out the addict's admission to hospital for a lengthy period of observation. Yet addicts cannot be compelled to enter hospital, nor to stay there. Addicts often discharge themselves prematurely from hospital, even if the doctor feels that with longer stay there may be a good chance of a recovery. Any wish on the patient's part to rid himself of his addiction may not prove strong enough to withstand the knowledge that he can easily obtain the drug as soon as he leaves the hospital. One also meets the addict who leaves hospital after his dose has gradually been much reduced, only to demand the original amount again outside hospital, leaving him in possession of much more than he requires for himself.

In 1961 the Interdepartmental Committee on Drug Addiction made certain strong recommendations.¹ One wonders whether, in the light of experiences in the meantime, it might not be advisable to put teeth into these recommendations and not just leave them at mere suggestion—quite apart from the need for research into prevention and treatment of addiction.—I am, etc.,

St. Bernard's Hospital, M. M. GLATT.
Southall, Middlesex.

REFERENCE

- ¹ *Drug Addiction: Report of the Interdepartmental Committee, 1961.* H.M.S.O.

SIR,—Few of us would attempt to define normality, but surely no experienced clinician or scientist would designate as normal those who require therapeutic agents to enable them to seem normal to themselves and others. Drugs are the equivalent of crutches and those who require them are suffering from a disability. There is a world of difference between a person who is reasonably happy, efficient, well adjusted, and symptom-free and one who is only temporarily in such a condition while under the influence of a drug. But few will disagree with the real point which Mr. R. Lefever (4 April, p. 911) makes—namely, that it is in the addict's best interests that the doctor should waive meticulous adherence to the ethic of "privacy of consultation" and check his prospective patient's history with the Dangerous Drugs Department of the Home Office before prescribing for him.—I am, etc.,

London W.1. ELLIS STUNGO.

Hodgkin's Disease at 83

SIR,—Although any disease may apparently be encountered amongst the aged it is unusual to meet examples of Hodgkin's disease in later life. The following case history shows that this condition may occur.

Mrs. A. B., a widow of 83, was referred to Queen's Hospital, Croydon, in December 1963 on account of weakness, fatigue, and anorexia. She gave a history of operations for hernia and cholecystectomy during the past 10 years. On examination she was mentally clear. Physical signs detected were few. There was some pallor; poor air entry at the base of the left lung; an apical systolic murmur; a blood-pressure of 125/85 mm.; and a palpable left lobe of the liver. Glands were palpable in the right supraclavicular fossa. The following investigations were completed before death. Haemoglobin was 64%; blood film showed slight polychromasia with hypochromia; the sedimentation rate (Westergren) was 42 mm. in 1 hour. Blood urea

was 66 mg. per 100 ml. The stools showed one positive result for occult blood. The provisional clinical diagnosis before necropsy was carcinoma of the stomach with secondary deposits in the liver and lymph nodes.

Necropsy.—At post-mortem examination the lungs showed basal congestion with some purulent bronchitis. There was slight atheroma of aorta and coronary arteries. The left ventricle was hypertrophied, with fibrosis in the upper part of the septum. The spleen was large and firm, with grey nodules in a dark red pulp. The liver also showed similar nodules. There were enlarged lymph nodes (to a size of 5 by 3 cm.) at the carina, the lower paratracheal group, the right supraclavicular area, and the head of the pancreas. Histology indicated that glands, liver, and spleen presented the appearance of Hodgkin's disease.

It is usually considered that Hodgkin's disease is commonest in young adults. Although it may occur later little is written about its upper age limit. The condition is rarely mentioned in textbooks of geriatric medicine. A. Mueller Deham quotes ten cases between 60 and 83 years old.¹ R. G. Monroe noted 16 cases in his series of 7,941 subjects.² All but five of these were between the ages of 60 and 70, while the oldest was 76. In Piggot's series of 2,221 subjects aged 65 and over, only two cases were found.³ One of these was a female aged 82, in whom the condition had been diagnosed some 22 years previously; the other was a male of 72. The present case, therefore, is one of the oldest recorded.

My thanks are due to Dr. D. J. O'Brien, pathologist to the Croydon group of hospitals, for his help in the morbid anatomy and histology of this case.

—I am, etc.,

St. John's Hospital, TREVOR H. HOWELL.
London S.W.11.

REFERENCES

- ¹ Monroe, R. T., *Diseases in Old Age*, 1951. Harvard University Press, Cambridge, Mass.
² Mueller-Deham, A., and Rabson, S. M., *Internal Medicine in Old Age*, 1942. Williams and Wilkins, Baltimore.
³ Piggot, A. P., personal communication.

Sulthiame in Epilepsy

SIR,—During the past three years we have carried out a trial of "ospolot" in the treatment of epilepsy and reported¹ briefly on the results in a group of 22 epileptic, subnormal in-patients, comparing the incidence of fits for a period of a year before and after the addition of ospolot to their previous treatment with phenobarbitone and/or phenytoin. The diagnostic categories were very similar to those of Drs. H. Garland and H. Sumner (22 February, p. 474): brain damage, 7 cases; hemiplegia, 2; idiopathic, 9; Sturge-Weber, 2; temporal lobe, 2.

Over the period the total annual number of fits fell from 338 before ospolot was added to 156 afterwards. In two cases of brain damage there was an increase in the number of fits. In this series the environment was kept as stable as possible during the trial. No side-effects were observed and most patients appeared to be more socially adaptable. Since then we have used the drug routinely in over 50 cases of epilepsy, always combined with phenobarbitone, with similar results.

It would have been helpful if Garland and Sumner had given more information about their patients, such as intellectual level,

environmental circumstances, personality, etc., in that such factors must be considered in assessing the efficacy of any treatment, rather than to regard such treatment as an exercise in toxicology.—We are, etc.,

T. S. DAVIES.

M. W. LEYSHON.

Llanfrehfa Grange Hospital,
Llanfrehfa, Cwmbran, Mon.

REFERENCE

- ¹ Davies, T. S., Leyshon, M. W., *Lancet*, 1963, 2, 939.

Factitious Strokes

SIR,—The recent letter (14 March, p. 697) by Dr. T. Lehoczy and Dr. D. Williams's paper "Vertebro-basilar Ischaemia" (11 January, p. 84) prompt me to record a case of factitious stroke.

A white woman, aged 63 years, was sent for admission as a case of right hemiplegia. By the time of her arrival at the hospital all weakness of the right side had disappeared, and an extensor plantar response was the only neurological abnormality noted. Retinal exudates were present, and the apex beat was displaced into the anterior axillary line. There was no evidence of valvular disease of the heart, and it was obvious that the recorded blood-pressure of 105/60 was incongruous with the cardiac size and retinal changes. E.C.G. examination revealed left ventricular hypertrophy, and transaminase was not elevated.

The blood-pressure rose spontaneously and the plantar response became flexor within 24 hours. The patient was rapidly mobilized. Further questioning revealed that she suffered from headaches, and for this complaint took some tablets which she had had by her for some years. Often she had transient weakness or blackouts after taking these tablets, and it is odd that she persevered with them. They had been prescribed for hypertension some years previously, and fortunately she remembered the name—"ansolysen" (pentolinium tartrate), 40 mg.

The blood-pressure stabilized about the 190/110 level, and there was no residual neurological deficit, but there was evidence of chronic nephritis.

It is felt that with potent medicines left lying in the bathroom cupboard for subsequent use in trivial complaints we must be on the lookout for new and bizarre syndromes—not iatrogenic in the usual sense, but the consequence of earlier medical endeavour.—I am, etc.,

Newcastle General Hospital, G. F. BAINES.
Newcastle upon Tyne 4.

Day-attendance Centres

SIR,—May I support Dr. T. C. N. Gibbens's suggestion for day-attendance centres as a means of reducing the number of persons remanded in custody for psychiatric reports (14 March, p. 691)? In 1960 Dr. D. J. West and his colleagues¹ published a valuable study in which matched samples of offenders, remanded for reports to prison and to London clinics, were compared and followed up. Their data showed *inter alia* that the choice between bail and custody was often arbitrary in relation to the characteristics of the individual offender. Just over a third of the prison cases were first offenders, the choice seemed particularly arbitrary for the less serious sex offenders. An incidental finding was that first sex offenders remanded to prison did better in terms of reconviction than their clinic counterparts. The study