had started to rise just before the transfusion. The effects on uric-acid excretion were certainly not the effects of the blood transfusion *per se*, since control observations were made on this same patient on the three days following his second transfusion (also of 2,500 ml. of fresh blood) in August, 1958. On this occasion the uric-acid excretion on the three days after transfusion was 573, 548, and 715 mg./24 hours—that is, a greatly increased amount, sharply contrasted with the abrupt fall after the first transfusion (illustrated in the Chart).

Further work is needed, particularly since there may be fallacies in relying on the results of uric-acid studies. It is remotely possible, for example, that accelerated uricolysis (Bien *et al.*, 1956) could entirely explain the observations made in this patient. However, this would entail a rate of uricolysis exceeding 60% of the normal daily production—a rate which has not yet been shown to occur in human beings. The simplest explanation is that acute reduction in the rate of normal white-cell destruction was the first event, which, by tilting the balance in favour of the normal cell population, produced a temporary clinical and haematological remission.

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Hypotension Due to Meprobamate Overdose

Attention has been drawn to the dangers of meprobamate (*Brit. med. J.*, 1958). The following case of meprobamate overdosage is thought to have some features of interest.

CASE REPORT

A 19-year-old Swedish girl, employed as a resident maid in a children's home, shared a room with another girl and was not noticed to have been depressed or to have been behaving abnormally until at 6.30 a.m. on the day of admission an unsuccessful attempt was made to awaken her. At 8.15 a.m. a doctor was called as she was still unrousable. She was unconscious, with stertorous breathing. The pupils were dilated but reacted to light, and the corneal reflexes were present, as were the tendon jerks. The plantar reactions were down-going. The muscles were flaccid.

At 9.45 a.m. the patient was admitted to hospital, where the original findings were confirmed. The blood-pressure was 100/60, the pulse 70, and the temperature 96.6° F. (35.9° C.). She could be roused by loud speech, when she would open her eyes briefly and look around her. She would also react in a purposive manner to unpleasant stimuli such as pin-prick or plantar stimulation, and would try to cover herself with the bedclothes when these were removed during examination. Though her muscular tone

was low, power appeared to be fairly good. She was given 2 ml. of nikethamide intravenously and her stomach washed out. No tablets were recovered. Gastric washings and urine were negative to tests for barbiturate and aspirin derivatives.

One hour after admission the blood-pressure had dropped to 90 systolic, and at two hours it was 80 systolic. No further change in the level of consciousness had occurred; the pulse was 80 and weak. She showed no evidence of shock. Her general appearance gave no idea of her falling blood-pressure. She was not cyanosed and her skin was warm.

Three hours after admission the blood-pressure was 60 systolic and the pulse was becoming difficult to feel. At this time no tablets had been discovered, and as the clinical picture did not fit barbiturate or aspirin poisoning a lumbar puncture was done, the findings being normal. She was still conscious enough to object to this procedure by moving her limbs. It was decided to treat the hypotension symptomatically, and while a drip trolley was being prepared the blood-pressure became unrecordable. There was no change in respiration. Mephentermine sulphate, 30 mg., was given intravenously; the blood-pressure rose at once to 80 systolic, falling during the next 15 minutes to 60 systolic, when an intravenous infusion of 4 ml. of L-noradrenaline in a pint (570 ml.) of glucose-saline was begun. The blood-pressure responded at once, being readily controlled and maintained between 100 and 120 systolic.

The patient's consciousness gradually returned, so that six hours after admission to hospital her eyes were open and she was able to say that she felt better. At about this time a box containing 70 whole 200-mg. tablets of meprobamate and some broken fragments was brought to the ward, having been found among her belongings. She admitted taking some of her tablets the previous evening, but would not state how many or what her consumption of tablets had been over the period immediately prior to her illness.

The patient's mother arrived from Sweden 24 hours after the patient's admission and gave the history that her daughter was "nervous" and had taken overdoses of the same tablets in January, 1957, and February, 1958. She had not been treated in hospital on either occasion. The tablets in her possession were the remainder of 200 sent her from Sweden three months previously. A sister aged 22 years had received insulin-coma treatment and electric convulsion therapy.

Eleven hours after her admission noradrenaline was omitted from the drip without further disturbance of blood-pressure, which remained at about 120/70. The patient was fully ambulant 36 hours after admission, and was discharged home to Sweden on the fifth day after admission. Up to this time no sequelae had been noted.

COMMENT

In this case of meprobamate overdose the fall in blood-pressure was out of proportion to the depression of consciousness. The occurrence of hypotension is described in most of the 17 or so other cases reported (Shane and Hirsch, 1956; Heberden and Cooper, 1957; Powell *et al.*, 1958; Bedson, 1959). The patient's general condition gave little indication of her falling blood-pressure; the symptom responded readily to mephentermine and noradrenaline.

I thank Dr. Philip H. Willcox for his kindness in allowing me to report his case.

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