can behave naturally and fearlessly, as Dr. Latham pointed out.—I am, etc.,

London W.1.

G. DALLEY.

Oral Contraceptives and Alopecia Areata

SIR,—We are interested in the report by Dr. Rosamund Vallings (23 October, p. 1005) concerning three patients who developed alopecia areata shortly after commencing oral contraceptives. We note that this report has already provoked further correspondence in your journal. We would like to make the following comments:

(1) The remarks of Dr. H. Hill (6 November, p. 1124) are well taken; alopecia areata is of course a relatively common condition in women of child-bearing age, so that an occasional case developing shortly after commencement of an oral contraceptive drug is to be expected.

(2) In our own rather extensive experience with alopecia areata we have not been impressed that such cases occur more frequently than would be anticipated by coincidence.

(3) We too have a few cases of alopecia areata developing in women who have been on oral contraceptive drugs for a longer or shorter period, and the course of the disease in response to treatment in these cases is in no way remarkable as compared with alopecia areata in women not on such drugs.

(4) We have a larger number of cases of alopecia areata in women who initiated oral contraceptive drugs after onset of the alopecia. In none of these cases were we impressed by any detrimental or beneficial effect of such hormones on the status of the hair loss.

(5) There have of course been a number of extensive series of cases of alopecia reported over the years, and in such series the influence of pregnancy is in no respect clear cut. We ourselves have found cases which regularly improve during successive pregnancies, and others which seem to exacerbate in pregnancy. If pregnancy can in some respects be equated with oral contraceptive medication, these observations are also of interest in connexion with Dr. Vallings's report.—We are, etc.,

NORMAN ORENTREICH.
ROBERT A. BERGER.

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New York.

Cot Deaths

SIR,—The attitude of the *British Medical Journal* to the Ministry of Health Report (No. 113) "Enquiry into Sudden Death in Infancy"¹ is puzzling.

A leader on the physiology of lactation (13 November, p. 1137) when citing reasons for breast-feeding made no mention of the report's recommendation that infants should be breast-fed for the first two weeks of life.

The leader (11 December, p. 1384) on child deaths and infection, while mentioning the report, omits any mention of this recommendation or of the reason for it—hypersensitivity to cow's milk. This has been shown² to have as one of its symptoms chronic or recurrent respiratory infections. The paragraph concludes, "There is in fact no evidence that these cot deaths could be

prevented by either parents or family doctors."

Thus the *B.M.J.* has appeared to question the reliability of the suggestions made by the Ministry of Health and by the authors of the report. The Editor should correct this position.—I am, etc.,

Belfast 9.

MARY N. M. PAULIN.

REFERENCE

- ¹ Ministry of Health Reports on Public Health and Medical Subjects No. 113: *Enquiry into Sudden Death in Infancy*, 1965. H.M.S.O., London.
- ² *Brit. med. J.*, 1963, 1, 561.

Tonsillectomy

SIR,—Further to the article and correspondence on tonsillectomy in the *B.M.J.*, I wonder if Mr. A. B. Alexander (29 January, p. 294) would not agree that the anaesthetist (who should be experienced and capable) is possibly a better person than the surgeon to keep a watchful eye and attentive ear concentrated on the patient recovering from tonsillectomy operation.

Having anaesthetized many thousands of children without immediate serious post-operative incident, I always keep patients just outside the theatre door until they cough and swallow. I insist on a senior nurse taking the patient back to the ward or recovery room, and she is not allowed to go from the theatre precincts until told to do so by me. Needless to say, a sucker is also readily available in the theatre and in the ward.

I agree with Mr. Alexander about pre-medication, and I have found a dose of $\frac{1}{2}$ –1½ gr. (32–97 mg.) of Nembutal (pentobarbitone sodium), according to body weight, effective with most children without abolishing their cough reflex.—I am, etc.,

H. J. RICHARDSON.

Peterborough Memorial Hospital,
Peterborough.

SIR,—Your leading article (4 December, p. 1321),¹ the article by Mr. H. B. Holden and Dr. J. J. Maher,² and the correspondence which has followed concerning bleeding after adenotonsillectomy are of the utmost interest, especially since fatalities following this operation are so particularly tragic.

All the authors are agreed that the operation of adenotonsillectomy should not, nor can it, be considered a minor one. This being so, and the operation being on a part of the airway, it is logical to suggest the use of an endotracheal tube. Ayre³ suggests that the use of an endotracheal tube for this operation is "nearly always unpopular with the operator." This I challenge. Where a Doughty gag and connexion are used, and where the surgeon with the assistance of the anaesthetist has persevered and overcome the slight technical difficulties of placing the gag and tube correctly, there is nothing but satisfaction. The advantages of endotracheal intubation are, among others, complete control of the airway, preventing gagging, straining, spasm, etc.^{1,2}; conservation of expensive vapours⁴; and also the reduction to an irreducible minimum of vapour—ether or halothane—inhaled by the surgeon, the benefit of which is to be experienced to be believed.

Ballantine⁵ suggests that "intubation should be performed after adequate anaesthesia with ether has been achieved." But

why? It is standard practice to-day to pass endotracheal tubes under conditions of total paralysis using a muscle relaxant. This is both less traumatic and less "toxic" than using ether anaesthesia. It is also standard practice to induce anaesthesia with a barbiturate intravenously prior to intubation, and to maintain anaesthesia by paralysis and controlled respiration.

The result of using such a technique is that the airway is always under control³⁻⁵: there is always "a little in hand for contingencies."³ Recovery of all reflexes and consciousness (response to the spoken word) is achieved before the patient leaves the theatre—which takes care of the second hazard mentioned by Zwiefach and Ransome,⁶ and should satisfy Ayre's request for "early recovery of consciousness."³

Holden and Maher made the point that there was no statistical difference in blood loss using ether or halothane anaesthesia. It would be interesting to know whether there is any difference between ether or halothane and the technique I have outlined.

I challenge the statement made by Holden and Maher, "that induction of anaesthesia with halothane and maintenance with ether would be the ideal method" of anaesthesia for adenotonsillectomy, using a Boyle-Davis gag, whether from the point of view of operative blood loss, safety, or convenience.—I am, etc.,

Woking, Surrey.

D. C. HUGHES.

REFERENCES

- ¹ *Brit. med. J.*, 1965, 2, 1321.
- ² Holden, H. B., and Maher, J. J., *ibid.*, 1965, 2, 1349.
- ³ Ayre, P., *ibid.*, 1965, 2, 1486.
- ⁴ Hawksley, M., *ibid.*, 1966, 1, 46.
- ⁵ Ballantine, R. I. W., *ibid.*, 1966, 1, 47.
- ⁶ Zwiefach, E., and Ransome, J., *ibid.*, 1966, 1, 46.

Droperidol and Monoamine-oxidase Inhibitors

SIR,—The potentiation of the effects of other drugs by monoamine-oxidase inhibitors has frequently been reported: for example, of sympathomimetic agents, rauwolfia alkaloids and guanethidine, imipramine, and analgesic drugs such as pethidine and morphine. Barbiturates, alcohol, cheese, game, some wines, especially Chianti, broad beans, and meat and yeast extracts have also been implicated.

Droperidol (a butyrophenone compound) is a neuroleptic agent and the potentiation of this drug by phenelzine (Nardil) is now reported.

The patient was a 61-year-old male, otherwise fit (weight 12 stone 10 lb. (81 kg.), B.P. 160/100 mm. Hg, haemoglobin 16.3 g./100 ml.), who was about to undergo an operation for a detached retina of two months' duration. He had been on phenelzine 15 mg. t.d.s. and perphenazine 2 mg. t.d.s. for five months for a depressive illness, these drugs being discontinued four days previously. Premedication consisted of tab. Droperidol 20 mg. and tab. hyoscine 0.4 mg. by mouth two hours previously. He was placed on the operating table, and appeared adequately sedated. Eight to ten minutes later he was noticed to be pale, sweating profusely, and slightly cyanosed. He complained of feeling "clammy and sticky," but not of nausea. His blood-pressure was 75/60 mm. Hg and pulse 60 per minute. He at no stage appeared excitable, nor was his respiration noticeably depressed. The operation was postponed, and he was returned to bed. The blood-pressure rose gradually over 45 minutes to 115/80 mm.