, *Lancet*, 1969, 2, 666.

⁵ Chien, L T, et al, *American Journal of Clinical Nutrition*, 1975, 28, 51.

On the waiting list

SIR,—By tradition, when a patient is to be put on the waiting list for admission to hospital he is simply told so, and the general practitioner may get a letter to confirm this.

I have found it is not very uncommon for a patient to think he is on the list when in fact this is not so. This is unsatisfactory for everybody and may be the source of some of the horror stories one hears about people waiting incredible lengths of time for admission. It is often hard to check on a patient's assertion that he is on a list, especially if, for example, he is seen at one hospital outpatient department and told he will be admitted to another hospital. There are many other causes of confusion, such as the patient who has remarried, changed her address, and gives to the weekend duty doctor the name of a long-gone registrar instead of the consultant.

We may curse the necessity of bits of paper for everything, but often they serve a purpose. Patients have to fill in complex forms to get an outpatient appointment; is it asking too much for hospitals to give someone a "ticket" to confirm in writing that he is on a waiting list? I recently met a patient who was expecting to be sent for to go in to hospital at Newcastle, when she was actually on the list for New Cross. Such a ticket might reasonably bear some reminder of the need to tell the hospital of change of address and, where lists are periodically reviewed, there could be an "expiry date" when it would be due for renewal. Renewal would at least assure the long-suffering patient that he was not forgotten.

J B GLASS

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Fluorinated corticosteroids on the skin

SIR,—Dr S H Roussounis (4 September, p 564) is to be congratulated on bringing to our notice yet another complication of the misuse of topical fluorinated corticosteroids on the infant's skin. There are now very few infants who develop a rash who are not exposed to this risk, which, on the napkin area, is greatly increased by the almost universal use of plastic

pants. This occlusive action greatly enhances the transport of these preparations through the skin and although plastic pants are not mentioned in the article, they would almost certainly have been worn by this baby.

Some years ago I was asked to see a child aged 18 months in the Radcliffe Infirmary who had had a fluorinated corticosteroid preparation applied to the buttocks daily for at least 15 months. There was marked atrophy of the skin and muscular wasting of the area covered by the plastic pants.

If fluorinated corticosteroids are indicated, they must be used for only a limited time and plastic pants forbidden, unwilling though the modern mother may be to obey one's instructions.

H R VICKERS

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Life in Lister's wards

SIR,—In the interesting article on "Hospital life a century ago" (28 August, p 515) the authors refer to W E Henley's poem about Miss Mary Logan, "the young staff nurse" who was in charge of Lister's female ward when Margaret Mathewson was a patient in the Old Infirmary, Edinburgh, in 1877. The poet also came under her nursing care in a little private ward under Lister. He shared this room with two boys, William Morrison, aged seven, a collier's son, and Roden Shields, aged six.

In 1905, in an article in the *Cornhill Magazine*, "A blurred memory of childhood," R Shields told how he was nursed first in a crib in the centre of Lister's female ward. There the staff nurse was a Mrs Porter, "a rare old nurse of the old school, whose rugged kindness and skill of thirty years' experience inspired love, reverence and awe in doctors and patients alike." Owing to the accommodation in Lister's ward being "taxed to the utmost" he was speedily relegated to the little room where Henley lay to share the bed with little William. Miss Logan too was their staff nurse, "a broad-minded cultured Scottish gentlewoman." Roden came to know her well, "for over two years she was my foster-mother rather than a professional nurse." Frequently he was taken to her sitting room to play with her collie or to have tea with Mrs Porter and other senior nurses. On a rare occasion she would hire a carriage to take him for a two-hour drive. He recalled the weekly ward visits of Professor Lister and tells how once his "poor bed-ragged" mother was conveyed in his carriage to the hospital, for in the wind and rain Lister had picked her up in Princes Street, having come from Glasgow to visit Roden.

The "stricken poet," who was a patient in the Old Infirmary from August 1873 to April 1875, was Roden's "good comrade and kind friend." Mention is made of Henley's visitors, R L Stevenson and (Sir) Leslie Stephen. Some of Henley's hospital verses were published in the *Cornhill Magazine* in 1975, but the whole series appeared in his *Book of Verses* in 1888. His "Hospital Sketches" are included in *The Story of an East London Hospital* (1904), which was then the Children's Hospital in Shadwell. Henley and his two fellow-patients recovered to be carried out "into the wind and sunshine into the beautiful world."

Margaret Mathewson's and R Shields's reminiscences and Henley's verses give a good picture of Lister's wards from their bed of

sickness in the 1870s and echo the words of John Masefield in his tribute "In Praise of Nurses":

"I thank and bless you: that I write at all
Is, by itself, your work's memorial."

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Psychotropic drugs in depot form

SIR,—The paper entitled "A controlled comparison of flupenthixol and amitriptyline in depressed outpatients" by Dr J P R Young and others (8 May, p 1116) interested me, particularly their suggestions concerning the possible parenteral use of the depot form of the former drug, for I have been using fluphenazine in depot form since the latter part of 1975 for the treatment of refractory anxiety.

The dosages given have been in the range of 12.5 mg fortnightly in most cases and the side effects have been so minimal with this dosage that few patients require any anticholinergic drugs, which are never given as a routine. Few problems have arisen as experience has been gained, and the use of the injection is now being extended to alcoholics in view of the exceptionally good responses discovered in a number of symptomatic alcoholics in recent months.

I confirm the presumed advantages touched upon by Dr Young and his colleagues, in particular the maintenance of adequate blood levels of the drug (for I am sure that it is this feature which is largely responsible for the superiority of the depot form over orally administered drugs), and an anticipated disadvantage—the possibility of induced depression—has not occurred with fluphenazine at the low dosages being given. The greatest advantage is the clearly superior response which so many of my patients have demonstrated, sometimes after rather exhaustive experience with other types of treatment.

These early clinical impressions have been sufficiently impressive for me to introduce a more scrupulous control over the use of the drug in this form in order that a more worthy report might eventually be made.

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Emergency medical care

SIR,—In the final paragraph of his article (28 August, p 511) Dr Hugh Conway makes the point that the hospital plays a major part in primary emergency care and advocates a hospital-based emergency service in urban areas.

I would certainly not like to underestimate the importance of the hospital in this situation, but I feel that Dr Conway may be underestimating the role of the general practitioner. There is an implied criticism of the availability of primary care by the GP in a group practice which is not justified by his figures. Dr Conway appears to take little or no account of the total number of patients who require emergency care out of hours and are seen by their GP. It is surely only a small proportion of patients seen by GPs out of hours who are

referred to a hospital. I have recently reviewed my own out-of-hours visiting for the first six months of this year, (after 6 pm, weekends, and bank holidays). Of patients seen at these times, only 9.5% were referred to our local district general hospital. It is a relative rarity to refer a patient to an acute medical ward.

It may be that group practice makes personal care as once understood rather more difficult. However, at least members of the group can easily discuss problems which have arisen out of hours. The patient's own doctor is then in a good position to ensure continuity of care. Dr Conway's scheme would make communication very difficult and cumbersome. The service would be impersonal and remote and would in time, completely destroy general practice.

W J MAY

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Thyrotoxicosis induced by iodine in food

SIR,—We hope we shall not appear churlish if we respond to Dr Peter Wahlberg's thoughtful comments (24 April, p 1016) on our paper about thyrotoxicosis induced by iodine in food (14 February, p 372) by saying that his explanation of iodine-induced thyrotoxicosis is incomplete.

He suggests that the thyroid gland in endemic goitre, enlarged by thyroid-stimulating hormone (TSH) stimulation and geared to maximum iodine utilisation, will retain its avidity for iodine after iodine repletion and produce excess hormone. On the contrary, unless there is loss of normal hypothalamic-pituitary control any tendency towards an increase in circulating thyroid hormone will be matched by a fall in pituitary release of TSH and the euthyroid state will be maintained. If this were not so and Dr Wahlberg's explanation were correct, then everyone with goitre would be likely to become thyrotoxic when iodine intake rose. Although iodine-induced thyrotoxicosis is certainly not the rarity it once was thought to be, it still affects only a minority of the goitrous after iodine repletion.

Few would argue with Dr Wahlberg's explanation of the development of endemic goitre. To account for iodine-induced thyrotoxicosis it need only be extended to say that the TSH stimulation which gives rise to the thyroid enlargement also, in time and in some patients, gives rise by benign neoplastic change to autonomous nodules. Such nodules are not uncommon in people with nodular goitre and the frequency increases with age¹; the same is true of iodine-induced thyrotoxicosis. The Tasmanian patients with iodine-induced thyrotoxicosis whom we have studied had Graves's disease or autonomous nodules, the latter being the more common. No evidence of a third pathogenesis was found.^{2 3}

We agree that an increase in the incidence of thyrotoxicosis among those who are middle-aged or elderly at the time of iodine supplementation is probably the inescapable price that must be paid for normal thyroid physiology in the young and subsequent generations. We expect that as these older persons who had nodular goitre before iodine supplementation are gradually expended the incidence of thyrotoxicosis will wane, probably to below the preiodination level. The graph in our paper illustrates this trend.

The purpose of the paper was not to question the desirability of iodine supplementation but to remind physicians that iodine-induced

thyrotoxicosis really does exist so that those older people who, in consequence of chance iodine supplementation, are buying the good health of later generations at the cost of their own may at least enjoy prompt diagnosis and treatment.

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¹ Miller, J M, and Block, M A, *Journal of the American Medical Association*, 1970, **214**, 535.

² Adams, D D, et al, *Journal of Clinical Endocrinology and Metabolism*, 1975, **41**, 221.

³ Vidor, G I, et al, *Journal of Clinical Endocrinology and Metabolism*, 1973, **37**, 901.

Sexual disinhibition with L-tryptophan

SIR,—We would like to report an unusual side effect occurring in patients under treatment with preparations containing L-tryptophan.

Four male patients aged 19-32 (one with chronic schizophrenia with a moderate degree of depression, two with schizophrenia with severe depressive features, and one with paranoid psychosis with depressive features) who were taking different phenothiazine drugs were given Pacitron (L-tryptophan) tablets 1 g three times a day. One, aged 22, was completely upset, agitated, and disturbed and the drug was discontinued after one week. The other three showed considerable improvement in their depression within 1-2 weeks. But at the same time both medical and nursing staff observed that they became sexually disinhibited, with obvious marked over-friendliness to female patients. Their talk became dominated by sex topics and they frequently touched parts of female patients' bodies, behaviour not previously manifested. When we reduced the dosage to 500 mg three times a day they became well controlled sexually. The picture of disinhibition was, to some extent, reminiscent of that seen in manic states.

Another male patient, aged 71, with manic-depressive psychosis was given Optimax tablets (L-tryptophan 0.5 g, pyridoxine hydrochloride 5 mg, and ascorbic acid 10 mg) in the recommended dose of two tablets three times a day and six at night during the depressive phase. He suddenly became sexually disinhibited and indecently assaulted a woman in the road, his condition justifying admission to a psychiatric hospital.

We would be interested to hear whether colleagues who have used Pacitron or Optimax have come across similar manifestations.

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Patients' days

SIR,—I was interested in your leading article on this subject (28 August, p 490). For many years now I have had open visiting (2.30-7.30 pm) in my gynaecological ward, the only restriction being two visitors to one patient at any time. Over-visiting and prolonged stay of visitors, which you mention as a problem associated with prolonged visiting hours, does not seem to occur. In fact the system seems to work exceedingly well and the nursing staff are very much in favour. I think one is more

likely to have visitors staying too long with visiting hours of the order of 1-2 hours, when it is felt that they are expected to stay for that length of time. For my own part I would abolish all restrictions on hours and I feel sure that there would be little abuse.

LLOYD RANKIN

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SIR,—Your leading article (28 August, p 490) on the recently issued guidelines to the organisation of the hospital inpatient's day missed the opportunity of making one very important comment. The guidelines rightly stress the need for medical staff to be sensitive, sympathetic, and, in so many words, "loving" in their relationship to patients and their relatives; but no one has unlimited reserves of good will and particularly resident staff who often work long hours under great personal stress. Their reserves need refilling from time to time; and this used to be in good hospitals one function of the domestic staff, who would make sure the exhausted resident had his emotional and physical needs lovingly attended to (let the juvenile snigger) when he or she could snatch a few minutes of off-time. Not so now: in the interests of false economy the domestic life in hospitals has become almost wholly impersonal and it is not uncommon on entering the communal dining room for the hungry resident who has stuck at his job to find that the cupboard is bare and his reception frosty. No wonder our residents like to marry young and that the hospital has become to them like a factory rather than a farmhouse. Perhaps the DHSS should be reminded that you get out of people only what you put in.

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Community health councils and the public

SIR,—I attended a meeting of the Peterborough Community Health Council on 1 September to which members of the public were invited. No member of the public had a copy of the agenda under discussion. No member of the public was allowed to speak. No member of the public stayed until the end of the meeting.

The object of the community health council is to increase the public's involvement in their health care and I feel this is not the way to do it.

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Splinter organisations

SIR,—I admire unconditionally your quaint liberal tradition—the Voltaire spirit—which leads you to publish topical correspondence even when it consists, like that of Dr Sam Baxter (11 September, p 643), of invitations to BMA members and others to transfer their support elsewhere. Dr Baxter's argument if accepted—"existing bodies such as the BMA . . . [do not] adequately represent [whole-time NHS consultants'] point of view"—could deprive you of several thousand