prophylaxis is all-important, and here doctors and nurses should obviously occupy leading roles. The finding that so many members of the medical and nursing professions themselves become victims of drug-dependence and alcoholism once more illustrates the urgent need for much better coverage of these subjects in the medical and nursing curriculum.—I am, etc.,

St. Bernard's Hospital,
Southall, Middlesex.

M. M. GLATT.

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Psychotropic Drugs

SIR,—Recently I was called urgently to see a young woman complaining of severe headache. She had been on a monoamine oxidase inhibitor drug for a considerable time, and was under consultant psychiatric supervision for a moderately severe depression.

During the previous night she had been unable to sleep as a result of an irritating cough. In scientific parlance, she took 30 ml. of a proprietary children's linctus, freely available over the counter, and thereby ingested a total of 9 mg. of the antihistaminic agent promethazine hydrochloride. Shortly afterwards she suffered the typical pounding occipital headache of the M.A.O.I. adverse reaction.

In lay language, here was a young woman who while taking a drug for her depression at the same time took a moderate dose of a children's cough mixture, as a result of which she could in theory have died from a brain haemorrhage, leaving a motherless young family. I make no apology for the dramatic nature of the last sentence. Fortunately, she recovered fully, and I should also point out that she had been well warned about the usual agents likely to cause this reaction. I would be the first person to agree with Dr. William Sargant (27 January, p. 249) that the antidepressants have a specific action, and are not mere placebos supported by the therapeutic personality of the physician. However, from the above experience, I would suggest two things.

First of all there would appear to be a case for regarding the M.A.O.I. group as potentially very dangerous drugs, to be used solely on consultant psychiatric advice. I would suggest that the vast majority of depressive states met with in general practice can be successfully and safely treated with the tricyclic compounds such as amitriptyline and imipramine.

Next, it should behave all practitioners prescribing the M.A.O.I. drugs to impress upon their patients the need not only to avoid the well-known adverse reactors, such as cheese, broad-beans, and Marmite, but to eschew every drug and proprietary medicine

unless previously approved by their physician.—I am, etc.,

Leicester.

LOGAN MITCHELL.

SIR,—Psychotherapists should be able to take heart from Dr. William Sargant's letter (27 January, p. 249). The value of their work has often been criticized because they failed to supply statistics convincing enough to support their claims. But now we are told that even the "most refined statistics" can equally prove or disprove the alleged efficacy of a particular therapy. This being so, psychotherapists like pharmacotherapists can argue their case on the strength of bedside experience, and similarly claim gratifying results in selected patients, without bothering too much about statistics.—I am, etc.,

Weybridge,
Surrey.

I. ATKIN.

Diphenhydramine in the Treatment of Oculogyric Crisis

SIR,—The recent interest in your correspondence columns (2 December, p. 554) in the bizarre manifestations of oculogyric crises following phenothiazine therapy prompts us to record the following unusual instance in a child, and its treatment with the antihistamine diphenhydramine.

The patient, a boy aged 2½ years, was seen two hours after the ingestion of about 6 ml. of a film cement containing as a solvent 80% ethylene chlorhydrin and 20% acetone. His stomach was washed, but he continued to vomit and became increasingly drowsy and shocked. In addition to the usual resuscitative therapy amphetamine sulphate 2.5 mg. was administered orally as a stimulant, followed by a similar dose four hours later, together with an intramuscular injection of 1 mg. because of profuse vomiting. There followed an increase in respiratory and pulse rates, and a rise in blood pressure, which were attributed to the effect of amphetamine. Twenty-four hours after ingestion episodes of upward rolling of the eyes with a fixed gaze,

opisthotonos, and gustatory movements in the mouth were noticed. Neurological examination, liver-function tests, serum electrolytes, and blood urea were normal. The attacks were initially thought to be a form of petit mal (there was no previous or family history of this), and two doses of phenobarbitone 15 mg. each were administered at 12-hourly intervals. The patient had a total of six attacks and a few milder ones in the next 24 hours, when it was realized that they were in fact "oculogyric crises." Oral diphenhydramine 10 mg. six-hourly was then started, and no significant attacks followed, other than two mild ones, within the following 24 hours.

No similar neurological disturbance is known to follow amphetamine¹ or ethylene chlorhydrin. Toxic effects of the latter² include central nervous system depression, peripheral circulatory and respiratory failure, and impairment of liver and kidney functions. There was no evidence that the small dose ingested resulted in any residual deleterious effects, but its association with the oculogyric crisis is very strong. This was also the case with the striking improvement following the administration of diphenhydramine.

A similarly dramatic response was witnessed by one of us (J. A.) in a 10-year-old girl with Riley-Day syndrome (familial dysautonomia) who developed oculogyric crisis following a relatively small dose of chlorpromazine. Besides the well-known effect of the solanaceous drugs in the treatment of oculogyric crisis attention is drawn here to diphenhydramine, which is also useful in the treatment of other extrapyramidal manifestations of phenothiazine toxicity.³—We are, etc.,

DON HILSON.

J. M. ABRAHAM.

The General Hospital,
Ashton under Lyne, Lancs.

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Gynaecomastia in Renal Failure

SIR,—We quite agree with the conclusions of Dr. R. M. Lindsay and others that "gynaecomastia may occur not uncommonly in male patients with chronic renal failure during the early stages of regular dialysis treatment" (30 December, p. 779).

Gynaecomastia has been documented in eight of our 22 patients receiving maintenance haemodialysis. On occasions, breast enlarge-

ment may be extreme, as shown below. Since reporting this "complication" of haemodialysis to the American College of Physicians in April 1967¹ we have learned of over 25 additional cases. In addition, lactation in women has apparently been noted following haemodialysis.²

We are also unaware of any reports specifically dealing with gynaecomastia in

uncomplicated chronic renal failure without regular dialysis treatment. In 1954, however, Wheeler *et al.* reviewed 160 cases of gynaecomastia collected over a 10-year period.³ Bilateral gynaecomastia was noted in four patients in whom chronic pyelonephritis or chronic glomerulonephritis was the underlying disease. Hypertension and decreased renal function were present in three, and atrophic testes were noted in two of these patients. Although we have also observed gynaecomastia in the non-dialysed uraemic patient, its incidence seems to be greatly increased by maintenance haemodialysis. The resemblance to refeeding gynaecomastia is indeed striking.—We are, etc.,

R. M. FREEMAN.

R. L. LAWTON.

MARGERY O. FEARING.

Renal Dialysis Center,
Iowa City,
Iowa.

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SIR,—I have sent to the Glasgow University writers on gynaecomastia (30 December, p. 779) details of a case of uraemia with gynaecomastia.

A man of 68 years with chronic nephritis and hypertension had been treated over a long period with methyl dopa and bendrofluazide or frusemide, with recent addition of promethazine hydrochloride or trimetopazine tartrate to allay itching.—I am, etc.,

Tewkesbury,
Glos.

D. M. WILKINSON.

Malaria in Britain

SIR,—The letter by Professor B. G. Maegraith and Dr. D. H. Smith (20 January, p. 179) prompts me to report a case of malaria which occurred recently in north London.

A 60-year-old man had come from Jamaica 12 days ago to take a postgraduate course at a theological college. There had been several cases of influenza in the college, and when the patient developed malaise, anorexia, and a moderate pyrexia after five days the presumptive diagnosis was of a similar viral infection. When I first saw him three days later he had also been taking penicillin for three days to treat concurrent pyorrhoea and facial pain (thought to be of dental origin), and an appointment had been made for him to see a dental surgeon.

I was called because of a vague worsening in his condition. I found an intelligent man who was rather sleepy and whose speech tended to falter to a halt before the sentences were complete. Although he was possibly anaemic, with a temperature of 100.5° F. (38° C.) and a raised erythematous rash on the trunk, he was not jaundiced and the liver, spleen, and lymph glands could not be palpated. Apart from the faltering cerebration there were no abnormal neurological signs. He also told me that he had had two days of diarrhoea at the start of his illness.

I asked for hospital admission for him as a case of a "P.U.O.," of possible malarial or even typhoid origin, with a penicillin skin reaction. He was admitted to the local infectious diseases hospital, where *Plasmodium falciparum* malaria was diagnosed. He is reported to be improving after 24 hours'

treatment, although his mental condition is still somewhat confused.

I have recently seen many patients with influenza-like illness, some of whom had not long returned from abroad. As Professor Maegraith and Dr. Smith suggest, it would have been easy to miss the diagnosis at its relatively early stage (and blame some of his symptoms on an unfortunate reaction to penicillin).—I am, etc.,

London N.2.

M. F. GREEN.

Community Child Care

SIR,—I write as the editor of a book, *The Community's Children*,¹ recently published. I am grateful for the encouraging notice you gave it in your leading article (20 January, p. 134) under the above heading.

However, in restricting your comment to the suggestion that voluntary workers in the community should, under supervision, be encouraged to take more practical interest in the lives of children in care, I feel you have missed the whole point of the book.

One page alone out of 93 mentions the role of such helpers. The main recommendation, on the contrary, is for an increased recruitment of professional staff to the child care services, and the provision of better training facilities and improved working conditions for them.

The book sets out to provide a basic knowledge about the child care services (with particular reference to children in long-term residential care) for the concerned general public, members of local authority committees, and professional workers in related fields. It should be of interest to all those readers of the *B.M.J.* who, in the course of their general practice or clinic work, come into touch with children living away from their homes, the staff who look after them, or parents who are not fulfilling their parental roles. It is hoped that this book will be of some service to such doctors in helping them to understand the background of these family breakdowns, the types of substitute care provided, and the strains and stresses to which all concerned are subject.

Finally, the number of children in England and Wales living away from home in 1965 was 79,000, not 19,000 as stated in the leading article.

Inner London Education
Authority,
Greater London Council,
London S.E.1.

JESSIE PARFIT.

REFERENCE

- ¹ *The Community's Children*, 1967. Longmans in association with the National Bureau for Co-operation in Child Care.

** We corrected the figure of 19,000 to 79,000 in our issue of 3 February, p. 328.—Ed., *B.M.J.*

Improving the Psychiatric Services

SIR,—I was most interested to read Dr. J. H. Raphael's letter (30 December, p. 806). May I first firmly state that I agree to the utmost that treatment should be tempered with humanity and common sense? I should like to make it clear that there was no question of a blanket "x weeks in and x weeks out" service. Every patient was most carefully assessed by interview. An assessment was also made of the home set-up, support from the relatives, and so on before this

system was adopted in an individual case. I would agree that shuttling old people about can affect them adversely; and one is always happier to have patients staying at home and coming up to the day hospital, unless there is really severe disturbance and difficulty at home. Our service was certainly not run with unfeeling uniformity, and I am sure that geriatric services should be flexible to the patients' response.

I admit that if some miraculous cure for the ills of old age was arrived at I with many others would wish it to cause a happier end to life. However, I certainly agree that there is no panacea, and I have not thought there was. I would agree that one should always be sceptical of much-praised schemes with an apparently wonderful simplicity, which some might feel more harnessed to the needs of impact for the doctor than to meet humanely the needs of the patient.

Dr. R. S. Ferguson (13 January, p. 119) asks for statistics on the results of day hospitals and also poses the query of who is to be judge of any improvement to services. May I refer him to the published proceedings of the Symposium on Psychiatric Disorders in the Aged, held in London in September 1965 by the World Psychiatric Association? In this there is a wealth of commentary from many people with experience in running services of this kind, with detail and analysis of the ways these patients can be helped by day hospitals and community facilities. In particular, for a most careful and thorough statistical analysis, may I refer him to the papers by Dr. Peter Sainsbury, Dr. Costain, and Dr. Jacqueline Grad ("The Effects of Community Services and the Referral Rates of Elderly Psychiatric Patients"), and particularly by Dr. Jacqueline Grad and Dr. Peter Sainsbury ("An Evaluation of the Effects of Caring for the Aged at Home")? In this field I think it is vital in assessing benefits to consider very carefully the effect of the phrasing of questions on those answering them. It may be that the primary persons involved may be considered to be the patients. In this case it may be important that before answering queries they be made aware that the alternative to day-hospital care or intermittent periods in hospital may well be a much earlier and/or final consignment to an institution.

The lowly rating of day hospitals in Blackpool could in part be an index to pressure on general practitioners from the offspring of elderly patients. A vocal minority of these may perhaps find the extra care and devotion needed by elderly relatives not to be part of their scheme for "modern living." In such cases it may be that while the patient is only moderately eccentric and with minimal memory upset the relatives try furiously toward their being "put away." In an earlier age (and elsewhere, as in India, where, in addition, there are not such easy ways of getting rid of the old) they would have accepted the trials of looking after the declining as a labour of love, within reason.

The final issue of the quality of being enabled, with help, to live with one's relatives, or in the home one has known for a lifetime, as opposed to consignment to a mass institution, may be hard to analyse statistically.—I am, etc.,

Colchester, Essex.

HARRY JACOBS.

REFERENCE

- ¹ *Psychiatric Disorders in the Aged*, 1967. Manchester.