Among 18 explorations there were four in which incision of the periosteum revealed no pus, but drilling of the underlying bone released pus under tension. Moreover, in two other cases incision of the periosteum over the point of maximum tenderness proved negative, but on further separation of the periosteum a gush of pus was released from the opposite side of the bone. In both these examples, representing one-third of the cases, aspiration would have been negative and failed to relieve tension, which must, however marginally, have prejudiced the vascularity of the cortex.

I feel, therefore, that, although aspiration is clearly often adequate, it is not always the optimal treatment and, when negative, must be followed by exploration to exclude the possibility of inaccessible pus.

In all the 17 cases quoted satisfactory healing of the bones followed without sequestrum formation. The only significant complication was the development in one case of delayed avascular necrosis of the femoral head twelve months after an osteitis of the femoral neck.

My thanks are due to my colleague Mr. Martin Brett for allowing me to quote cases under his care.

—I am, etc.,

Salisbury, Wilts.

B. H. BROCK.

REFERENCE

- ¹ Bremner, A. E., Neligan, G. A., and Warrick, C. K., *Lancet*, 1954, 1, 953.

Bullous Lesions in Acute Barbiturate Intoxication

SIR,—We were interested to read the letter from Drs. D. M. I. Freeman and M. Raza (5 June, p. 1495). Before commenting on the cases which they report, we would like to point out that we did not state that the lesions were specific for barbiturate intoxication nor was it our intention to infer this. We would like to quote our concluding sentence, which was, "We believe that, clinically, these lesions are sufficiently characteristic to suggest strongly the possibility of acute barbiturate poisoning when the clinician is presented with an unconscious patient." One reason for carrying out this study was to attempt to determine the incidence of these lesions which we have observed over a number of years as a useful diagnostic sign. We have found from personal communications and the letters from Dr. C. G. Warnock (1 May, p. 1188) and Dr. J. D. Spillane (15 May, p. 1308) that others appear to have had experience very similar to our own. Furthermore, we have seen a few cases with signs suggesting that the patient has sustained a cerebral vascular accident; when they developed bullous lesions, however, a serum-barbiturate level confirmed that their condition was due in part to barbiturate intoxication which was previously not suspected. We noted that the epidermal changes are comparable to those seen in toxic epidermal necrolysis (Lyell's disease), and while peripheral vascular changes may be responsible for the localization of the lesions, it appears that the epidermal change is the result of a direct effect of the barbiturate on the epidermal cells. The aetiology of Lyell's disease remains obscure, but some cases appear to have been due to drugs (phenolphthalein, antipyrin, barbiturates, anticonvulsants, sul-

phones, penicillin, and phenylbutazone).¹ On the basis of this it is possible that other drugs which produce unconsciousness may give rise to similar bullous lesions. However, over the past five years in the cases admitted to the Poisoning Treatment Centre in the Royal Infirmary, Edinburgh, which deals with approximately 700 cases of poisoning annually, bullous lesions have been noted only in patients suffering from barbiturate intoxication.

There is no doubt that bullous lesions and trophic changes can occur in the skin in patients following leucotomy² and in patients with cerebral damage due to organic brain damage. In an interesting paper Dr. Elizabeth Robertson reports lesions in patients with a glioblastoma, cerebral damage due to carbon-monoxide poisoning, subdural haematoma, and quotes the occurrence of lesions in encephalitis.³

The lesions described became very extensive and there was marked involvement of the dermis and the subcutaneous tissues. These lesions were all delayed and did not occur in the early stages when some of the patients had a disturbance of unconsciousness. During the period of our investigation and up to the present time only two cases similar to the above have been seen with organic brain damage. In one the patient had severe brain stem damage the result of a head injury, and it was only after several months of unconsciousness that he developed bullous lesions and trophic ulcers following minimal pressure. These lesions were deep and had the appearance of pressure sores, except that they occurred with minimum pressure and despite the routine measures in the unit, which in comparable patients were sufficient to prevent the occurrence of pressure sores. The other case sustained severe brain damage following exposure to carbon monoxide, but the bullae did not appear until three days after the patient had been exposed and when he had recovered consciousness. In both cases the lesions tended to spread and the skin was damaged over a wide area. Presumably these changes which appear to be due to lesions in the central nervous system are primarily due to peripheral circulatory changes.

These cases are we think similar to those described by Drs. Freeman and Raza, and we would agree that it would be of great interest to know the incidence of such lesions in patients who have neurological lesions. From our experience, which is very incomplete, it would appear that this is an infrequent occurrence. Finally, we would also be interested to know more of the mechanism which is responsible for the formation of the bullae, because blistering is not a recognized feature in the development of pressure sores.—We are, etc.,

G. W. BEVERIDGE.

Royal Infirmary,
Edinburgh.

A. A. H. LAWSON.

Northern General Hospital,
Edinburgh.

REFERENCES

- ¹ Zak, F. G., Fellner, M. J., and Geller, A. J., *Amer. J. Med.*, 1964, 37, 140.
² McLardy, T., *J. Neurol. Neurosurg. Psychiat.*, 1950, 13, 106.
³ Robertson, E. E., *Brit. med. J.*, 1953, 1, 291.

Diagnosis of Hysteria

SIR,—This diagnosis should normally be made by the exclusion of physical illness, by the demonstration where possible of non-organic physical signs (like a cough with aphonia), and, not least, by the demonstration

of an adequate psychogenesis. In Dr. Eliot Slater's series (29 May, p. 1395) 24% were not available for follow up, including 16 instances where it was refused by patients or by their doctors. One wonders whether psychological factors were not important in these cases. In the patients who could be followed up Dr. Slater gives prominence to his own mistakes in diagnosis, but he nevertheless reports that psychological factors were twice as frequent in those correctly diagnosed as in those in whom errors were made. He also indicates that less than one-third of the patients traced had been assessed by a psychiatrist. The moral of these findings is surely not that the diagnosis of hysteria is without value but that it should be made jointly by physician and psychiatrist. We cannot speculate what the results might have been if these conditions had been satisfied. The fact that they were not satisfied casts doubt on Slater's conclusions.

There may be better reason to reject "hysteria" as a diagnosis because it does not describe a homogeneous entity. Yet it is common in medicine to use diagnoses which have this failing. For example, the aetiological homogeneity of such diagnoses as essential hypertension and schizophrenia is open to dispute, but they too are generally accepted. What matters is the unifying concept, and the concept of hysteria developed from Freud's work¹ is still significant and widely current. An incidental demonstration of its value has been provided recently in a study² where a group, which included patients diagnosed more than 20 years previously by one pair of observers as having hysterical fits, was re-examined by a different pair of workers. If we are now ready to distinguish subtypes like acute conversion reactions or the hypochondriacal syndrome of Guze and Perley³ or hysteria as a manifestation of psychosis this is an advance and not a breakdown in the use of the term.

As your leader-writer (29 May, p. 1389) points out, "hysteria" has acquired a derogatory flavour. So have some other words like syphilis, but there has been no campaign to replace them. Even if "hysteria" does not constitute "disease entity" this does not dispose of hysterical symptoms whose reality is constantly with us. We cannot deal with "hysteria" by denial of its existence, but if we are able to treat patients with hysteria with the same respect and some of the consideration which we extend to those with a brain tumour we need not fear to make the diagnosis—or even sometimes to be wrong.—I am, etc.,

H. MERSKEY.

Saxondale Hospital,
Radcliffe-on-Trent,
Nottingham.

REFERENCES

- ¹ Breuer, J., and Freud, S., *Studies on Hysteria*, 1893-5, 2nd ed., 1955, London.
² Rawnsley, K., and Loudon, J. B., *Brit. J. Psychiat.*, 1964, 110, 830.
³ Guze, S. B., and Perley, M. J., *Amer. J. Psychiat.*, 1962-3, 119, 960.

SIR,—Your leader "Eclipse of Hysteria" (29 May, p. 1389) represents a challenge to a long-established diagnostic category. To many of us hysteria, or the hysterical patient, represents a specific neurosis or a type of individual who is clearly characterized by fixed personality traits. This diagnosis is found prognostically valuable, is useful from the point of view of assessment in case con-

ferences or in one's own case list, and even when we consider the origins of the malady we find that these, too, are not unspecific.

Typically the hysterical individual is someone who suffers from severe headache, has a distressing pain in some part of the body, constantly demands sympathy, or tends to complain of not being understood. She is self-centred, constantly feels people are not good enough to her, and is so preoccupied with her own problems that she has little or no time to consider the needs of anyone else. It is this chronically complaining attitude with perpetual sense of injury that is characteristic. Occasionally there exists some other disability such as paralysis, lameness, or blindness, without there being an organic basis for such symptoms, which can, therefore, disappear or interchange with each other. Hysterical patients often are frigid. The treatment of such patients can be wearing, as they make such pathetic demands for sympathy or help, but at the same time they are selfish to a degree.

These patients from a very early age have suffered from a sense of not being loved, and the origins of this quality have become so deeply unconscious by the time adult life is reached that they are seldom accessible to therapy, with correspondingly disappointing prognosis. Male hysterics are in a small minority.—I am, etc.,

Barnet Green,
Birmingham.

DAVID T. MACLAY.

Electrocardiography with Music

SIR,—You kindly published my letter (24 October 1964, p. 1077) in which I suggested that an induced current from the ring circuit connecting patients' headphones in the wards might be responsible for the Light Programme of the B.B.C. being picked up when recording electrocardiograms at Bedford Hospital.

Of your correspondents who were good enough to offer possible explanations of the phenomenon, Dr. H. R. A. Townsend (14 November 1964, p. 1268) suggested a simple cure—namely, the use of abrasive saline jelly; M. J. Brice (5 December 1964, p. 1464) thought a "dry joint" causing high contact resistance in the input circuit of the electrocardiograph was the probable cause; and Mr. A. K. Dobbie (12 December 1964, p. 1532) considered direct radio pick-up the most likely explanation.

As a result of tests at Bedford Hospital by the Ministry of Health, the cause of the trouble has been identified and cured. For the benefit of those who may be troubled by radio programmes when recording electrocardiograms in hospital wards, here is the explanation:

(1) The music from the E.C.G. machine ceased when the hospital wired radio system was switched off.

(2) The wired radio system carried 300 mV. p-p of the Light Programme at the original modulated 200 kc/s on one wire of the Light Programme pair and a 2 V. p-p audio signal on the other wire.

(3) The Home Service pair carried a balanced signal of 500 mV. of audio signal superimposed on 3 V. p-p of 50 c/s.

(4) The galvanometer of the E.C.G. machine had a mechanical resonance at 800 c/s which was audible when an in-phase signal of 10 mV. p-p was applied.

(5) The highest radio field measured in the ward was 2 mV./m.

(6) One E.C.G. machine which reproduced the radio programme already had r.f. rejection components in its input circuit.

(7) No magnetic fields could be detected throughout the audio frequency range.

(8) With all E.C.G. leads connected, the Light Programme could be heard from the machine if the lead to the patient's headphones were draped over the iron bed-head or over part of the patient, the volume being considerably increased if the RL lead were disconnected.

(9) The hospital radio equipment was faulty, being unbalanced with respect to earth, and was incompletely screened on account of the conduit in the ward not being earthed. These faults have been corrected and it is now not possible to hear the radio programme from the E.C.G. machine, even when the lead to the patient's headphone is draped across his body.

The phenomenon noticed was thus caused by *electrostatic* induction from a wired radio system which was faulty (the audio signal being unbalanced with respect to earth) in conjunction with an E.C.G. machine that had an audible mechanical resonance at 800 c/s with an in-phase signal of only 10 mV. p-p.

Since not one of your correspondents suggested the correct explanation no bouquets can be presented, except to the Ministry of Health, whose careful investigation supplied both the answer and the remedy.—I am, etc.,

Bedford General Hospital,
Bedford.

DAVID LEWES.

City of Birmingham Vacancies

SIR,—It was with a sense of shock and fury that I read the Birmingham Executive Council's advertisement in the *B.M.J.* (26 June, p. xxv). The advertisement obviously refers to vacancies left by the collective resignation of the small courageous group of Birmingham general practitioners.

One was always under the impression that the *B.M.J.* was the instrument of the B.M.A., and, as such, would always act in the best interests, and for the protection, of doctors. One can only regard the *B.M.J.*'s acceptance and publication of this advertisement as an act of treachery, and a "stab in the back" for those same courageous Birmingham doctors.

The advertisement should have been returned to its senders, together with a severe reprimand for their effrontery. It is for the *B.M.J.* and the B.M.A. to curb, not to encourage, our blatant enemies.—I am, etc.,

London W.5.

H. R. POMSON.

SIR,—An advertisement appeared on 23 June in *Medical News* to fill the vacancies created by resignation of 13 doctors from the Birmingham Executive Council. These doctors must be admired by all for having the courage of their convictions and resigning in the belief that practice outside the N.H.S. is for their own and their patients' benefit.

Firstly, it is to be hoped that the Medical Practices Committee will resist any application for the areas to be classified as "designated." Secondly, that their colleagues will not apply for these jobs, so that an opportunity can be taken to see how a mass of previously N.H.S. patients take to a private scheme. The public appears to view the cost of private medicine as being beyond its pocket. A look at the projected B.M.A. Insurance Scheme shows that the average annual cost would be only £3 per head.

It was seen from the two recent meetings at B.M.A. Headquarters that there is a growing body of opinion that nothing will come of the present negotiations between the profession and the Ministry and that the best hope for general practice is for it to be outside political influence.

It is to be hoped that any doctor so convinced will have the courage of these Birmingham doctors and resign from the N.H.S. despite B.M.A. advice to the contrary.—I am, etc.,

Basingstoke, Hants.

B. WINCHURCH.

SIR,—I observe in to-day's *B.M.J.* (26 June, p. xxv) an advertisement offering several N.H.S. practices in Birmingham.

These vacancies arise from the mass resignation of a group of general practitioners for reasons connected with our present dispute with the Government. I am horrified that this advert should appear in the *B.M.J.*

Does the right hand of the B.M.A. know what its left hand is doing?—I am, etc.,

London S.E.14.

A. BERRY.

** The S.R.M. of 23 June decided by 281 votes to 143 not to advise the British Medical Guild to hand in the resignations it now holds. If this policy is reversed, and if the British Medical Guild decides to hand in these resignations from the N.H.S., the Council of the B.M.A. would have to decide its policy about accepting for publication in the *B.M.J.* general-practitioner vacancies in the N.H.S. It would be in conformity with Association policy to reject advertisements of posts the terms and conditions of which are unacceptable to it.—Ed., *B.M.J.*

Discrepancies in the N.H.S.

SIR,—The Ministry of Health's attention being firmly focused, eventually, upon the many discrepancies in the present running of the N.H.S., may I take this opportunity of bringing to their notice, through your journal, yet one more and quite recently introduced problem that has been created both for the general practitioner and the patient?

This is the seemingly unreasonable restriction now being imposed upon the prescribing of medicine for the sufferers of chronic disorders. My son, for example, is on prophylactic therapy following two attacks of acute nephritis. There was a time when I could get three months' supply of Gantrisin (sulphafurazole) at a go, but I now find myself haunting my doctor's waiting-room every fortnight, along with dozens of others in a similar predicament, simply to get the necessary prescription. Surely nothing could be more calculated to worsen the relationship between the doctor and his patients, or to aggravate the general practitioner's grievances.

One of the main complaints against the N.H.S. is the very fact that doctors are finding themselves so snowed under with the writing of prescriptions that they are hard pressed to find the time needed to deal with really ill patients. Would it be asking too much of the Ministry of Health to at least consider some kind of solution to this trouble, such as, for instance, a book of prescriptions not unlike those used for pensions and