actual fact these lenses darken only very slightly if at all while driving, even in very bright sunlight. Also when driving you very rarely have the sun shining directly on to your face and this further minimises the darkening of the lenses.

Consequently there is no need to carry round a "regular" pair of glasses. All that is needed is a way to make the eye accommodate faster when this occasion arises—suggestions, please?

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"Press that bruise"

SIR,—Mr B M Tracey, while broadcasting his slogan "Press that bruise" (2 October, p 814), mentions that he taught that pressure should be applied in control of haemorrhage for 3–5 min, until the clotting time of blood had been passed. Surely what is of importance, however, in first aid is the bleeding time rather than the clotting time. The normal bleeding time may be as long as 7 min.¹ Any pressure applied for less than this period may thus be ineffective in control of haemorrhage.

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¹ *Human Blood Coagulation, Haemostasis and Thrombosis*, ed R Biggs, 2nd edn, p 676. Oxford, Blackwell Scientific, 1976.

Sexual disinhibition with L-tryptophan

SIR,—We wish to report a case which may be similar to those of Drs G P Egan and G E M Hammad (18 September, p 701) although the patient was a woman.

A 63-year-old married woman was admitted to this unit on 8 November 1975 suffering from psychotic depression (ICD No 296.2) characterised by delusions of guilt and unworthiness, several with sexual connotation. Her first illness had occurred 27 years previously but she had then remained well until September 1973. Between 1973 and 1975 she had had six previous admissions each lasting between two and eight weeks with a good response to treatment followed by subsequent relapse. The usual diagnosis had been psychotic depression, although on one occasion the bizarre nature and sexuality of her thoughts had led to a diagnosis of schizophrenia. Treatment had included amitriptyline, trimipramine, lithium, thioridazine, chlorpromazine, fluphenazine decanoate, and electroplexy. From 11 to 18 November she received L-tryptophan (as Optimax) 2 g three times daily with no effect. However, she then received five electroplexes and changed dramatically. She was talkative and flirtatious, her conversation was mostly of sexual matters, and she purchased an instruction book on sexual techniques. Her husband confirmed that she had not been like this before. This change settled over the next three weeks. On a subsequent admission she has had L-tryptophan (as Pacitron) 500 mg three times daily without subsequent electric convulsion therapy, with no effects, good or bad.

Most of the drugs that alleviate depression can cause hypomania, though paradoxically L-tryptophan has been used as an antimanic agent.^{1,2} The rationale for its use as an antidepressant is based on the known disturbances of indole metabolism in depression,³ though there is no clear correlation between mood and plasma levels of tryptophan⁴ except in some subgroups of patients.⁵ We felt that this patient had bipolar manic-depressive illness, although the exact status of such hypomania

seen in response to treatment is uncertain, and that the sexual disinhibition was more related to her thought content when depressed than specifically to an effect of L-tryptophan. Possibly the L-tryptophan acted as a priming mechanism, which was then activated by the electroplexy, as our patient responded to fewer treatments than previously. Three of the patients reported by Drs Egan and Hammad were suffering from schizophrenia, in which indole metabolism may be disturbed,⁶ and were exposed to other drugs which may also have acted upon the increased amount of indoleamine present.

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- ¹ Murphy, D L, *et al*, *Psychopharmacologia*, 1974, **34**, 11.
- ² Prange, A J, *et al*, *Archives of General Psychiatry*, 1974, **30**, 56.
- ³ Ridges, A P, *Journal of International Medical Research*, 1974, **2**, suppl C.
- ⁴ Rees, J R, *et al*, *Psychological Medicine*, 1974, **4**, 334.
- ⁵ Aylward, M, *International Research Communication Systems*, 1973, **1**, 30.
- ⁶ Smythies, J R, *Lancet*, 1976, **2**, 136.

Comparative diagnostic accuracy of barium meal and endoscopy

SIR,—Dr G W Stevenson and his colleagues are misleading in using the word "prospective" to describe their study of the diagnostic accuracy of barium meal and endoscopy (25 September, p 723). That it was a planned study is undeniable, but there was no element of looking forward. If there were, then they could perhaps have attempted to answer the critical question—at least if their numbers were larger—namely, whether improving diagnostic accuracy helps the patient.

We have now compared the results of double-contrast barium meal examination and endoscopy conducted randomly on over 200 patients with acute upper gastrointestinal bleeding and have as yet been unable to satisfy ourselves that endoscopy, with its higher positive diagnosis rate, in fact lowers mortality.

A simple analogy would be with the routine intravenous pyelogram in hypertension, which may give information about a renal cause for high blood pressure but seldom helps the patient.

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Preventing infection at the operation site

SIR,—In your leading article on operation site infection (2 October, p 773), in presenting a few of the current fashionable methods aimed at prevention, you have overlooked a most important consideration.

It is pointless for a surgeon to change knives after incising the skin if the gloves are allowed to contact the skin and then the deeper structures. Gloves would, of course, be unnecessary if the skin could really be sterilised—why not treat the surgeon's hands like the patient's skin? Few would subscribe to this, yet contact between gloves and skin is often allowed by those using elaborate filters, etc, to screen the

wound from far less substantial sources of infection. To blame skin sutures is also not reasonable when wounds are exposed, allowing the capillary effect of a seton to take place from infected skin and blankets. Adhesive tape closures may prevent this, but they, like topical applications, have their own drawbacks too.

In short, wound infection today depends on contamination directly introduced by the surgeon just as it did a century ago, and anti-bacterial agents and machines, whether carbolic acid in sprays or antibiotics in tents, are no substitute for non-contamination by careless hands.

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SIR,—I don't know who wrote your leading article on preventing infection at the operation site (2 October, p 773) but he can't have been a surgeon. There are paragraphs of reference to carriers, disinfectants, scrubbing, towelling techniques, antibiotics, etc, but no mention whatever of the main causes of surgical sepsis—namely, haematoma (an in-situ blood agar medium), devitalisation of tissues, and leaking anastomoses—in other words, bad surgery.

A cleanly and gently incised wound will be able to overcome all but heavy contamination with pathological bacteria. A devitalised wound with a haematoma will fall foul of a light shower of usually harmless commensals. Any wound will become infected if continuously inoculated by a leaking anastomosis.

The prevention of wound sepsis lies in the hands of the surgeon, not in the ramifications of high technology.

HAMISH THOMSON

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Compulsory seat belts

SIR,—In reply to the points raised by Dr F B Singleton (25 September, p 753) my action in recommending laminated windscreens rather than compulsory seat belts is anything but negative as it is the only action which I see as being acceptable. I have said nothing to decry the use of seat belts for those who are willing to wear them, but, although I also have been roused from my bed to deal with injuries which might not have happened had the patient been restrained by a seat belt, I would be the last to add to his miseries by sitting in moral judgment and prating about enforcing restraint. As to the legal blackmail which his colleague seems to employ, one should be warned against following such a course as, if a seat-belt injury arose, legitimate claim could probably be taken against someone virtually denying a certificate.

Of course the cost of death and injury concerns us all, but as medical people the dead and dying scarcely concern us: it is the injuries which are our main concern and many of these, at least in Britain, are only serious because of broken glass. So far as I know there are no figures for the estimated injuries and therefore cost which might be attributed to lack of seat belts as distinct to lack of laminated windscreens. I am suggesting that we should get our priorities right and advocate something feasible and practically harmless rather than controversial and sometimes fatal. It is rather like advising a patient with a known dangerous condition, such as cerebral aneurysm, to