On the other hand, the less well-educated and often ignorant wife of an unskilled labourer may not only misunderstand instructions, or even forgo available prenatal care, but is also more likely to be in indifferent health prior to pregnancy. The question of economics and ability to buy additional nutriment obviously has some bearing on the problem. There is also a greater likelihood that the less sophisticated labourer's wife will be content enough with the care of the midwife or the general practitioner. Unfortunately because of the attitude of some practitioners, or the heavy load placed upon them, the important tests for anaemia or for estimating the Rh factor may have been overlooked.

All in all, it is likely that the poor even in Great Britain get poorer care than the better off. Of course the trained obstetrician, being a specialist, may say in one and the same breath: "But we look after both the rich and the poor and deplore the poor performance of the G.P. and the midwife," and then add, "But, of course, the G.P. is O.K. really, old chap, provided he keeps to his field of competence." But so do all the other specialists say the same thing in regard to their own particular specialty. Yet one man, even a specialist, can only do so much. The growing shortage of physicians, including obstetricians, will further accent the problem of the division of the load between the family physician and the specialist ("Recruitment," November 3, p. 1186).

You just cannot have it every way. Either the family physician has a role in obstetrics as in the other specialized areas, or he has not. If he has a role it ought to be clearly defined. It also ought not to be so limited that there is no challenge in the task (see "Deliveries in General Practice" (Conclusion), October 27, p. 1118). Having defined his role, then in a planned approach to care he should really be given the task allotted and encouraged forthrightly to carry it out, *as a member of an integrated health team.*

As for the patient, there seems to be a growing need for education, and more education, whether this be for the pregnant female or the father-to-be or for any other individual needing health supervision or advice.—I am, etc.,

City of Cincinnati Board of Health,
Cincinnati 2, Ohio.

KENNETH I. E. MACLEOD.

Annual Registration Fees

SIR,—The proposed implementation of the Professions Supplementary to Medicine Act, 1960, has drawn my attention to yet another example of short-sighted policy on the part of the Government departments.

It is proposed that "medical auxiliaries" should pay an initial registration fee, then an annual fee of £2 10s. Most of these, physiotherapists, dietitians, chiropodists, occupational therapists, radiographers, remedial gymnasts, and medical laboratory technicians, are girls who qualify about age 21, work for a few years, marry, and cease work. They are not going to continue to pay a fee for five or ten years while they bring up a family. Even though it will no doubt be possible for them to be readmitted to the *Register*, has it ever crossed the minds of those drafting the regulations how these women come back to work? Usually they are drawn back to do short locums—this keeps them interested and up to date. If they have to go through the formalities of re-registration then there will be less inducement to return to work, yet these regulations are being made at a time when

there is a growing shortage of this type of medical help. This is perhaps a step towards an annual fee for medical registration. I am sure that this would arouse strong feelings from the doctors of this country. Why, then, should less well-organized supplementary professions be penalized?

Would it not be more sensible and practical to pay an initial registration fee, if necessary divided into five annual payments, and then give permanent registration. This would allow income-tax relief on the payments, rather than demanding payment from those who may not be earning.

I have checked to-day with several nurses, who, in Scotland, pay an annual fee for each certificate that they hold. I find that when they have their General Certificate the tendency is to let lesser certificates, such as R.F.N., lapse, although they may save as little as 4s. per year.—I am, etc.,

Glasgow S.3

ALLAN BAIRD.

Accidental Overdose of "Parstelin"

SIR,—*"Parnate"* (trans-DL-2-phenylcyclopropylamine) is a powerful mono-amine oxidase inhibitor. It is widely used for the symptomatic treatment of depression. In combination with "stelazine" (trifluoperazine) as "parstelin" it is effective when used in anxious or agitated depressive states. There are very few cases of overdosage of parstelin recorded in the literature,¹ so the following may be of interest.

On January 17, 1962, a girl aged 20 months was found at about 1 p.m. playing with a bottle containing parstelin tablets (parnate 10 mg., stelazine 1 mg.). It seems probable that she had swallowed four or five tablets. The relatives took no immediate action. At about 4 p.m. she vomited three times, but subsequently seemed well and normally lively. Her parents noticed that she was rather restless during the night and became alarmed when the following morning she was very drowsy and difficult to arouse. They contacted their general practitioner, who brought the child to hospital at 9 a.m.

On arrival—about 20 hours after having swallowed the tablets—she was semi-conscious. There were marked athetoid movements of the limbs and some spasm of the neck muscles. Muscle tone was variably increased and reflexes were brisk. There was unsustained ankle clonus and both plantars were flexor. The pupils reacted sluggishly to light. There was no nystagmus and the fundi and disks were normal. Her blood-pressure was 130/90.

"Sparine" (promazine hydrochloride) 10 mg. and pyridoxine 20 mg. were given intravenously, producing a transient fall in blood-pressure to 110/70 but leaving the athetoid limb movements unchanged. Two hours later sparine 10 mg. was repeated intramuscularly. The girl now appeared to be more aware of her surroundings.

Twelve hours after admission she was able to take fluids by mouth, although her limb movements were still uncontrolled. An hour later she quite suddenly became fully conscious and the athetoid movements ceased. Thereafter she remained quite normal in behaviour. Her blood-pressure remained at 110/70. There were no abnormal neurological sequelae and she was discharged from hospital 48 hours later.

Vomitus from the child's clothing and samples of urine were examined by the S.W. Forensic Laboratory. Traces of parstelin were detected in the vomitus, but the urine samples yielded negative results.

Parnate overdosage has been recorded² as producing agitation, incoherence, followed by coma, opisthotonos, extensor rigidity, and tremor. Stelazine overdosage causes Parkinsonian symptoms, C.N.S. depression, agitation, and restlessness. Following gastric lavage,

Robertson³ recommends the use of intravenous anti-histamines to help counteract the Parkinsonian side-effects.

I wish to thank Dr. B. D. Corner for permission to publish this case, and Messrs. Smith Kline and French Ltd. for supplying information on the drugs concerned.

—I am, etc.,

Southmead Hospital,
Bristol.

R. E. MIDWINTER.

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- ¹ Bateman, C. R., *Canad. med. Ass. J.*, 1961, **85**, 759.
- ² Baldrige, E., Miller, L. V., Dyce, B., and Haverback, B. J., *Clin. Res.*, 1962, **10**, 83.
- ³ Robertson, W., *Amer. J. Dis. Child.*, 1960, **100**, 290.

A Ward Resuscitator

SIR,—At any hospital where acutely ill patients are treated there exists the possibility of sudden respiratory emergencies on the wards. Only too often it is found

that the essential apparatus is hard to find and deficient in necessary items when assembled. There exist various resuscitators utilizing room air, but for the neurological patient the use of oxygen seems indicated. Accordingly the set illustrated herewith has been standardized at the National Hospital, Queen Square, for distribution to each ward and to the x-ray department, recovery room, and out-patients. It will be seen that the essential items are clipped in labelled positions in a "perspex" box while the oxygen key is chained and riveted to the stand. The equipment is adequate for

patients with tracheotomy as well as normal individuals. Oxygen cylinders are checked by the dispensary twice weekly and must be more than half full.

The advantages of this set are: (1) It is ready for immediate use; (2) being transparent, it is immediately noticeable should anything be missing; (3) the handbag unit is carried ready assembled so that no mistake can possibly occur.

The original prototype shown above was made by Mr. Noel Nelson, of the engineer's department.—I am, etc.,

R. ATWOOD BEAVER.

National Hospital for Nervous
Diseases,
London W.C.1.

Spontaneous Rupture of the Right Ventricle

SIR,—I have been very interested in the paper by Dr. Bernard Knight (November 3, p. 1167) and the subsequent letter by Dr. David Bowen (December 8, p. 1544) on the subject of spontaneous rupture of the right ventricle. Both authors were kind enough to quote the work of Piggot and myself, but neither has apparently seen a later paper reporting seven cases.¹

In our experience rupture of the right ventricle usually occurred in patients who had been long bedfast and who had attempted sudden exertion. The pericardium did not always contain a large amount of blood, so that pericardial tamponade was not always the obvious cause of death. Histological examination of the muscle in the region of the rupture usually showed characteristic changes of fatty infiltration.—I am, etc.,

Geriatric Research Unit,
St. John's Hospital,
London S.W.11.

TREVOR H. HOWELL.

REFERENCE

- ¹ *Geriatrics*, 1957, **12**, 711.

Polythene in Dermatology

SIR,—Dr. S. Patrick Hall-Smith's preliminary communication on "polythene" coverings in dermatological treatment (November 10, p. 1234) confirms my impression that this new form of treatment is of great beneficial effect in various recalcitrant dermatoses.

The bugbear here in this climate, however, is that many patients develop miliaria rubra, folliculitis, and boils. I have been able to overcome this disadvantage more or less by using the polythene dressing or gloves at night only, and sealing the dressing with a wide rubber band instead of "scotch" tape.

I do not think that this form of treatment is suitable for cases of lichen planus hypotrophicus as the pruritus seems to be aggravated by the occlusion.—I am, etc.,

Bulawayo, S. Rhodesia.

H. J. KINGSLEY.

Diuretics and Leg Ulcers

SIR,—There are several basic factors to be understood before any success with therapy for varicose ulcer can be achieved. Dr. D. B. Fox, in an excellent paper on this subject (November 24, p. 1370), certainly goes some way to achieving this goal. The main aims are to produce an adequate arterial capillary blood supply to the ulcer's growing edge, which must be free of oedema and pathogenic organisms, and to remove the venous flow away from this edge by external pressure. Dr. Fox emphasizes two of the main factors required to achieve this:

1. Elimination of bacterial infection from the ulcer and its surrounding tissue. This can be done by a suitable broad-spectrum antibiotic in a sufficient concentration at the site of the infection. One must eliminate so far as possible the stasis and extra capillary pressure of oedematous tissue and give the antibiotic orally or parenterally. The infection is usually a combination of a low-grade erysipelas and/or a cellulitis.

2. The oedematous tissue is a difficult problem, but, like Dr. Fox, I have found that orally diuretics are essential in the majority of cases. I personally use "hygroton" tablets at three and four days' interval in a week. This particular diuretic has a more prolonged action than its competitors and is more acceptable to the patient, as they rarely feel they've "been drained