an excessive amount of other drugs as well, such as aspirin, caffeine, and sedatives. As it is not impossible that these other drugs may be responsible for causing or aggravating the disease of chronic interstitial nephritis with papillary necrosis they should be mentioned, and the estimated quantities consumed should be stated in cases published as examples of chronic phenacetin nephropathy.

Further, to form a fair and objective judgment of the part played by phenacetin in chronic interstitial nephritis with papillary necrosis all cases of this disease found at post-mortem where phenacetin has not been taken in excess should be published. In less-developed countries, where phenacetin is usually not taken in excess or at all by patients, it will be enlightening to learn of the incidence of renal disease similar to chronic phenacetin nephropathy.

Finally, where phenacetin and other drugs have been taken in excess in chronic kidney disease it should be ascertained, if possible, whether the kidney disease preceded the consumption of the phenacetin or followed in consequence thereof.—I am, etc.,

Kroonstad,
South Africa.

F. A. LOMAX.

Death and Cremation Certificates

SIR,—Dr. C. Allan Birch's most interesting letter (28 March, p. 841) is accurate except for one fundamental omission.

A doctor who issues a death certificate is required to sign the statutory form which includes the words, "I hereby certify that I was in medical attendance during the deceased's last illness." No doubt there are differing opinions as to what is "the last illness," but if a doctor—as in Dr. Birch's example—very properly goes away for three weeks, in the apparent belief that his patient will require no medical attention during that time, it would seem that the death must have been unexpected. Can the doctor on his return, and after the patient's death, know that some quite unknown cause of death has not supervened? It is precisely in circumstances such as these that post-mortem examinations have disclosed barbiturate poisoning and other unnatural causes of death.

Dr. Birch rightly says that the certifying doctor must have either seen the patient within 14 days before death or the body after death, but it is still necessary that he should have attended during the last illness. It would be plainly absurd if the law permitted a doctor to issue a valid death certificate after he had merely seen the body after death, however far back in time his earlier attendance had been, and the present law, unsatisfactory as it is, is not quite so ineffective.

I do not think that Dr. Birch is right in thinking that the registrar of deaths would have accepted the doctor's certificate in the example he cites. Most alert registrars would not do so, and would refer the case to the coroner; clearly delay, distress, and inconvenience to the relatives are reduced if the doctor reports directly to the coroner.—I am, etc.,

Surbiton, Surrey.

C. F. J. BARON.

SIR,—I feel that Dr. C. Allan Birch's letter (28 March, p. 841) re death and cremation certificates calls for some comment.

He appears to emphasize what a doctor need not do and not what he should do. It is a well-known fact that death certificates are of little statistical value, as they so often bear no real relation to the cause of death. Practitioners would greatly benefit, and possibly be more humble, if they attended post-mortems on their own cases only to find that the real cause of death had not been appreciated.

Apart from statistics, the main object of certification is to exclude the possibility of criminal acts, and this is obviously even more necessary in the case of cremation. Medical referees are constantly having to contact doctors who have incorrectly filled in these forms, and I have known of several cases where responsible doctors have refused to complete Form C as there has been some doubt about the validity of Form B.

The case of the doctor who on arriving home after three weeks' holiday found his patient dead and hesitated to contact the coroner because the widow did not want it could be open to interpretations other than those of an emotional dislike of necropsy.—I am, etc.,

London E.12.

M. C. STARK.

SIR,—Many of the deaths referred to a coroner are not in practice limited to unexpected ones. If the public knew how many necropsies were performed unnecessarily in their name, with neither clinical nor legal interest, there would be an outcry.

There is a convention, widespread anyhow in the south-east of England, that all deaths occurring within 24 hours of admission to hospital be reported to the coroner, even though there is no question of foul play or unnatural causes (nor even any doubt about the diagnosis) and indeed even though the general practitioner has been in attendance. Sudden death in the street is reported in spite of the knowledge of predisposing causes. Almost all such cases come to necropsy, but often perfunctorily and often without a report of results to the doctor. On the other hand deaths more than 24 hours after surgical operation, in which there may well have been misjudgment or a fault in technique, are not reported.

Is there not a somewhat artificial distinction between hospital and coroner for historical, but to-day invalid, reasons? Should not all consultant pathologists be recognized as reliable, scientific, independent assessors, and should not coroners' necropsies be part of their duties and not rewarded with a special fee?—I am, etc.,

London W.2.

R. B. WOODD-WALKER.

Antidepressant Drugs and Liver Damage

SIR,—Following a letter by Dr. William Sargent on the above topic (14 March, p. 694), I thought it justifiable to refer briefly to the following case.

The patient was a man aged 38, who had been treated by myself with phenoxypropazine ("drazine") for several months. He then developed a severe jaundice and was admitted to this hospital under the care of Dr. J. Vallance-Owen. Dr. Vallance-Owen and I to begin with felt that his was probably a drug-induced jaundice. How-

ever, a liver biopsy was performed and the report (by Dr. R. Schade) reads as follows: "The specimen consists of a cylindrical piece of liver tissue. Histologically this shows a *severe infective hepatitis*. There is evidence of some bile thrombi."

This case occurred in July 1962. Clearly, if this man had died without full investigation a coroner might well have said that his death was due to phenoxypropazine. The man made an uneventful recovery, being treated with steroids, and has remained well since. So frequently a patient is quoted as having developed jaundice due to one of the antidepressant drugs, and equally frequently there is no very good pathological support for such a conclusion. This, at least, is one case where the pathological evidence tends to exonerate the drug.—I am, etc.,

ROBERT ORTON.

Department of Psychological Medicine,
The Royal Victoria Infirmary,
Newcastle upon Tyne 1.

SIR,—I hesitate to contribute further to this lengthy correspondence, but some reply is needed to the comments on my letter (25 January, p. 237) made by Dr. William Sargent (14 March, p. 694) and by Dr. Edward V. Bevan (29 February, p. 562).

My father may well have taught that barbiturates could cause liver damage as they are partially detoxicated in the liver; but such damage is far more likely in cases of established liver disease, such as cirrhosis, and in those cases of prolonged administration where virus hepatitis may supervene. His phobia of the barbiturates was, however, mainly concerned with the commoner toxic effects on the brain and lungs, as is obvious when one studies his writings and addresses containing case histories. I have sent Dr. Sargent and Dr. Bevan reprints of the relevant articles on this subject.

One case is quoted of toxic hepatitis in an epileptic man aged 60 treated with phenobarbitone, 1½ gr. (97 mg.) daily for 18 months. In this case it is evident that he developed infective hepatitis, no doubt was made more seriously ill by the drug, and rapid improvement followed its withdrawal.¹

Let it not be thought that I am unsympathetic to Dr. Sargent's perplexities described in his letters concerning antidepressant drugs in general; and as a general physician I fully agree that psychiatry should be well represented on any committee dealing with drug safety, especially at a time when drugs are being used by psychiatrists and physicians more and more. Any doctor prescribing drugs must bear the responsibility for toxic and side-effects; and in view of the widespread prevalence of infective hepatitis in the community the profession deserves congratulation, rather than criticism, on the rarity of liver damage resulting directly or indirectly from their use.—I am, etc.,

Windsor, Berks.

PHILIP WILLCOX.

REFERENCE

- ¹ Willcox, W., *Proc. roy. Soc. Med.*, 1934, 27, 489.

SIR,—As a result of reports in the press and the activities of the Witts and Dunlop Committees, the number of drugs commonly prescribed for depression has shrunk from some ten preparations to one or two in the

past year. It is remarkable that this has been achieved without accurate proof of specific pathological damage by these drugs. It is more remarkable that the Witts and Dunlop Committees have issued guidance to the profession on these matters without including any psychiatrist among their numbers. This unusual attitude is placing psychiatrists in an extremely difficult position. It does not seem to be realized adequately enough that there are now more psychiatrists than general physicians, and that psychiatric disorders account for the bulk of general practice. It is most remarkable that this large area of medical practice should be dictated to by people who play no part in it.

Recently I was asked to see a patient who had been on "marsilid" (iproniazid) for three years, with a view to changing his medication because the Witts Committee had considered that the drug was not of proved therapeutic value and there was thus the possibility that the patient's general practitioner might have to bear the cost of prescribing it. I found that the patient's liver function was normal, but on the advice of the Dunlop Committee I forced him to go through an agonizing period of three weeks without any drugs before prescribing a modest dose of "tofranil" (imipramine). However, his mental state did not improve, and a few days later he developed an acute retention of urine and went into a general hospital. By chance I heard of this and contacted the surgeon in time to avert a prostatectomy and to point out that if he stopped the imipramine the normal urinary flow would be re-established. This patient remains depressed on an even more homoeopathic dose of imipramine than before.

Last year another depressed patient responded successfully to a course of "drazine" (phenoxypropazine) and his general practitioner continued to prescribe a maintenance dose of this drug. When the manufacturers withdrew phenoxypropazine from the market last summer in the light of unfavourable publicity this patient's medication ceased. He became depressed again, indeed he became grossly retarded, lost his job, and eventually entered a psychiatric hospital. Treatment with available antidepressant drugs had no effect. Eventually phenoxypropazine from unused dispensary stocks was supplied and the patient made a good recovery. He returned to work and attended my out-patient clinic. Since it is not possible for his general practitioner to prescribe this drug, I am reduced to carrying his monthly requirements from the dispensary store of my psychiatric hospital to the out-patient clinic, where I see him.

The Dunlop Committee is a British attempt to emulate the efficient American Food and Drug Administration. They ought to study the American practice in greater detail. It is not representative of internal medicine to the extent that the Dunlop Committee is. Its workers go out into the field and visit psychiatric hospitals. As an ordinary British psychiatrist I have had the privilege of meeting representatives of the United States Food and Drug Administration, but I have yet to hear of even an eminent British psychiatrist who has had the privilege of advising the Dunlop Committee.—I am, etc.,

Cane Hill Hospital, JOHN T. HUTCHINSON.
Coudsdon, Surrey.

SIR,—Dr. William Sargent (14 March, p. 694) implies that chlorpromazine jaundice does not exist. I have had close personal experience of a serious case of cholestatic jaundice which I have no doubt at all was due to chlorpromazine. A little personal involvement is really awfully good for the attitudes, and I now use in general practice other phenothiazines whose administration so far has not coincided with an outbreak of infective hepatitis.

By the same token I wonder whether Dr. Nathan S. Kline (14 March, p. 694) would have been quite so merry about "marsilid" (iproniazid), if he had been required to take some himself. His quoted figure of 1 jaundice in 10,000 is grossly at variance with other published figures of 1 in 600.

In an earlier letter (28 September, p. 806) Dr. Sargent states the need to give iproniazid to a selected hard core of patients. This seems a valid assessment of the balance of risks. Moreover, a physician of Dr. Sargent's acumen, experience, and authority may properly give any treatment he wishes. Not so when a junior registrar prescribes iproniazid in out-patients. Here at least the general practitioner should be informed so that additional observation may be kept. It is disconcerting to find, as I did recently, that a patient with "gastritis" had a large supply of iproniazid tablets. As it happens she thought they upset her and stopped taking them. Another case was similar. This raises intriguing thoughts as to conclusions reached regarding the efficacy of tablets that have not in fact been taken—but this, I suppose, should be the subject of another communication.—I am, etc.,

Sutton, Surrey.

E. SAPHIER.

Imipramine in Depressive Illness

SIR,—Dr. E. H. Hare and his colleagues (28 March, p. 818) by implication suggest that imipramine has little advantage over a placebo in depressive illness. Recently I treated a woman patient suffering from the outward manifestation of profound depression, of sudden onset on the fourth day of her puerperium. "Tofranil" (imipramine), 25 mg. thrice daily, was given. The mother, who in the morning rejected all help and sat in abject misery on the side of her bed taking no notice or interest in her baby, when visited later the same day, after she had taken only her second dose, was full of life and joy. Not a controlled trial, but effective.—I am, etc.,

S. W. VIVIAN DAVIES.

Camborne, Cornwall.

SIR,—Is the penny beginning to drop at last? Dr. E. H. Hare, Dr. C. McCance, and Dr. W. O. McCormick's finding that imipramine, and by extension the other "antidepressant" drugs, have no specific action on depression (28 March, p. 818) may indicate so. For years now psychiatrists—and British psychiatrists in particular—have effectively shielded themselves from the realities of their patients' problems and personalities by the diagnoses of "endogenous" and "involutional" depression on the one hand and the use of the antidepressant drugs on the other.

The terms endogenous and involutional—and involutional is as meaningless to clinical

picture as it is to aetiological significance—have been the boon of psychiatrists seeking clinical determinism without the necessity of looking at the patient further. It is precisely the application of the label endogenous which, if it exists at all outside true manic-depressive illness, is an uncommon entity—to what are in fact neurotic and/or reactive depressions which has led to the claims made for the efficacy of the antidepressants in endogenous depression. The phenomenon, however, which the clinician is really seeing is the amelioration of a neurotic condition in response to the sedative effect of the drug.—We are, etc.,

St. Loman's Hospital,
Palmerstown,
Co. Dublin.

IVOR W. BROWNE.
DERMOT WALSH.

Problems in Adoption

SIR,—I read Dr. J. G. M. Hamilton's letter (28 March, p. 834) with interest, although I did not hear the B.B.C. programme to which he refers.

It has been my experience that neither prospective adoptive parents nor medical practitioners consider the problems of adoption "in a very light-hearted and casual way," and I am sure that the case that Dr. Hamilton describes is very much the exception to the rule. On the contrary, I have been most impressed how seriously young couples consider the problems of adoption when they have discussed these with me as their family doctor.

It is right that the home conditions, financial position, and medical health of the prospective parents should be considered before adoption is agreed to; however, I think that we must be very careful that the assessment of the couple by the social worker is not allowed to become a veritable inquisition with three or four interviews (possibly with independent ones for husband and wife) and many exacting and intimate questions. I know of one couple who were much distressed by being put to such a procedure by a Scottish adoption society that they withdrew their application—to the loss I am sure of some little child.

Dr. Hamilton states that most of the best societies have fully qualified social workers. What is the qualification? Is it the best qualification for assessing adoptive parents? On what is the final assessment based? One could make a case that the best person to assess the problem is the mature woman who has herself brought up successfully one or more adopted children of her own.

I write this letter to make the point that couples who come forward to ask sincerely about adoption will probably be good adoptive parents, allowing that they qualify under the terms of the Adoption Act. Nothing can be sure; but nor is the happiness of a natural child with its own parents sure.

Because there are nowadays so many prospective parents wanting to adopt so relatively few babies it does not follow that the societies should go to extremes to assess the suitability or otherwise of the couple.

My wife and I have two young adopted children, so I write with "subjective" as well as "objective" interest.—I am, etc.,

Lasswade, Midlothian.

H. M. S. NOBLE.