As I have written before, if these patients are told that stopping the tablets might ultimately improve their sleep and reduce their level of anxiety and if this is done sympathetically and with suitable explanation of what to expect they may become among the most appreciative patients a psychiatrist can have.⁷

SAMUEL I COHEN

Department of Psychiatry,
The London Hospital Medical College,
London E1 2AD

- 1 Tyrer P. Risks of dependence on benzodiazepine drugs: the importance of patient selection. *Br Med J* 1989;298:102-5. (14 January.)
- 2 Ashton H. Risks of dependence on benzodiazepine drugs: a major problem of long term treatment. *Br Med J* 1989;298:103-4. (14 January.)
- 3 Cohen SI. Overprescription of psychotropic drugs. *Br Med J* 1975;iv:1520-1.
- 4 Freeman H, Rue Y, eds. *The benzodiazepines in current clinical practice*. London: Royal Society of Medicine, 1987. (International Congress Symposium Series No 114.)
- 5 Cohen SI. Are benzodiazepines useful in anxiety? *Lancet* 1987;iii:1080.
- 6 Snaith RP. Benzodiazepines and dependence. *Bulletin of the Royal College of Psychiatrists* 1988 June 12:241-2.
- 7 Cohen SI. Benzodiazepines and dependence. *Bulletin of the Royal College of Psychiatrists* 1988 June 12:241.

Delirium tremens

SIR,—As two doctors who have recently been working in the busy emergency clinic of this psychiatric hospital we found the editorial by Dr Jonathan Chick most valuable.¹ From our experience there are several points worth emphasising.

We very much agree with Dr Chick that patients alone cannot be relied on to give an accurate account of their alcohol consumption—in fact it could be said that the risk of delirium tremens begins with “an admitted alcohol consumption” of zero grams a day. It would seem, however, that though the patient may seek to deceive the doctor, many cases are spotted late or never at all because the importance of visual hallucinations is not recognised and thus the history of alcohol intake is not pursued. In our first eight weeks of emergency practice we saw seven cases of delirium tremens that had been diagnosed by the referring doctor as various psychiatric states ranging from acute anxiety through affective disorders to schizophrenia. In only one was a history of abrupt alcohol withdrawal detected, though in all the striking feature of visual disturbance had been noted. Although visual hallucinations can occur in other psychiatric disorders, their presence strongly suggests an organic cause, in particular alcohol consumption.

Perhaps one way to make the lesson indelible would be for medical trainees to read Zola's *L'Assommoir* (1876), in which there is a clear and disturbing account of delirium tremens that was left untreated. The author also chronicles the social and emotional difficulties still to be found in the lives of patients living in the inner city, where alcohol abuse is rife.

ROGER HOWELLS
MATTHEW PATRICK

Maudsley Hospital,
London SE5 8AZ

- 1 Chick J. Delirium tremens. *Br Med J* 1989;298:3-4. (7 January.)

SIR,—One of the dangers of chlormethiazole not mentioned by Dr Jonathan Chick¹ is the fact that it contains no electrolytes.

Several years ago I saw a 48 year old man being treated for lobar pneumonia. He had three major convulsions followed by a cardiac arrest after four days of continuous intravenous chlormethiazole. His plasma potassium concentration was found to

be less than 2 mmol/l and after administration of potassium the seizures ceased. He had taken virtually nothing by mouth and his only other therapy over four days was parenteral antibiotics. His fluid intake had been judged adequate from the fluid balance charts, but this was all in the form of electrolyte free chlormethiazole.

NICK SAWYER

London N12 0AZ

- 1 Chick J. Delirium tremens. *Br Med J* 1989;298:3-4. (7 January.)

Mental illness in doctors

SIR,—The editorial by Dr Lyn Pilowski and Ms Geraldine O'Sullivan¹ “rang true” for members of the British Doctors' and Dentists' Group.

This independent self help group has been in existence since 1973 and has 10 autonomous regional groups. Attendances vary from 10 to 70, and some regional groups have separate sections for family members and also for teenage children. These subgroups, whose discussions are completely confidential, help coaddicts to detach themselves and grow in their own right. Dental practitioners were admitted to the group in 1977.

Members have suffered from addiction to mood altering chemicals from alcohol to opiates, via benzodiazepines, dihydrocodeine, coproxamol, etc. Growing together we have succeeded in rehabilitating ourselves, a task we could not accomplish alone. Life is fun and fulfilling now, instead of the hell it was. Our sobriety has ranged from 1 month to 32 years.

Doctors and dentists may contact us in complete confidentiality via the Medical Council on Alcoholism (telephone 01 487 4445) at 1 St Andrews Place, London NW1 4LD. Family members may contact the family group even if the addict or alcoholic shows no inclination to seek help for himself or herself.

ANONYMOUS

South West Branch of the British
Doctors' and Dentists' Group

* * This letter has been printed anonymously at the request of the writer because anonymity is one of the group's traditions. — ED, *BMJ*.

- 1 Pilowski L, O'Sullivan G. Mental illness in doctors. *Br Med J* 1989;298:269-70. (4 February.)

Autoimmunity: a risk factor for allosensitisation to blood products?

SIR,—The paper by Dr A S Wierzbicki and Mr D M Cousins¹ cannot be left unchallenged. Among three patients who had autoantibodies and a history of blood transfusions (as well as pregnancies in two) they found that two had multiple red cell alloantibodies (in one case with HLA antibodies); HLA antibodies alone were found in the third. From these findings they concluded that such patients might benefit from “more accurate crossmatching for minor blood groups to avoid the possibility of later delayed haemolytic transfusion reactions.” We interpret this suggestion as a recommendation for the provision of red cells matched for antigens other than ABO and Rh D. It is irresponsible to make this type of recommendation on the basis of isolated findings. The number of patients with autoantibodies of some kind is relatively high in the recipient population; if we were to supply them with phenotyped red cells matched for antigens other than D the cost of blood transfusion would be substantially increased with virtually no compensatory benefits.

It has long been known that patients with systemic lupus erythematosus² or with autoimmune haemolytic anaemia³ have a higher incidence of alloimmunisation after transfusion. The most important comment that should have been made on cases 1 and 3 is that the production of one red cell alloantibody may augment the immune response to other alloantigens; good responders to one red cell antigen (especially Rh D) are generally good responders to other red cell antigens.² The recommendations that should have been made for treating patients who developed red cell alloantibodies are: (a) if at all possible try to avoid transfusion; (b) if one or more red cell alloantibodies are found in a prospective recipient of blood use the most sensitive serological techniques to detect the presence of additional red cell alloantibodies; (c) give the patient a card with the specificities of any clinically significant red cell alloantibodies and keep the records in the hospital blood bank in case of subsequent transfusions. These measures are considerably more cost effective than the provision of fully matched blood.

The finding of HLA antibodies in case 2 is not surprising. The patient had received eight units of red cells and 12 units of platelets in the past. It is well known that HLA antigens are highly immunogenic and that many women develop HLA antibodies after only one pregnancy; previous transfusions given to this patient would have increased the chance of her developing HLA antibodies. A few inaccuracies need to be put right in the report of this case. HLA antibodies cannot be disclosed by crossmatching; as the patient did not respond to platelet transfusions her serum was screened by lymphocytotoxicity for HLA antibodies. Also, what the patient required was platelets matched for HLA before revision of her bone flap.

The authors have called attention to an association which is well known but have proposed inappropriate measures for dealing with the consequences.

MARCELA CONTRERAS

North London Blood Transfusion Centre,
Edgware,
Middlesex HA8 9BD

- 1 Wierzbicki AS, Cousins DM. Autoimmunity: a risk factor for allosensitisation to blood products? *Br Med J* 1989;298:95-6. (14 January.)
- 2 Mollison PL, Engelfriet CP, Contreras M. *Blood transfusion in clinical medicine*. Oxford: Blackwell Scientific, 1987.
- 3 Wallhermfechtel MA, Pohl B, Chaplin H. Alloimmunization in patients with warm autoantibodies: a retrospective study employing 3 donor alloabsorptions to aid in antibody detection. *Transfusion* 1984;24:482-5.

Coronary flow reserve and the J curve

SIR,—Dr P C Waller and colleagues¹ and Drs John Coope and Thomas S Warrender² in response to my paper³ have repeated much of what they said in letters in the *Lancet*.^{4,5} I therefore do not intend reiterating much of what I have said in past replies.^{6,7} At this point, when entrenched positions are being taken up, it is as well to attempt to reappraise the situation.

That a J curve relation between diastolic blood pressure and myocardial infarction exists in heterogeneous (including ischaemic) hypertensive populations is, hopefully, no longer an issue, particularly as the hypertension detection and follow up programme study of more than 10 000 hypertensive patients has just reported a J curve relation between reduction of diastolic blood pressure and mortality.¹⁰ What is under debate is the mechanism of this phenomenon. That a vital organ served by a severely stenosed artery should be critically dependent on perfusion pressure is pathophysiologically highly plausible. Such a concept has been readily recognised, without resort to large prospec-

tive studies, in renal artery stenosis and stroke. In renal artery stenosis injudicious lowering of blood pressure long term can decrease renal perfusion pressure with a resulting loss of renal function¹¹ and possible death.¹² Likewise, long term antihypertensive treatment in patients with cerebrovascular atheroma can cause a critical fall in cerebral blood flow,¹³ which may be accompanied by neurological symptoms and stroke.¹⁴ Raising the blood pressure in such cases can abolish transient ischaemic attacks,¹⁵ as occurred in the case reported by Dr Mark Oliver.¹⁵

It is difficult to understand why Dr Waller and colleagues and Drs Coope and Warrender are so resistant to the concept that in hypertensive patients with severe atheromatous narrowing of their coronary arteries, particularly in the presence of left ventricular hypertrophy, autoregulatory processes are impaired owing to a fall in coronary flow reserve. They prefer instead an explanation for the J curve for which apparently no evidence exists (to my knowledge) in the database of Dr Waller and colleagues.¹ Their graph of the coronary mortality versus diastolic blood pressure relation in ischaemic and non-ischaemic patients shows a clear J curve in ischaemic patients but only a blurred picture for the non-ischaemic patients.

As difficult to understand is the reluctance of Dr Waller and colleagues to countenance a simple, minor change in clinical practice in treating hypertensive patients with myocardial ischaemia (that is, a goal diastolic blood pressure (phase V) of 85-90 mm Hg instead of less than 85 mm Hg), which would almost certainly not harm the patient in terms of preventing stroke⁴ and might prevent death from myocardial infarction. A prospective study in well characterised hypertensive patients to confirm the retrospective observations of at least 10 studies would, of course, be welcome.

Drs Eoin O'Brien and Kevin O'Malley remind us¹⁶ that excessive lowering of nocturnal blood pressure might cause subendocardial ischaemia, as recently proposed by Floras,¹⁷ and contribute to the J curve relation between diastolic blood pressure and myocardial infarction. Even "dippers," however, have hypertension at night (with mean nocturnal blood pressures similar to mean daytime blood pressures of normotensive subjects),¹⁸ and nocturnal blood pressure seems to be an excellent positive predictor of organ damage (G Mancia, personal communication). Dr Morris J Brown correctly points out that hypertension itself may not be the cause of increased coronary risk, and a broader view should be taken incorporating other risk factors.¹⁹

Dr Lennart Hansson has suggested that the J point could lie anywhere between 0 and 89-90 mm Hg.²⁰ This view is surprising as three studies that have looked at two or more points below the J point have shown that the "step up" in the incidence of myocardial infarction occurs between 84 and 90 mm Hg diastolic blood pressure (phase V). To be more precise than this would require data on a massive number of end points. Dr Hansson's lack of concern about the mechanism of the J curve could lead to a flawed prospective study on an inappropriately low risk hypertensive population, a trap that he and his coworkers might well have already fallen into.

J M CRUICKSHANK

ICI Pharmaceuticals,
Macclesfield,
Cheshire SK10 4TG

1 Waller PC, Isles CG, McInnes GT. Coronary flow reserve and the J curve. *Br Med J* 1988;297:1606. (17 December.)
2 Coope J, Warrender TS. Coronary flow reserve and the J curve. *Br Med J* 1988;297:1607. (17 December.)
3 Cruickshank JM. Coronary flow reserve and the J curve relation between diastolic blood pressure and myocardial infarction. *Br Med J* 1988;297:1227-30.
4 Coope J. Heart attacks and lowered blood pressure. *Lancet* 1987;i:865-6.
5 Coope J, Warrender TS. Lowering blood pressure. *Lancet* 1987;i:1380.
6 Waller PC, Isles CG, Lever AF, McInnes GT. How far to lower blood pressure? *Lancet* 1987;ii:969.

7 Cruickshank JM, Thorp JM, Zacharias FJ. Heart attacks and lowering of blood pressure. *Lancet* i:1154.
8 Cruickshank JM, Thorp JM, Zacharias FJ. Lowering blood pressure. *Lancet* 1987;ii:223.
9 Cruickshank JM, Thorp JM, Zacharias FJ. How far to lower blood pressure? *Lancet* 1987;ii:695.
10 Cooper SP, Hardy RJ, Labarthe DR, et al. The relation between degree of blood pressure reduction and mortality among hypertensives in the hypertension detection and follow-up program. *Am J Epidemiol* 1988;127:387-403.
11 Hricik DE, Browning PJ, Kopelman R, Goorno WE, Madias NE, Dzau VJ. Captopril-induced functional renal insufficiency in patients with bilateral renal-artery stenoses or renal-artery stenosis in a solitary kidney. *N Engl J Med* 1983;308:373-6.
12 Speirs CJ, Dollery CT, Inman WHW, Rawson NSB, Wilton LV. Postmarketing surveillance of enalapril. II. Investigation of the potential role of enalapril in deaths with renal failure. *Br Med J* 1988;297:830-2.
13 Bertel O, Marx BE, Conen D. Effects of antihypertensive treatment on cerebral perfusion. *Am J Med* 1987;82(suppl 3B):29-36.
14 Strandgaard S. Autoregulation of cerebral blood flow in hypertensive patients. The modifying influence of prolonged antihypertensive treatment on the tolerance of acute, drug-induced hypotension. *Circulation* 1976;53:720-7.
15 Oliver M. Coronary flow reserve and the J curve. *Br Med J* 1988;27:1607. (17 December.)
16 O'Brien E, O'Malley K. Coronary flow reserve and the J curve. *Br Med J* 1988;297:1607. (17 December.)
17 Floras JS. Antihypertensive treatment, myocardial infarction, and nocturnal myocardial ischaemia. *Lancet* 1988;ii:994-6.
18 Mancia G, Ferrari A, Gregorini L, et al. Blood pressure and heart rate variabilities in normotensive and hypertensive human beings. *Circ Res* 1983;53:96-104.
19 Brown MJ. Coronary flow reserve and the J curve. *Br Med J* 1988;297:1607-8. (17 December.)
20 Hansson L. J curve relation between diastolic blood pressure and myocardial infarction. *Br Med J* 1989;298:52. (7 January.)

Time to let the patient speak

SIR,—Having read Dr J N Blau's article,¹ we thought that patients would take less time to describe their presenting problem in general practice than in a hospital outpatient clinic. We (a trainer and a trainee) therefore decided that we would each record the length of the initial speech of 50 consecutive patients seen in normal surgery hours in response to a general opening question such as, "What can I do for you today?"

The results showed that of 100 patients seen, only one patient managed to speak for more than two minutes and 87% spoke for less than a minute. The mean length of speech was 35 seconds, the mean value for the trainee being 27 seconds and that for the trainer being 45 seconds, which probably reflects the different age groups of the patients and their type of complaint—64% of the trainee's patients were under 30 compared with only 30% of the trainer's patients.

Dr Blau's patients spoke on average for 1 minute and 40 seconds. This difference is not surprising: for most patients this will be their first encounter with the specialist, who has no previous knowledge of them. They will often present a well rehearsed speech covering all the details of their complaint. In general practice the patient and some aspects of the presenting complaint are usually known to the doctor or the patient may be returning to discuss test results or request a service. In our study the longest initial speeches recorded were for problems such as depression, general malaise, or requests for advice.

Criticism is sometimes levelled at general practitioners for not giving their patients sufficient time. It would seem from this brief study that most of our patients do not require much time to state their problem. Allowing them to do this

Length of speaking by 100 patients

	Length of speaking (s)						Mean time
	<15	15-29	30-59	60-89	90-119	>120	
Trainer	6	15	18	8	2	1	45
Trainee	6	22	20	1	1	0	27
Total	12	37	38	9	3	1	35

uninterrupted should not increase consultation times but might increase patient satisfaction—it may at least be worth a try.

B OLSBURGH
DIANA M JELLEY

Whitley Bay,
Tyne and Wear NE26 2ND

1 Blau JN. Time to let the patient speak. *Br Med J* 1989;298:39. (7 January.)

Aluminium accumulation and immunosuppression

SIR,—Dr K P Nordal and colleagues suggested that the accumulation of aluminium in transiliac bone was associated with a reduction in the incidence of episodes of renal allograft rejection.¹ We have previously commented on patients with subclinical or mild forms of aluminium encephalopathy who became frankly encephalopathic after successful renal allograft transplantation² owing to the mobilisation of aluminium in tissue.³ Interestingly, we noted that these patients had an appreciable reduction in the number of acute episodes of renal allograft rejection but had a high mortality due to infection.

We subsequently followed up 58 patients after successful renal allograft transplantation (mean follow up 11.8 months, range 6-15). Urinary aluminium excretion was used as a marker of tissue aluminium accumulation, as we think that this best reflects the amount of aluminium that is freely available for mobilisation. The total aluminium content includes precipitated aluminium complexes that cannot be mobilised. The patients were divided into two groups on the basis of the number of rejection episodes diagnosed on Tru-Cut graft biopsy, fine needle aspiration cytology, and trough concentrations of cyclosporin. Twenty eight patients had one or no rejection episodes and 30 had two or more. The two groups did not differ significantly in age or sex, the type or duration of dialysis, or the prescription of phosphate binders containing aluminium. The median daily urinary excretion of aluminium was greater in the group with one or no rejection episodes than in the group with two or more during the first year after transplantation (table). Renal function as assessed

Urinary excretion of aluminium (μmol/24 h) after successful renal allograft transplantation. Values are medians (ranges)

Time after transplantation (months)	Rejection episodes	
	0 or 1	≥2
0-3	2.8 (0.6-25.1)	1.8 (0.2-6.6)**
4-6	2.5 (0.7-14.3)	1.4 (0.3-6.2)*
7-9	1.9 (0.9-12.4)	1.1 (0.5-3.1)*
10-12	1.8 (0.5-9.4)	1.0 (0.1-3.3)*

*p<0.01, **p<0.001, Mann-Whitney U test.

by measurements of 24 hour creatinine clearance was not significantly different between the groups. These data support the argument that the mobilisation of aluminium after successful renal allograft transplantation affects the immune response and results in fewer acute episodes of allograft rejection.

We have also reported that bacterial infections may result in a release of aluminium from tissue