E.C.T. and Drugs

SIR,—I am grateful to Dr. Gibbons (November 2, p. 1119) for his valuable criticisms of my book. They will be taken into account in the forthcoming second edition. I should like, however, to correct two of his statements. He writes that I advise E.C.T. "in the treatment of chronic anxiety, severe hysteria, and other neurotic disorders," and he considers this unorthodox. In fact, however, I wrote (page 12), "It is generally accepted that the milder neuroses should be treated by psychotherapy." Under "Anxiety neurosis" in the index I cite six procedures which are adjuvant to psychotherapy. I recommended E.C.T. (page 16) "when the neuroses are so severe as to be obviously resistant to psychotherapy." This is a course recommended by many experts as being preferable to leucotomy, which is often recommended by orthodox "psychiatrists." The reviewer also states that the indications for E.C.T. are "cursorily dealt with," although 15 pages are devoted to the subject.—I am, etc.,

A. SPENCER PATERSON.

London W.1.

Side-effects of Tranlycypromine

SIR,—To the many letters which have appeared in your journal I should like to add my own observations.

I have used the drug on several hundreds of patients, and the percentage of cases displaying the one particular side-effect—namely, the headache—was similar to the one found by Milligan and Macdonald—namely, 4%.

One of the cases which showed the most dramatic symptoms simulating subarachnoid haemorrhage was fully investigated, and no abnormality in the C.S.F. was found. The patient made an uneventful recovery within twelve hours from the onset of symptoms.

With further experience of "parnate" (tranlycypromine) and with further cases presenting severe headache, I investigated all my cases again, trying to find out whether they were "headache sufferers." In all of them this was the case, similar to the ones reported by Blackwell,¹ Enoch,² and Green.³ Some of them, prior to becoming depressed, suffered occasionally from throbbing headache, or migrainous type of headache, and others from so-called tension headache. I then stopped giving parnate or "parstelin" (tranlycypromine and trifluoperazine) to depressed patients with a past history of headaches. No more severe headaches have occurred in patients taking these preparations.

Accumulating evidence seems to point to this particular side-effect occurring when the level of the circulatory sympathicomimetic amines is raised by some exogenous or endogenous factor in patients whose amine balance has already been disturbed by treatment with parnate. Thus a situation is created in which "a

vascular storm" may be precipitated, particularly in individuals who have a predisposition to cerebral vascular instability or in whom amine metabolism is constitutionally abnormal.

It would be a great pity not to use tranlycypromine because of these side-effects, as reports generally agree that it is an effective anti-depressant. The "preventive measure" mentioned by Drs. P. W. Richmond and A. H. Roberts (October 19, p. 999) is a relatively easy one—namely, before using this drug make sure that there is no past history of headaches.—I am, etc.,

G. BRAM.

Mabledon Hospital,
Dartford, Kent.

REFERENCES

- ¹ Blackwell, B., *Lancet*, 1963, 2, 414.
- ² Enoch, M. D., *ibid.*, 1963, 2, 464.
- ³ Green, D., *ibid.*, 1963, 2, 586.

Drugs for Depression

SIR,—The letter by Dr. J. J. Hobbs (October 26, p. 1062) on the subject of "Drugs for Depression" raises the important question of how much the doctor as a person contributes to the alleviation of depression since the advent of effective antidepressant drugs.

If Dr. Hobbs accepts that depressions are somewhat roughly divided into those that are mainly endogenous and those that are mainly reactive, then it must be admitted that there is a reactive or emotional factor in nearly all endogenous depressions.

Persons who suffer from depressive illnesses often display an inability to express feelings of aggression and/or hostility. They are often unaware of the intensity of such feelings within themselves. If the doctor, by means of understanding and respect for such patients, can help them to face up to their hostile feelings (towards spouse, parent, etc.), then he may contribute to a more lasting cure of the depressive illness than if he limits his function to prescribing tablets. In this sense I disagree with Dr. Hobbs's opinion that "[the doctor's] 'personality' is becoming of much less importance with the advent of specific treatment with a biochemical basis."—I am, etc.,

DAVID COMMON.

London S.E.22.

Antibiotic Cover for Dental Extractions

SIR,—The clinicopathological conference on valvular disease of the heart (August 31, p. 545) and the letter from Drs. C. G. Barnes and Rosalinde Hurley (November 9, p. 1205) again raise the question of subacute bacterial endocarditis after dental extractions. Attention is rightly directed to the method, extent, and nature of antibiotic cover, which is so effective that the infection is usually cured. Despite the decreased mortality, the morbidity of the disease is considerable in that, in spite of sterilizing the

blood, some patients die of the damage caused by the infection, and those that live suffer considerably from a further decrease in cardiac efficiency and the many sequelae of that.

With the efficiency of the antibiotic cover being nearly 100%, further advance can only come from elsewhere. The two obvious fields are (a) prevention of the underlying rheumatic or congenital heart lesion, which is a matter for general medical research, and (b) prevention or reduction of the precipitating shower of bacteria at operation, which is in the hands of the dental surgeon performing the operation. The degree to which the incidence of bacteraemia can be modified by the operator was clearly shown by the results of an investigation into this matter published some years ago.¹

From 958 patients having straightforward teeth removed with no antibiotic cover and a general anaesthetic, 1,223 samples of blood were obtained. An overall positive blood culture of 15% was found. As would be expected, the more teeth removed then the higher the incidence of a detectable bacteraemia. But two points of greater importance were that (a) the incidence also depends upon the particular teeth removed, and (b) the technique of the operator.

(A) In 346 patients a single tooth was extracted with the following results:

	No. of Patients	No. of Positive Blood Cultures
Incisors and canines ..	29	0
Premolars ..	74	6 = 8.1%
Upper molars ..	103	15 = 14.6%
Lower molars ..	140	13 = 9.3%

(B) Fourteen operators, who were labelled A–N, took part in the investigation.

The following had sufficient cases to justify comparison.

Operator	No. of Samples	No. of Positive Blood Cultures
A ..	361	21 (6.6%)
B ..	99	7 (7.0%)
C ..	65	9 (13.8%)
E ..	73	13 (17.8%)
H ..	333	53 (15.9%)
J ..	111	14 (12.6%)
K ..	85	14 (16.4%)

Of these operators, A and B were skilled senior men. C, E, H, J, and K were more junior. A and H had by far the largest series and, as it happened, two contrasting styles of extraction. A (and B) had developed a very economical style in which movement was restricted to the minimum and consisted of simple rotation of all single rooted teeth and a steady buccal movement with multiple-rooted ones (except upper first premolars, which, because of their peculiar anatomy, he extracted along their length). H (and C, E, J, K) used the method usually adopted by dentists of, after grasping the tooth with forceps, a pendulum-like movement of the arms and forceps, which alternately partially dislocates from and then replaces the tooth into its socket. The amplitude of the movement increases until the tooth is completely removed. The more difficult the tooth the more prolonged the manipulation has to be. This method converts the root into a piston pumping the tissue fluids, contaminated by the tooth, back into the blood stream, and is particularly prone to occur with upper molars owing to the anatomical arrangement of the roots of these teeth.

The body defence mechanisms and a given level of antibiotic should have a better chance of dealing with and destroying the bacteria in a small shower than in a large one before they can cause permanent structural damage. It therefore seems reasonable that an attempt should always be made to reduce the size and incidence of the bacteraemia caused by tooth extraction, and yet too often, as the extractions are easy ones and because of the present accent on conservation of teeth, they are given to the houseman to do as a good opportunity for him to gain practice in extractions. Dental clearances, even when properly indicated, cause the greatest general upset of any dental operation. They should be performed with the utmost care by skilled operators, actively trying to inflict the minimum of trauma, instead of by those with the least experience, as is often the case. Surely physicians in charge of these susceptible cardiac cases, besides considering so very carefully the antibiotic cover, should also insist upon their patients being operated upon by the most skilful person available.—I am, etc.,

FRANK COFFIN.

London W.1.

REFERENCE

- ¹ Coffin, F., and Thompson, R. E. M., *Lancet*, 1956, 2, 654.

Postgraduate Training in Obstetrics

SIR,—I was distressed and appalled to read the letter by Dr. M. J. Ball (September 28, p. 806).

The value of postgraduate work has long been recognized, and the answer to the problem of general practice care in obstetrics is surely not to cut it off entirely but to try and incorporate the services of the practitioner into the general hospital. This system works very well in Canada, and I see no reason why it should not do so in Britain. The solutions to the overcrowding of the hospital beds in maternity wards can, of course, only be rectified by building new hospitals with more facilities. However, I doubt that the patients themselves would wish to be excluded from the care of their general practitioner during their antenatal period, their confinement, and the post-natal period, to be looked after instead by some busy, hurried, junior houseman who has no knowledge of the patient's particular problems and will likely never see the patient, or her baby, again after delivery.

Then the solution lies in: (a) Paying the general practitioners more and thereby decreasing the work load on individual practitioners; (b) increasing the stimulus for general practitioners to attend postgraduate courses; (c) to incorporate general-practitioner services in obstetrics into the hospitals in Britain so that the general practitioner can admit a patient into hospital, be present at her delivery, and follow her in her post-natal course; and (d) to provide facilities for this service by making available more hospital beds.

Here in British Columbia we have long recognized the importance of the general practitioner in obstetrics. All general practitioners in this province have the right and the privilege of admitting patients to hospital. This includes patients who have been looked after in their prenatal course. Of women in British Columbia, 98% have their babies in hospital. Only 40% of these are delivered by certified specialists, yet the figures for maternal mortality and for foetal mortality bear a close resemblance to those that the World Health Organization finds acceptable. Any general practitioner in this province can find stimulus, excitement, and confidence from working in a hospital where certified specialists also look in on his patients; where he is kept up to the mark and has freely available to him all the services that a hospital can provide. If there are more doctors like Dr. Ball in Great Britain who recommend that the general practitioners take less and less part of the total care of their patients and exclude them from participating in yet one more service I fear that the National Health Service will slowly come to an end. Perhaps Dr. Ball and his associates can then spend their time in splendid isolation while the general practice, the bulwark of British medicine, will be practised on in Canada and the United States.—I am, etc.,

JAMES TURNBULL.

Powell River, B.C.,
Canada.**Cot Death in Twins**

SIR,—We have been interested for several years in this occurrence, and particularly when both of a pair have died at or about the same time. We have ourselves examined two dead pairs and through newspaper reports and the help of colleagues are aware of several other deaths having occurred in pairs.

To increase our knowledge of this event, we would be grateful if any doctor who learns of, or has met, such a fatality—that is, unexpected death at home of a twin baby, and particularly when both twins have died at or about the same time—would communicate with us.—We are, etc.,

R. T. COOKE.

Department of Pathology,

R. G. WELCH.

Department of Paediatrics,
General Hospital,
West Hartlepool,
Co. Durham.**Seasonal Variation in Leukaemia Incidence**

SIR,—I have been interested in the report by Dr. J. A. H. Lee (June 23, 1962, p. 1737) demonstrating a seasonal variation in the clinical onset of leukaemia among young people. Within each 5-year age-group under 20 years Lee found more cases beginning in the summer, with

a peak incidence in June, than in the winter; this excess was restricted to the acute lymphatic cases, with no seasonal variation occurring for myeloid leukaemia. In a letter (September 7, p. 623) Dr. Lee reported a similar variation for leukaemia among adults aged 20–44, with acute lymphatic cases again showing a summer peak.

Execution of a comparable nation-wide study in the United States is hampered by lack of a data resource equivalent to the National Cancer Registration Scheme of England and Wales, containing items on leukaemia cell type and month of first symptom. Nevertheless, information on the seasonal incidence of childhood leukaemia was obtained by preliminary analysis of results from the National Co-operative Leukemia Survey, a comprehensive epidemiologic study of leukaemic children under 16 years of age. Twelve medical centres located in various sections of the U.S. participated in this survey. The cases were diagnosed between 1958

Cases of Leukaemia in Patients Aged 0–15 by Season of Clinical Onset and by Cell Type; National Co-operative Leukemia Survey

	Mar.– May	June– Aug.	Sept.– Nov.	Dec.– Feb.	No. with Month of Onset Stated
Acute lymphatic	74	44	54	65	237
Acute myelocytic	15	12	11	19	57
Acute monocytic	8	4	4	2	18
Acute, other, and unspecified	41	54	49	45	189
Chronic	5	1	0	4	10
Total	143	115	118	135	511

and 1961, and the date of onset and cell type of leukaemia were abstracted from hospital records.

Of the 541 cases of leukaemia studied, the month of clinical onset was recorded in 511 instances. Utilizing the same groupings of months as Dr. Lee, an excess of cases with clinical onset during the winter and spring was found for most of the cell types (see Table). Only the category of acute leukaemia termed "other and unspecified"—many of which were stem-cell types—did not have this pattern, showing instead a slight summer excess. The seasonal distributions for all cases combined and for cases within each cell type were tested for statistical significance by the chi-square test, after correcting for variations in the length of calendar months. Significance was limited to the acute lymphatic type ($P=0.035$), which had a seasonal variation attributable mainly to its relatively frequent onset in the spring and infrequent onset in the summer.

The excess of cases of childhood leukaemia with clinical onset in the winter and spring months agrees with the seasonal distribution of acute leukaemia of all ages reported from a single hospital in the United States.¹ This distribution is possibly related to the prevalence during