a particular child should be visited whilst in hospital, or whether he should be protected from a distorted relationship with his natural mother, we have to consider the nature and circumstances of that particular mother-child relationship. Privation, deprivation, or distortion of such a relationship may be equally damaging, and all need to be considered in a preventive mental health programme.

Finally, may I comment upon Dr. Howells's study² of the prevalence of separation experience among emotionally disturbed children. This study failed to demonstrate an association between separation experience and maladjustment, but only as these were recorded in his study. In another longitudinal study³ in which a group of maladjusted children were identified and compared with a control group drawn from the same population the occurrence of hospital admission and the total number of hospital admissions were significantly greater in the maladjusted group. A detailed examination of the other separation experience of these children suggested that the circumstances rather than the fact of separation were critical, those separated under adverse circumstances being concentrated in the maladjusted group.

Whether on grounds of common humanity or of mental hygiene, hospital admission at any age is a resource to be used only when specifically indicated. The procedure can be greatly beneficial, but can also be harmful, and these effects may be short-lived or long-lasting. We can do a great deal to avoid unnecessary hospitalization, and where admission is necessary we can do much to ensure that the process carries maximum benefit and minimal damage.—I am, etc.,

The Royal Victoria Infirmary,
Newcastle upon Tyne. S. BRANDON.

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SIR,—I have been in close daily contact with disabled children at this hospital for a number of years. In many cases I have had the opportunity later to see them grow up into nice sensible well-adjusted adults. This experience leads me to believe that the ill-effects of hospitalization have been greatly exaggerated. My opinions are shared by the matron, the assistant matron, probably the whole of the nursing staff, and by the school-teachers working here. The headmistress, who has the unique opportunity to compare the atmosphere on our wards with that in a hospital with unrestricted visiting, tells me that it compares very favourably.

Mine is an unpopular view, and it might well be asked why we resist a change to unrestricted daily visiting. Could it do any harm?

The reasons are threefold. First of all there is the question of scientific truth. I do not believe that our children suffer irreparable psychological damage. Secondly, frequent visiting is a great strain for the parents and often disorganizes the life of the rest of the family completely. Thirdly, our patients are drawn from a very wide area. With the best will in the world, some parents

can visit only rarely. Because of the publicity which has been given to Dr. Bowlby's views, a feeling of guilt and anxiety is aroused in these parents. This is thoroughly unfair.—I am, etc.,

King Edward VII Hospital, Sheffield. E. G. HERZOG.

Hallucinosis on Combined Methyldopa and Pargyline

SIR,—Three years ago attention was drawn^{1,2} to the occurrence of acute excitement in experimental animals given methyldopa after pretreatment with the monoamine oxidase inhibitor pargyline (*N*-benzyl-*N*-methylprop-2-ynylamine hydrochloride). The use of such a combination in humans was regarded as contraindicated. A patient is now reported who developed a vivid hallucinosis while on the combination.

The patient was a 55-year-old widow, living alone. She was described by a son as having always been a simple-minded person, with little knowledge of outside affairs. Eleven years before she had herpes zoster of the ophthalmic division of the right Vth nerve; there was no previous history or family history of psychiatric illness. One year before admission she complained of headaches, dizziness, and buzzing in her ears, which sometimes sounded like whispered conversation. Her general practitioner found her blood-pressure to be 230/120 mm. Hg and started her on pargyline, gradually increasing to 25 mg. q.d.s. Her blood-pressure fluctuated, the tinnitus diminishing when it fell. Six weeks before admission, because her blood-pressure was still 210/110 mm. Hg, methyldopa, 250 mg. daily, was added to the pargyline, and two weeks before admission the dose was increased to 250 mg. b.d. A few days before this dose increase she began to experience visual hallucinations, in colour, which she accepted as real. They were mainly of people and faces, and included the faces of children and women peering over a fence into her garden, men on her wardrobe, people in a boat, and a priest rolling back the ceiling like a carpet. They were present equally by day and night; during the two and a half weeks for which they persisted she was able to look after herself and her house up to her usual high standard and there does not appear to have been any significant clouding of consciousness. Ultimately she was referred for a psychiatric opinion and admission was arranged, both drugs being stopped just before admission.

On admission her blood-pressure was 155/90 mm. Hg, with clinical evidence of left ventricular enlargement, later confirmed radiologically, a trace of ankle oedema, which rapidly subsided, and mild bilateral deafness of nerve type. She was able to give a fairly clear account of her symptoms, and was fully orientated with no evidence of clouding of consciousness. No further hallucinations occurred after admission. Psychological testing showed an I.Q. of 76, with doubtful evidence of organic deterioration. She was initially treated with thioridazine, 25 mg. t.d.s., which was later stopped. On treatment with pargyline in doses increasing to 25 mg. t.d.s. the blood-pressure fell to 110/60 mm. Hg, without, however, any recurrence of the hallucinosis or deterioration in repeated psychological testing; it was thought advisable to stop treatment before she was discharged, without any symptoms.

In view of the tolerance of relative hypotension, it would appear unlikely that this was responsible for the hallucinosis. It seems more probable that this involved a cerebral action of the drugs, either methyldopa alone, on which hallucinations have been previously reported,^{3,4} or the combination with pargyline. There is other evidence² that the effects of

such a combination may be mediated via increased levels of free cerebral catecholamines released from their binding sites.—I am, etc.,

Cane Hill Hospital,
Surrey.

E. S. PAYKEL.

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Parotid Gland Enlargement and the Insulin-oedema Syndrome

SIR,—I was most interested to read the letter from Dr. R. D. Lawrence (11 December, p. 1432) regarding evanescent parotitis in diabetes. There are indeed few references to this problem in the general medical literature, nor is it mentioned in current books on diabetes mellitus. It is, however, a condition with which we are very familiar in Uganda, and to which we are at present drawing attention. We not frequently encounter sudden parotid enlargement in diabetics on insulin therapy, and this may be sufficiently acute and severe to be diagnosed as mumps. The swelling is usually bilateral and equal, and the glands are usually smooth, tense, tender, and painful. The swelling may subside completely within a matter of weeks or months, or on the other hand may take several years to disappear completely.

In a review of the clinical pattern of diabetes mellitus seen in patients at this hospital over the period 1950–61 it became evident that an oedema syndrome was occurring in about 3–5% of diabetics on insulin treatment, and that parotid gland enlargement was one of the features of this insulin-oedema syndrome. The other features include weight increase, facial and limb oedema, hepatic enlargement and tenderness, and occasionally a raised jugular venous pressure and pulmonary oedema. In 10 of the 17 subjects described in the initial report of this condition¹ parotid gland enlargement was observed. In three subjects this was present before insulin therapy, but in two of these three there was a marked increase in gland size associated with the onset of oedema. In one of these three subjects there was an episode of acute painful parotid enlargement at a later date, without oedema but associated with an increase in insulin dosage and hypoglycaemic symptoms. In three subjects the enlargement of the parotid glands occurred during the oedema syndrome in close association with the oedema and weight increase. In three others the gland enlargement was associated with sudden weight gain without oedema, while on increased insulin dosage.

This oedema syndrome is almost invariably associated with the use of insulin, and there is a striking tendency in these subjects to hypoglycaemia. The condition appears to have been recognized some forty years ago,^{2–4} but no reference is made to parotid gland enlargement, although Duncan⁴ does describe a characteristic "insulin facies."

It seems likely that this condition, in which parotid enlargement may be a lone manifestation or occur as part of a more complete syndrome, may at present be frequent in areas such as Uganda, where a combina-

tion of irregular dietary patterns and consequent insulin overdosage is present. The mechanism is likely to be concerned with glycogen deposition, and associated fluid retention or an adreno-cortical mechanism may be concerned in the more severe and acute cases.—I am, etc.,

Makerere University
College Medical School,
Kampala, Uganda.

A. G. SHAPER.

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Trial of Salmocid

SIR,—I am dismayed that Salmocid is still being marketed in Great Britain. About one year ago we decided to do a clinical trial comparing the use of neomycin and Salmocid for the pre-operative preparation of the bowel. Before proceeding with the proposed clinical trial it was felt wise to carry out some preliminary tests on monkeys. One group of three rhesus monkeys was given Salmocid in a dosage of 1 g. b.d. by nasogastric tube, and another group of three received neomycin in the same dosage. Rectal swabs were obtained daily and cultured on blood agar, salt agar, and McConkey's medium.

The normal bowel flora proved to be chiefly coliforms, proteus, and yeasts. After two days' therapy, greater reduction in colonies was noted with neomycin than with Salmocid. During the next two weeks' therapy the swabs of the monkeys on neomycin therapy cultured mainly yeasts, whereas those of the Salmocid group showed a mixed growth of proteus, coliforms, and staphylococci. On discontinuing the drugs all the monkeys in the Salmocid group developed coagulase-positive staphylococci in their stools—none appeared in the neomycin group. In view of these experimental results it was considered unwise to embark on any clinical trial of the drug.

I communicated these findings to the manufacturers of Salmocid and was informed that they had decided on 30 April 1965 "to discontinue Salmocid because the clinical results were not constant, nor in keeping with the *in-vitro* tests."—I am, etc.,

GEORGE W. JOHNSTON.

Department of Surgery,
University of Belfast.

. We referred Mr. Johnston's letter to Geistlich Sons Ltd., Pharmaceuticals, and have received the following comment from their General and Sales Manager, Mr. G. M. Jackson:

"It is true that in April 1965 a decision to discontinue Salmocid was made. However, within days we received two favourable reports, one giving excellent results when combined with nitrofurantoin, the other an interim report of a British double-blind Salmocid/neomycin trial. This latter is not being liaised by this company.

"Until more satisfactory trials in statistically significant numbers were available it

was decided to discontinue the *promotion* of the product. In fact in January 1966 only seven packs of 50 Salmocid tablets left here.

"Before Salmocid was marketed all the usual small animal studies gave excellent results. Large animal work is progressing which is expected to produce confirmation of Mr. Johnston's findings or a successful dose pattern.

"When this evidence is available we shall be able to make a firm decision whether or not Salmocid is less clinically efficient than the accepted drugs available."—ED., *B.M.J.*

Resuscitation of the Apparently Dead

SIR,—Your correspondent Dr. J. Zeitlin (5 February, p. 357) may not easily get his question answered on humans, but I have one of the fittest and most intelligent dogs I have known, aged 4 years, who was stillborn. His birth was delayed over two hours and when he appeared he had clearly been "drowned" some time before. I sucked him out, pumped his rib cage (laterally in dogs not ventrally), and did mouth-to-mouth breathing for a very long 15½ minutes (such a puppy is at this time completely sterile), when he jerked a leg. One minute later he opened his mouth wide and since then he has never looked back. My wife directed heat on him while this was proceeding.—I am, etc.,

S. L. DRUMMOND-JACKSON.

London W.1.

Immunosuppression by Splenectomy and Lymph-node Irradiation

SIR,—Dr. J. R. Wheeler and associates described an improvement in immunosuppression by splenectomy and intralymphatic lymph node irradiation with colloidal gold (7 August, p. 339). Some modifications of this method may be useful.

The major portion of the lymphoid tissues in the dog are located in the visceral lymphatic system, composed mainly of the mesenteric lymph nodes. These nodes can be irradiated by two methods of intralymphatic injection: direct injection into visceral lymph nodes, or retrograde injection via the parietal lymph system.

Takashima and Benninghoff have shown, with Ethiodol lymphography in dogs, that after the thoracic duct is sclerosed by sodium tetradecyl sulfate (Sotradecol), injection into the parietal system via the hind foot produces retrograde opacification of the visceral lymph nodes (*Investigative Radiology*, to be published).

In the dog the remaining lymph nodes that cannot be injected by this one pathway are those of the mediastinum (8 nodes), the axilla (2–4 nodes), and head and neck (8 nodes). The large superficial cervical lymph node is accessible via intralymphatic injection of the thoracic limb.

The procedure of sclerosing the thoracic duct results in an immediate drop of the lymphocyte count, possibly helpful in the procedure of immunosuppression.—I am, etc.,

DAVID L. BENNINGHOFF.

State University
of New York,
U.S.A.

Family Care Service Ltd.

SIR,—How sick can the general-practitioner service of the N.H.S. get before it is finally laid to rest? This morning I received details of the "Family Care Service Ltd.," sponsored by the G.P.A. This is designed to run alongside the Health Service and provide the patient with freedom of choice. How simple do the instigators of the Independent Medical Services Ltd. and this latest alternative service think we are? A large part of my practice is in a suburban highly residential area, many of the occupants of which could well afford private treatment under the scheme suggested, but with *realistic* consultation charges.

However, I know of very few of my patients who would go for the alternative schemes whilst the N.H.S. exists with its "everything for free."

Until we all resign and the patients are presented with alternative schemes where some form of payment exists (with refund from the Government or some private insurance scheme), and where the patient learns again to have some responsibility and thought for his health, then we general practitioners are doomed, and alternative schemes running alongside the "free" N.H.S. are doomed.—I am, etc.,

Hull.

MAURICE FLASHER.

SIR,—I feel that in view of the further feeble attempts of the medical profession to seek recognition, the time has now come to state publicly, as a doctor, where the blame lies. It lies with the doctors themselves. The latest antic, i.e., the introduction of the Family Care Service Ltd., makes me cringe. Two shillings and sixpence per surgery consultation, five shillings per home visit (including medicines, etc.!). Have you ever heard of anything so ridiculous? It is because doctors value their services so little that they receive such meagre treatment at the hands of everybody, including politicians, review bodies, public, etc. A veterinary surgeon charges one to two guineas per visit (and rightly so), paramedical practitioners charge at least £1 1s. and their waiting-rooms are full. No self-respecting joiner or plumber would call to the house and do a job under £2. Good luck to them! People only appreciate what they pay for.

In this affluent society the doctor has had it as a man to be respected. Why should it be otherwise, when he does not even appreciate his own value? I am driven to confess something I have always known and realized about my profession generally. Regarding business acumen and the market value of their services, they are like newborn babies. Who else would have thrown away their birthright and goodwill for nothing and left themselves defenceless in the hands of the politician, whose public plaything they now are. The N.H.S. they say is beginning to crumble, family doctors and hospital doctors are grumbling and complaining of decrepit hospitals and overburdened terms of service. Well, the blame lies with them for continuing to bolster such a service. They await with great expectations the "Family Charter," but I am afraid they are going to get a "white elephant," for they are bargaining, in their own small way,