profound, is apparently non-fatal to the healthy heart. It is possible that the vagal effect of succinylcholine on the heart of the badly burned patient is to convert the sinus tachycardia so commonly present due to sympathetic overactivity and toxæmia to ventricular tachycardia and fibrillation. Animal experimentation may throw some light on the many hypotheses advanced.

The authors are to be congratulated on focusing further attention on an important contraindication to succinylcholine.—I am, etc.,

Department of Anaesthesia,
The Children's Hospital,
Winnipeg 3, Manitoba.

T. J. McCAUGHEY.

REFERENCES

- ¹ McCaughey, T. J., *Canad. Anaesth. Soc. J.*, 1962, 9, 220.
- ² ——— *ibid.*, 1962, 9, 293.

Temporary Withdrawal of Drug

SIR,—The *British Medical Journal* (December 1, p. 1446) contains a Preliminary Communication from the Director of the Epidemic Observation Unit of the College of General Practitioners. In this Dr. Watson draws attention to the foetal abnormalities which have occurred during pregnancies in which the mother was given an anti-emetic and a vitamin, separately or together. Dr. Watson asks that further investigation should be performed on these drugs if they are to be used during pregnancy.

The likelihood that pyridoxine, the vitamin now under suspicion, will be implicated is extremely remote. Nevertheless, pending a decisive demonstration that this vitamin is not culpable, Organon Laboratories Limited are withdrawing their product "duactin," which contains pyridoxine and which has been recommended solely for the control of nausea and vomiting in pregnancy.—I am, etc.,

Organon Laboratories Ltd.,
London.

W. J. TINDALL,
Medical Director.

Drug Advertisements

SIR,—The increasing childishness and naivety of advertisements which appear in the lay press and especially on I.T.V. are perhaps understandable because the advertisers hope to attract a future generation of purchasers at the earliest possible age.

I wonder if other members of the medical profession share my irritation that similar methods are spreading to the professional journals? In a recent number of an excellent medical journal the following pictorial themes, all basically irrelevant to the product advertised, were displayed in advertisements to catch my eye:

Human faces, expressing pain or relief, 15; children, either in pain or playing with toys, 8; children's toys, fluffy rabbits, puppets, jack-in-the-boxes, etc., 5; comic cartoon characters, 4; seascapes, depicting calms or storms, 3; family groups, 3; and one each of the following—barristers, dogs, dolls, egg whisks, flowers, fortune tellers, office letter presses, orchestras, potters at the wheel, queues at bus stops, smoking chimneys, sword swallowers, and taxi drivers. Total 51.

I suspect that most general practitioners, like myself, get their knowledge of new drugs from the exchange of conversation and ideas with their colleagues, from advice and lectures from specialists, and from their reading of the medical journals. I can read and I do understand what the words "24-hour control" mean without

having to have the meaning explained to me through the medium of a blotter embellished with budgies and owls.

Who exactly is this childish nonsense intended to impress?—I am, etc.,

H.M.S. Terror,
Singapore 27.

H. E. B. CURJEL.

Anterior Tibial Pain

SIR,—I was most interested to read the article on this subject by Drs. E. B. French and W. H. Price (November 17, p. 1290). Some 12 years ago, aged 18, I first suffered from a condition, in the left leg only, similar to that which they describe. It was brought on by fast walking and lasted for three weeks—considerably longer than the attacks they record. Thereafter fast walking always caused a similar pain in the same leg and discomfort could persist for days. Eventually I came across a suggestion that the condition might be due to muscle herniae, and although bandaging had previously had no effect I was prompted to apply a crêpe bandage extremely tightly. Discomfort from the bandage caused me to remove it a couple of hours later and I found that the anterior tibial pain had disappeared. Thereafter this procedure could be relied upon to produce rapid relief of symptoms, and I offer it to any interested readers for their consideration. Severe attacks no longer occur, but walking any distance in heavy boots or with galoshes over my shoes can cause great discomfort in either leg—no doubt due to the act of dorsiflexion against resistance used experimentally to produce pain.—I am, etc.,

Stafford.

J. H. E. BAINES.

Treatment of Macroglobulinaemia

SIR,—The treatment of macroglobulinaemia by plasmapheresis described by Drs. N. Conway and J. Miles Walker (November 17, p. 1296) is most interesting, but, although it produced a temporary improvement in the tendency to bleed, the remissions were of very short duration and the patient did not survive long. Moreover, the treatment appeared to be continually affected by the necessity for repeated blood transfusions.

It is therefore perhaps worth recording another form of treatment which has given a very satisfactory result.

In November, 1958, a woman aged 78, a known case of hypertension, was admitted to Farnham Hospital *in extremis* following severe epistaxis. She was collapsed and semi-conscious. Great difficulty was experienced in making a blood smear, as the blood clotted immediately.

Investigations showed that her serum was "stiff" with macroglobulin and the pathological investigations were as follows: Hb 28% (3.9 g./100 ml.), W.B.C. 8,000/c.mm. (polymorphs 78%, lymphocytes 18%, monocytes 4%). Blood group A, Rh positive. Total serum proteins 9.4 g./100 ml. Serum urea 66 mg./100 ml. Thymol turbidity more than 10 units. Zinc sulphate turbidity more than 10 units. Sia's test positive. Cryoglobulin present. Thymol flocculation shows coacervation. Electrophoresis shows an intense narrow band in the globulin region. Sternal puncture: polymorphs 40%, lymphocytes 10%, metamyelocytes 8%, myelocytes 20%, early normoblasts 2%, intermediate normoblasts 1%, late normoblasts 16%. Plasma cells 5%. Cellularity moderate, megakaryocytes plentiful. Section shows increased marrow cellularity with focal deposits of plasma cells. Urine—Bence Jones protein not detected.

Retinal haemorrhages were present in right eye, left fundus was obscured by cataract. X-ray examination showed no evidence of myelomatosis. A blood transfusion of several pints was given. She was discharged after five weeks when her Hb was 62% (9 g./100 ml.).

During 1959 and 1960 she had repeated epistaxis which did not respond to cauterization and she required admission to hospital four times for transfusion. During all this time her Hb could not be raised above 40% to 50%. During this time she also fractured her ribs twice and pelvis once following quite slight trauma, indicating a degree of osteoporosis.

In May, 1961, I referred her to Professor N. H. Martin, of St. George's Hospital, who suggested trying ethinyl oestradiol 0.02 mg. daily and methyl testosterone 2.5 mg. daily sublingually, as he had had a successful result in a similar case. This was done and she had no more epistaxis.

In August, 1962, she became worried by the hair which had been growing on her chin and I suggested she might stop the methyl testosterone. Between July and September she had some vaginal bleeding, which became severe in September, and as this distressed her very much and she had been free from epistaxis for 16 months I stopped the ethinyl oestradiol. One month later she had a severe epistaxis and ethinyl oestradiol was immediately started again, since when there has been no further epistaxis.

Incidentally, she is just recovering from an attack of bronchopneumonia, which at one time looked like terminating fatally. This may also have been due to stopping the ethinyl oestradiol and so making her more susceptible to intercurrent infection.

The treatment is entirely empirical and arose from a paper on the treatment of hereditary haemorrhagic telangiectasia by H. J. Koch, G. C. Escher, and J. S. Lewis in the *Journal of the American Medical Association*.¹ It is a much simpler form of treatment than plasmapheresis.—I am, etc.,

Farnham, Surrey.

F. BEDO HOBBS.

REFERENCE

- ¹ Koch, H. J., Escher, G. C., and Lewis, J. S., *J. Amer. med. Ass.*, 1952, 149, 1376.

Management of Viral Hepatitis

SIR,—Although your leader (December 1, p. 1454) on the management of viral hepatitis emphasizes the need to avoid where possible giving any drug to a patient with a damaged liver, I was rather surprised that no mention whatsoever is made of the hepatotoxic action of alcohol. It is, of course, well recognized that the ingestion of alcohol in patients with viral hepatitis may predispose to the later development of such sequelae as cirrhosis of the liver and liver failure, and I am sure that all who have dealt with outbreaks of viral hepatitis, particularly during the war years, will agree that even a small amount of alcohol taken during the convalescent stage may produce an almost immediate relapse, usually with a recurrence of jaundice. On the basis of this experience, I believe that complete abstinence should be advised for at least six months and that the quite natural desire to break this rule once in a while during "high days and holidays" should be very firmly resisted.—I am, etc.,

Swindon, Wiltshire.

A. G. FREEMAN.

POINTS FROM LETTERS

Health in Ghana

Dr. P. RABINDRAN (Effia Nkwanta Hospital, Sekondi, Ghana) writes: I thank you for publishing my letter "Health in Ghana" in your *Journal* (September 15, p. 732). I have had several queries from doctors all over the world who are desirous of coming to work in Ghana. I regret my inability to reply to them individually. I would suggest that they should write to the Ghana High Commission, 248-250 Tottenham Court Road, London W.1, from whom they can obtain all the necessary information.

Medicine and the Common Market

Dr. LESLIE HARTLEY (Camberley, Surrey) writes: "Why beholdest thou the mote that is in thy brother's eye, but considerest not the beam that is in thine own eye?" (St. Matthew, vii, 3). In your leading article on "Common Market Medicine" (September 22, p. 782) you draw attention to the different standards and conditions of qualification in the various European countries, and Lord Cohen of Birkenhead suggests that our own are unequalled. You point out that there is nothing on the Continent approaching our comprehensive N.H.S., the benefits of which are so attractive that it is not unknown for patients from the Continent to find ways and means of securing treatment in Britain rather than in their own countries. Is this due to the fact that treatment in this country is free, and the foreigner may even draw public assistance during his illness at the expense of the British taxpayer, or is it that the treatment in this country is superior? The imposition of charges to foreigners and the withdrawal of grants would soon solve this problem. . . . I have been most impressed by the high standards of my Continental colleagues, and with the very long hours they are prepared to work in the service of their patients.

Prevention of Carcinoma of Cervix

Mr. MALCOLM DONALDSON (Cancer Information Association, Oxford) writes: Mr. J. A. Stallworthy (October 13, p. 994) is correct in stating that many hospital centres use cytology and colposcopy in the diagnosis of carcinoma of the cervix uteri. Is it not true, however, that Edinburgh is the only area which provides a cytological service for the family doctors?

Detection of Glaucoma

Dr. L. H. G. MOORE (Birmingham 13) writes: I would draw the attention of Dr. P. Richard Day (November 10, p. 1257) to my letter in the *British Medical Journal* dated April 12, 1958 (p. 890), under the heading "Ministry Memorandum on Blindness." The suggestions which I made offer the only possible short-term solution to this problem, and I think that within the next few years some action on the lines which I suggested will have to be taken.

Dr. JOHN MATTHEWS (Liverpool 1) writes: The Ministry of Health pamphlet entitled *The Prevention and Alleviation of Blindness*¹ rightly states that "simple glaucoma may be accompanied by no clamant symptoms," but any doctor and certainly any ophthalmic medical practitioner should be able to suspect simple glaucoma from the appearance of the disks. The outstanding omission in the pamphlet is that there is no recommendation that all individuals over 40 years of age should have a medical eye examination.

REFERENCE

- ¹ Standing Medical Advisory Committee for the Central Health Services Council and the Ministry of Health, *The Prevention and Alleviation of Blindness*, 1962. H.M.S.O., London.

Appendicitis

Dr. KATHLEEN ALWIN-GIBSON (London N.W.1) writes: Quote: Sir Stanford Cade, F.R.C.S., "It is never too early but it is often too late to take an appendix out." I have been qualified 30 years and this wise advice given me as a student at Westminster Hospital is still remembered with gratitude by me.