against a College of Psychiatrists. It cannot be denied that it is desirable for a psychiatrist to have some postgraduate training and a higher qualification in organic medicine. I have never understood, however, why it is considered that this should be Membership of the Royal College of Physicians rather than a Doctorate of Medicine of a university. One rarely hears the other side of the argument. I consider that the ignorance of psychological medicine displayed by many general or organic physicians is a disgrace to our profession, and I look forward hopefully to the day when it will be essential for consultants in organic medicine, particularly those at teaching hospitals, to have a higher qualification in psychological medicine. A College of Psychiatry could afford facilities for our colleagues in organic medicine to obtain such a qualification.—I am, etc.,

London S.W.16.

F. H. TAYLOR.

SIR,—The proposed ballot on a College of Psychiatrists under the aegis of the Royal Medico-Psychological Association surely will not be satisfactory. Not all psychiatrists are members of this organization any more than all are Members of the Royal College of Physicians. One might expect that those who are members of the Royal Medico-Psychological Association will vote for a college formed by it, just as one might expect the M.R.C.P.s to vote for one under the Royal College.

The only fair method of discovering what is satisfactory to everyone is to hold a ballot in which all psychiatrists are invited to vote.—I am, etc.,

Chester.

CLIFFORD ALLEN.

Plasma Amylase after Gastrectomy

SIR,—I would like to congratulate Drs. G. K. McGowan and M. R. Wills on their paper (18 January, p. 160). The pertinence of their observations was brought home to me very recently when a man of 38 was admitted with abdominal pain and vomiting. He had had a Polya gastrectomy one year previously, the serum amylase was 8,000 Somogyi units/100 ml., and on clinical examination I came to a diagnosis of acute pancreatitis, probably of the haemorrhagic type—for the man was distended and very ill. To my surprise no methaemalbumin was present in the serum, and this should have led me to question my original diagnosis. Fortunately, the surgeon in charge of the case had decided that laparotomy was necessary. He discovered an internal strangulation due to a coil of small intestine passing behind the gastro-jejunal anastomosis. This in turn was causing obstruction of the afferent loop, with resulting peritonitis from the over-distended duodenal stump.

Your contributors' maxim that "a high plasma amylase after gastrectomy is not likely to be due to uncomplicated acute pancreatitis" will unquestionably prevent this type of mistake. Yet it must be remembered that uncomplicated acute pancreatitis does occur in patients who have had gastrectomy, for I have certainly seen one and possibly

two in my current series of 70 cases of acute pancreatitis.

The first was a moderately ill 38-year-old man who had had a Polya gastrectomy three years previously. His serum amylase was 2,000 units/100 ml., and the true diagnosis was facilitated by the presence of jaundice. Laparotomy a few days later confirmed the presence of gall-stone pancreatitis with no evidence of afferent-loop obstruction. The other case occurred within 24 hours of refashioning a Polya gastrectomy. Here the diagnosis was suggested by the onset of steady severe thoraco-lumbar back pain, and was supported by a significant glycosuria (orange to "clinitest") for two days. The highest serum amylase was 3,200 units/100 ml. The patient recovered on conservative treatment, so that I cannot exclude with certainty a mild afferent-loop obstruction (cf. Case 12 of McGowan and Wills); but whatever its aetiology he appeared to have uncomplicated acute pancreatitis. Both of these cases were of the oedematous variety, no methaemalbumin having been found in the serum.¹

Drs. McGowan and Wills have made a notable contribution to the interpretation of an elevated serum amylase in post-gastrectomy cases, but in the light of known causes of post-operative pancreatitis (e.g., operative trauma to the pancreas, etc.) the incidence of "false positives" in their series would seem to be unusually high.—I am, etc.,

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Phenacetin Abused

SIR,—Interest in phenacetin nephropathy, first described in 1953,¹ has recently been aroused by the report of the first case in the English literature by N. G. Sanerkin and C. M. Weaver (*B.M.J.*, 1 February, p. 288). The phenacetin had been taken in a proprietary preparation, of which there are 36 containing phenacetin in the current edition of *MIMS*. These drugs are frequently taken over long periods by patients with chronic painful disorders.

A man aged 61 was admitted to Chase Farm Hospital on 16 January 1964, under the care of Dr. T. Simpson, with a severe urinary infection. In the past he had had rheumatoid arthritis for many years, treated initially with gold injections, but never with steroids. He had had no treatment for 12 years bar "codis" tablets [each tablet contains codeine phosphate $\frac{1}{2}$ gr. (8 mg.), acetylsalicylic acid $\frac{3}{4}$ gr. (195 mg.), phenacetin 4 gr. (260 mg.), and caffeine $\frac{1}{2}$ gr. (33 mg.)], of which he had taken four a day for about that time. Culture of the urine grew *Proteus vulgaris*. Initially his haemoglobin was 90%, W.B.C. 11,000/c.mm. (77% neutrophils), E.S.R. 112 mm. in the first hour, blood urea 81 mg.%, acid phosphatase 1.8 K.A. units/100 ml., latex-fixation tests for rheumatoid arthritis positive to 1/20 dilution. There was no evidence of diabetes mellitus. In spite of the appropriate antibiotic therapy his condition deteriorated, and he died in uraemia six weeks after the onset of symptoms. Necropsy revealed bilateral papillary necrosis. There was no obstructive nephropathy.

Although the literature stresses that this condition is due to abuse of phenacetin, patients usually taking 15–20 tablets a day, this patient had taken no more than four a day; but the small daily dose may yet prove fatal when the duration of therapy is pro-

longed. This is particularly likely in patients with conditions like arthritis and chronic headache (which, of course, may be made worse by phenacetin and so willy-nilly lead to phenacetin overdosage). Furthermore, the renal lesion may occur in the absence of other signs of phenacetin poisoning, such as anaemia or methaemoglobinaemia. It is particularly important to recognize this cause of kidney damage, and that apparent low-dosage may cause it, for it may well be that it improves on stopping the drug. The condition is diagnosed by the appropriate history (which may be concealed) and characteristic clinical, radiological and pathological findings.^{2,3}—I am, etc.,

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H. S. JACOBS.

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- 1 Spühler, O., and Zollinger, H. U., *Z. klin. Med.*, 1953, 151, 1.
- 2 Reynolds, T. B., and Edmondson, H. A., *J. Amer. med. Ass.*, 1963, 184, 435.
- 3 Harrow, B. R., Sloane, J. A., and Lieberman, N. C., *ibid.*, 1963, 184, 445.

Doctor, Driver, and the Courts

SIR,—It is becoming increasingly difficult in certain areas to get doctors to examine the "drunk-in-charge." One doctor is reported to have said that unless they fall flat on their faces it is impossible to find their ability to drive impaired. I sympathize with this point of view. Indeed, if a man is so drunk as to be unable to stand, and therefore unable to co-operate in tests, and also has the misfortune (or good fortune) to have a small cut on his forehead, then his chances of being found guilty by a jury are remote. By the time the doctor has been in the witness-box for half an hour he also will be convinced that the man's condition was, of course, not due to alcohol at all but entirely due to his having hit his head on the windscreen. Supporting urine tests appear to make little impression on a jury. This is understandable when a barrister is able to quote a series of cases where a man with a much higher urine alcohol was considered to be "sober."

A great point is made by the defence and also usually in the summing-up that if there is the slightest doubt in the minds of the jury then it must quite rightly be given to the accused. I can imagine no case where after listening to accomplished speeches for the defence there is no doubt. If only those who plead guilty in magistrates' courts realized how much better are their chances in the quarter sessions then the number of convictions would fall drastically.

The ability of the "drunk-in-charge" to pull himself together temporarily is well known. There are, however, signs he is unable to control. These are slurring of speech, nystagmus, and usually the illegibility of his handwriting. One is not surprised to hear in court, of course, that the man had lost his teeth, forgotten his glasses, and also that he had been "a poor scholar at school." Romberg's test is of great value, but may be positive only after standing for longer than a minute. It is then surprising how many have to open their eyes to prevent their falling. I would go so far as to say that a man whose only positive sign is slurring of speech is unfit to drive. One can well imagine what would happen if one issued a positive