Side-effects of Cyclopentolate

SIR.—"Mydrilate" (cyclopentolate hydrochloride) has been available in this country for several years in the form of 0.5% and 1% aqueous solution, and during this time has been widely used as a cycloplegic and mydriatic with a quick onset and brief duration of action. The only untoward effect reported in the use of the aqueous solution as eye drops has been a complaint of transient stinging immediately after putting a drop into the eye.

Now from America, where cyclopentolate has been in use for ten years, come reports¹⁻⁴ of 19 cases in which use of the drug in the form of eye drops resulted in minor transient psychotic episodes. These side-effects took the form of "a schizophrenia-like behavior pattern associated with ataxia."⁴ The episodes lasted from one to five hours. The neurological side-effects consisted of dizziness, disorientation, purposeless movements, loss of memory, incoherent speech, and inability to stand.

Binkhorst *et al.*,³ in a double blind study of 35 patients, compared 1% hydroxyamphetamine (a mydriatic without cycloplegic effects) with 2% cyclopentolate, 1% cyclopentolate, and 1% homatropine eye drops for their psychogenic properties. One drop was instilled into each eye, every ten minutes, four times. "A single borderline reaction was found with the use of 1% cyclopentolate." However, "Cyclopentolate administered as 2% solution eye drops to a group of children and adolescents, produced a statistically significant incidence of psychotic reactions," and these authors suggest that "Its use in ophthalmology should be tempered because of this possibility." Similar but less dramatic side-effects have occasionally been reported following the ophthalmic use of atropine and homatropine.⁵

Mydrilate is available only in 0.5% and 1% concentrations in this country, but in these four publications five cases of psychotic reaction to 1% cyclopentolate are reported. Although ophthalmologists are likely to have seen the published reports, mydrilate is widely used, too, as a quick-acting mydriatic in diagnosis, by physicians who may be less familiar with the ophthalmic literature.

I should be grateful for brief reports of any cases of neurological or psychotic reactions to mydrilate that readers may have seen or heard about, and I would like to send copies of any such reports to the Subcommittee on Adverse Reactions (of the Committee on Safety of Drugs).—I am, etc.,

J. M. SIMISTER.

Ward, Blenkinsop & Co., Ltd.,
Wembley, Middlesex.

REFERENCES

- 1 Simcoe, C. W., *Arch. Ophthalmol.*, 1962, 67, 406.
- 2 Beswick, J. A., *Amer. J. Ophthalmol.*, 1962, 53, 879.
- 3 Binkhorst, R. D., Weinstein, G. W., Baretz, R. M., and Clahane, A. C., *ibid.*, 1963, 55, 1243.
- 4 Mark, H. H., *J. Amer. med. Ass.*, 1963, 186, 430.
- 5 Hoefnagel, D., *New Engl. J. Med.*, 1961, 264, 168.

Familial Cases of Cancer

SIR.—We are anxious to collect data on the natural history of cancer of the lung, breast, and stomach affecting more than one member of a family. The influence of genetic factors in disease is one of the current topics of research which is proving to be most fruitful in our understanding of disease processes and in aiding our attempts to prevent disease and to provide relief for the suffering patient. Simple inheritance of tumours in man following the Mendelian laws of single gene action is rare. A few unusual tumours—retinoblastoma, for example—are usually inherited, and in rare families more common neoplasms are seen to be transmitted in this way. In most cases, however, this line of investigation has not helped appreciably in the elucidation of the cancer problem.

Another facet of malignant disease, the variable natural history of neoplasms, is becoming more clearly recognized, and there are suggestions that the rate of progress of a tumour may depend to some extent on the constitution of the host. We propose to investigate the natural history of tumours in members of the same family to see what correlations exist and whether these may be ascribed to genetic factors.

We wish to trace families in which more than one member has suffered from the same type of cancer—that is, two brothers or father and son suffering from lung cancer, two sisters or mother and daughter suffering from breast cancer, or two members of a family both of whom have suffered from cancer of the stomach.

We should be most grateful if any doctor who can recollect a family or families in which more than one member has suffered from cancer of the lung, breast, or stomach will inform us at the Pathology Department, Morriston Hospital, Swansea.—We are, etc.,

DAVID J. B. ASHLEY.
W. O. WILLIAMS.

Morriston Hospital,
Swansea.

Addiction to Amphetamine

SIR.—We are concerned with the problems of demand in practice for amphetamine, in its many combinations. If a request by a patient is followed by a refusal, then clearly the patient under the present system would be able to move from practitioner to practitioner until demands were met. It is therefore an obligation for each of us to try and deal with the problem.

We would be interested in the views of other colleagues and in the way they contend with this problem themselves. In our practice we try the following measures:

1. A suggestion on prescribing that these compounds may cause lack of potency and have been known to cause blindness by cataract.

2. By breaking down the tablet into its ingredients and prescribing these separately, with a decreasing dose of amphetamine.

3. By substituting the dose of amphetamine for a short course of an anti-depressant, such as "nardil" (phenelzine), in those patients in whom it is justifiable.

The suggestion of a universally obtained placebo is, of course, dangerous because of the harm that would come from confusion, but we wondered if there is a place for a smaller dose—for instance, a 1-mg. tablet—which could be used to tail off the addiction.—We are, etc.,

W. H. MYERS.
EVELYN LAW.

London S.E.9.

"Without Prejudice"

SIR.—Readers of *The Times* and *Telegraph* and other journals will know that I have written a monograph, *Doctor and Patient*,¹ which examines some of the problems of medical practice to-day and comes down very firmly in favour of good general practice in Britain. One of its 11 chapters criticizes the policies of the B.M.A. quite seriously—in the sense that the criticism is not frivolous or ill considered. It was not to be expected that the B.M.A. would wholly approve of what I have said (but loud and many are the voices now telling me that it needed saying). The B.M.A. may choose to ignore my criticisms or through its journal write an equally serious reply, but the voice should be that of the Association and not that of a columnist, Pertinax, who lacking in humour or subtlety cuts one of my paragraphs completely out of its context in order to make a personal and contemptible attack.

It is particularly unpleasant because the paragraph quoted is from my epilogue, which is a tribute to the late Sir Ernest Rock Carling, which says in effect that, whatever surgeons and physicians privately think of themselves, Rock Carling combined all the virtues. It is this tribute which Pertinax has chosen to debase. Future researchers into the standards of journalism of the *B.M.J.* may now start at November 30, 1963.—I am, etc.,

ROBERT PLATT.

Manchester 14.

REFERENCE

- 1 Platt, R., *Doctor and Patient. Ethics, Morale, Government*, 1963. The Rock Carling Fellowship Lecture. The Nuffield Provincial Hospitals Trust, London.

SIR.—Pertinax (November 30, p. 1402) has blundered. That is very likely to happen if one comments on a lecture before the lecture is delivered. When Sir Robert Platt was analysing the difference between the physician and the surgeon there was a twinkle in his eye which his audience immediately appreciated. We enjoyed the jest as much as he did, but it was lost on Pertinax.—I am, etc.,

G. F. ABERCROMBIE.

London N.W.3.