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.

Orentreich Medical Group,
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.

Hg, the pulse remaining about 60 per minute throughout. At this stage he fell asleep. Although his blood-pressure continued to rise slowly, it did not regain the pre-operative figure for 36 hours.

Eleven days later (15 days after discontinuing phenelzine) and following the same premedication, his retinal detachment was operated on, this time without any hypotensive episodes.

Though the patient was also taking perphenazine for an equal time, it is considered that the phenelzine, with its known action in potentiating other drugs, was the agent responsible.—I am, etc.,

G. NAPIER PENLINGTON.

Addenbrooke's Hospital,
Cambridge.

Dilated Pupils in Cardiac Arrest

SIR,—Persistent dilatation of the pupils during cardiac resuscitation following cardiac arrest is often considered an indication to stop any further resuscitative procedures.¹ While this may be true of some cases, it certainly does not hold for all.

Following a myocardial infarction, cardiac arrest is most likely to occur in the first 24 hours. Such patients may have been given morphine during this time, which will prevent dilatation of the pupils. I have seen cases of cardiac arrest in patients not given morphine, in whom the pupils were small and remained so after resuscitation measures had failed. I have also seen patients with cardiac arrest who at the onset of arrest had widely dilated and fixed pupils yet nevertheless recovered following resuscitation. The pupils remained the same size and decreased only very slightly following recovery.

If adequate resuscitation (which includes oxygen through an endotracheal airway, external cardiac massage with the production of a palpable peripheral pulse, rapid correction of acidosis, defibrillation with or without the administration of procainamide when indicated, and external cardiac pacing when indicated), started within four minutes of an arrest and maintained continuously for 30 minutes, does not produce sinus rhythm or return of consciousness or an adequate circulation maintained by electrical pacing when indicated, there is little point in continuing, regardless of pupil size. In cases of ventricular fibrillation which fail to respond to defibrillation even after the correction of acidosis and administration of procainamide, chances of success after 30 minutes of resuscitation are virtually nil.

The pupils are of no real help, except that with a dilated pupil it is easy to look for "tracking" in the retinal blood-vessels.—I am, etc.,

Radclyffe Infirmary,
Oxford.

K. D. BARDHAN.

REFERENCE

- ¹ *Brit. med. J.*, 1965, 2, 1135.

Strangulated Cloquet's Hernia

SIR,—The record of a case of strangulated Cloquet's hernia by Mr. J. H. H. Webster (22 January, p. 215) prompts me to mention a case of my own which I operated on several years ago while a surgical registrar in a civilian hospital.

An elderly lady presented with a painful lump in the right groin and obstructive symptoms. A diagnosis of strangulated femoral hernia was made, and at operation a typical femoral hernia was revealed, containing some omentum but with little evidence of strangulation. This seemed insufficient to account for her fairly severe symptoms. On further exploration I felt another lump, deeper in the wound, and dissection revealed a second hernia lying between the pectineus fascia and muscle.

This Cloquet's hernia contained a small strangulated loop of ileum which recovered on reduction. The sac was also removed easily and was quite separate from the normal femoral sac. The patient recovered without incident.

In a rare condition I think this combination of circumstances is possibly unique—a Cinderella, as Mr. Webster observes.—I am, etc.,

R. D. H. PARKER.

British Military Hospital,
Rinteln.
British Forces Post Office 29.

Cuffed Gastric Tube for Neonatal Respiratory Resuscitation

SIR,—The article by Mr. G. F. Williams and Dr. W. H. Beasley (9 October, p. 860) was interesting reading, but it's difficult to imagine all of us general practitioners having to hand the gadget he describes, in a reasonably clean state, at the critical moment.

I found that if the right thumb is pressed firmly upwards and slightly to the right of the midline—much as one uses the left thumb when palpating for a tender gall-bladder—and the remainder of the thenar eminence kept in close contact with the "theoretical position" of the stomach, most of the air forced in through the mouth and nose would not inflate the stomach to nearly the same degree. I agree that the pressure required would, in a fully conscious and older subject, be ill-tolerated—but I have not let this deter me, since one is faced with an either/or situation.

There's room for a little thought here—a little foolproof spring-loaded tracheotomy gadget might, in the end, prove far easier and faster for the average general practitioner, instead of the syringe, pipes, and balloon.—I am, etc.,

Kuala Lumpur. HUGH A. L. WAGNER.

Deafness in Otitis Media

SIR,—I was most impressed by the article on deafness in otitis media (8 January, p. 75). If, as one may presume, the patients were a cross-section of the population of the United Kingdom, then more than 32,000 children under the age of 11 years must be acquiring some deafness each year. Of these 8,000 would "suffer permanent damage to the hearing in both ears." This is quite frightening, as we see a large number of cases of acute otitis media every year.

Unfortunately Mr. J. F. Neil doesn't tell us the exact treatment carried out. Is it possible that penicillin was given in high dosage and over a long period, thus accounting for the better results than those obtained

by Lowe *et al.*,¹ who used intramuscular penicillin (Triplopen) on alternate days for a week? This treatment is also recommended by Harrison.² This method is not popular with the child or the general practitioner. More recently I have used oral penicillin V in full dosage, four times a day (six-hourly is impractical, because mothers won't wake a sleeping child for more than a night or two), for at least ten days and even longer, dependent upon the look of the drum, which I insist on examining every five days or so. This I have believed to be adequate therapy.—I am, etc.,

Boston, Lincolns.

FRANK WALT.

REFERENCES

- ¹ Lowe, J. F., Bamforth, J. S., and Pracy, R., *Lancet*, 1963, 2, 1129.
² Harrison, D. F., *Medical Recording Service, College of General Practitioners*, 1965.

Hospital Records

SIR,—This group is investigating all aspects of the composition and handling of case records in both hospital wards and out-patient clinics; and also considering possible means of coping with the increasing strain on storage facilities for these records.

Recent correspondence regarding the Tunbridge Report¹ on the standardization of case sheets indicates that there is a widespread interest in the whole subject, and that widely differing opinions on it are held.

I should therefore be glad to receive any such views, and should also welcome information concerning the present position in other centres.—I am, etc.,

J. H. MITCHELL,
Director.

Medical Records Research
Group (Nurec),
Western Infirmary,
Glasgow W.1.

REFERENCE

- ¹ *The Standardization of Medical Records*, 1965. H.M.S.O., London.

Morbidity Following Radiological Procedures

SIR,—Although a very large number of x-ray examinations are carried out in this country every year, the incidence of major complications is very low indeed and individual radiologists see few cases. In order to obtain an overall picture of the incidence of such complications in this country I am at present undertaking a national survey.

I have already written personally to approximately 600 radiologists asking for details of major complications occurring during 1965. In some cases, however, the radiologist may be unaware of delayed morbidity or long-term effects. If any clinician has details of such cases, it would be helpful if he could inform the radiologist concerned. Where this is not feasible, the information could be sent direct to me. I should also be pleased to receive communications on this subject from any radiologists who may not have been included in the survey.

I would emphasize that all information will be treated in a strictly confidential manner.—I am, etc.,

GEORGE ANSELL.

Department of Radiology,
Whiston Hospital,
Liverpool.