interpretation of the assay figure may ensue.—I am, etc.,

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Aortic Medionecrosis and the Marfan Trait

SIR,—In Dr. M. G. Lewis's article (5 June, p. 1478) on the association between aortic medionecrosis and aortic incompetence in the elderly he also mentions that some of these cases show evidence of arachnodactyly, suggesting the presence of an underlying congenital connective-tissue defect. The classical Marfan syndrome of arachnodactyly, aortic dilatation, and congenital eye defects is fairly easily recognized in young adults, but patients have now been described in whom the cardiovascular changes have presented in the sixth decade.^{1,2} In these cases the Marfan trait must be less severely expressed, as the abnormal aorta is able to withstand the haemodynamic thrust of the circulation for a longer period before starting to dilate.

For several years I have been searching for patients with the characteristics of the skeletal disorder of dolichostenomelia (long slender limbs),³ originally described by Marfan.⁴ Viewed from this aspect, vascular and eye defects are uncommon, although the arachnodactyly may be as severe as that seen in patients with these complications. However, one of my patients was found to have aortic regurgitation and radiological evidence of dilatation of the first part of the aorta at the age of 61 years.

Sinclair *et al.*⁵ devised the metacarpal index from bone measurements of radiographs of the hands. I regard measurements above the 3 × Standard Deviation (S.D.) of the normal range of this index as being indicative of arachnodactyly.⁶ It is beyond this amount of bone slenderness (occurring in about 1 in 400 persons) that I began to find patients with an aorta which has dilated. Unfortunately the metacarpal index does not always detect the minor degrees of arachnodactyly, which one might expect in the older patients presenting with a vascular abiotrophy. Consequently I devised a method of estimating the relative slenderness of all the metacarpals and proximal phalanges.³ I now present this information on skeletal hand charts, in which the abnormal measurements are clearly indicated as multiples of the normal standard deviation. This has produced the interesting finding that the Marfan trait is expressed extremely irregularly even in one region such as the hands and may even be confined to one hand. In McKusick's case² the cardiovascular defect was also expressed irregularly, so that the aortic valve and descending thoracic aorta had dilated and yet the ascending aorta had withstood a greater haemodynamic thrust. Idiopathic Erdheim's cystic medionecrosis without the Marfan trait is a

diagnosis of exclusion, and skeletal hand charts may help to determine the presence of a connective-tissue defect before it is too late.

Now that it is possible to splint the aorta with a sleeve of synthetic material or replace a segment with a synthetic graft—a life-saving procedure in one of my patients—the diagnosis of this condition has become increasingly important.—I am, etc.,

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Experience in an Anti-smoking Clinic

SIR,—Dr. Keith P. Ball and his team (26 June, p. 1651) are to be congratulated on their splendid work at their anti-smoking clinic. The group therapy idea which forms the basis of several such clinics in this country has certainly much to be recommended from the very sound reasons stated in the report. While I don't think that any method employed in the treatment of smokers who really want to give up smoking can claim better results than those shown by Dr. Ball and his colleagues, I succeeded quite as well with the personal clinical approach. In January 1963 I inaugurated with the support of the Ministry of Health a "Smokers' Advisory Clinic" as a new service of the corporation's health and social services department in one of Newcastle's public health clinics. During the first year this new enterprise had been run as an experimental clinic with the special approval of the Ministry. After an interval of several months we reopened the clinic nine months ago. Since then 78 people—mostly referred by their doctors, unless they came from reasons of their own—attended the clinic. Though the corporation charges a fee of 35s. per patient in order to cover the expenses (overheads and drugs)—a payment also designed to deter those time-wasters who are not really serious about this business—15 customers (c. 20%) dropped out after the first or second session. Of the remaining 63 patients—among them many bronchitics—four are not yet "consolidated." Of the 59 under assessment 16 (27%) did not respond or gave up treatment prematurely; 43 (72%) gave up smoking, usually the same day as strongly suggested. The almost immediate results with a few exceptions who needed a week or so was, I believe, only possible by supplying the strong moral support and psychological influence (i.e., by demolishing the myth of the benefit of smoking and by dealing carefully with the patient's individual problems) with effective drug treatment. I used either lobeline (no less than 12-16 mg. per day) in order to prevent the craving, or Atarax (hydroxyzine) in individually required doses (10 mg. two to four times per day) for the suppression of "deprivation symptoms." The patient has to be warned against a

possible somniferous effect of hydroxyzine during the first two days.

Following up is notoriously difficult, as many people don't return the short follow-up questionnaire. So far we could trace nine relapses; three of these want to repeat the course of treatment. Of those who replied, 10 are still abstinent for periods from three to eight months.—I am, etc.,

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Buphthalmos and Photophobia

SIR,—In the section on buphthalmos in Mr. K. Wybar's interesting article on eye diseases in children in the *B.M.J.* of 22 May (p. 1361) he gives increasing myopia in early childhood, haziness of the cornea, redness of the eye, and photophobia as presenting signs, in that order. I entirely agree with him that these conditions occur, but would give a different order of, as it were, priority, and add lacrimation.

Increasing myopia would be unlikely to become manifest until the child is at least 2 or 3 years old, whereas lacrimation and photophobia present themselves in the first months or year of life, and this is the time when it is most important for the case to be observed and treated. Furthermore, it is remarkable how often these two symptoms are not given the consideration they deserve. The lacrimation is ascribed to blocked tear ducts and the photophobia is thought to be something out of which the child will grow; so that it is sometimes months or even longer before it is realized that there is something seriously wrong.

Congenital glaucoma is treatable, and satisfactorily so if it is "caught" in the first year of life, after which the prognosis becomes progressively worse. The reason for this letter, therefore, is to draw the attention of all who have to do with young children to the possibly sinister significance of photophobia and lacrimation, especially the former.—I am, etc.,

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Death after Combined Dexamphetamine and Phenelzine

SIR,—Episodes of hypertension may occur during treatment with monoamine-oxidase inhibitors, and are sometimes related to the simultaneous administration of other drugs—e.g., amphetamine—or to eating cheese. The following is an account of a case in which dexamphetamine was taken during a course of treatment with phenelzine, resulting in a rise of blood-pressure, cerebral haemorrhage, and death.

A 30-year-old woman with depression was being treated with phenelzine (Nardil) 15 mg. three times daily, and trifluoperazine (Stelazine) 2 mg. at night. One afternoon, after she had been taking these drugs for some five weeks, she acquired some dexamphetamine tablets (Dexten) from a friend, and took two (each equivalent to 10 mg. dexamphetamine sulphate). Within a quarter of an hour she was complaining of a headache, so severe that she called her doctor and told him "her head was bursting." Her blood-pressure when taken an hour after the ingestion of the dexamphetamine was 150/100 mm. Hg, but at this time there were no physical