analgesia. This has been another factor in the abolition of the old boggy of "failed forceps."

I respect Mr. Donaldson's views and I will give further thought to them as the occasions arise, but I still regard the concept of trial forceps as a most valuable one and I would be sorry to see it abandoned.—I am, etc.,

Banbury, Oxon.

J. M. GATE.

Ileus after Amitriptyline

SIR.—Although the anticholinergic side-effects of amitriptyline are widely recognized, there is, so far as we can determine, only one clearly documented case in which paralytic ileus has occurred during administration of this drug,¹ although in the case in point some doubt has been cast on the aetiology of the ileus because of the other medication concurrently employed.² Constipation particularly has been noted to occur commonly in patients taking amitriptyline.

We would like to draw attention to the following case which was recently admitted with pustular psoriasis to the Royal Waterloo Hospital.

The patient, a 54-year-old married woman, had received out-patient treatment in 1962 for her psoriasis. On February 4, 1963, she was admitted because of reactivation of the psoriasis on her feet, and this was treated with "synalar" cream. On February 7 depressive symptoms were noticed, and a psychiatric opinion was sought: amitriptyline 25 mg. thrice daily was prescribed. On February 21 the dose was increased to 50 mg. thrice daily. At that time there were no significant side-effects, and within a few days there was some lifting of her depressive symptoms.

On March 10 she became severely constipated, and this, on March 12, became absolute, with passage of neither flatus nor faeces. She complained of generalized colicky abdominal pain which continued for seven days, by which time her abdomen had become more distended and tender and she developed a slight irregular pyrexia. There was not, at any time, any evidence of renal dysfunction. On the evening of March 19 bowel sounds were very much diminished, and on rectal examination no faeces were palpable. Laparotomy was performed that evening. Her ileum was found to be distended and the terminal 18 in. (47.5 cm.) were filled with formed faecal material. The whole of her colon was similarly loaded. Post-operatively she was managed with naso-gastric suction and intravenous fluids.

The following day she showed little improvement, and on March 21 she was given an olive-oil enema followed 12 hours later by a soap enema with no effect. On the afternoon of March 22 her condition deteriorated further; her abdomen was therefore reopened and a left iliac colostomy performed. The hard scybalous masses in her colon were broken up and squeezed out through the colostomy and the faecal material in the terminal ileum milked into the ascending colon. On this occasion the small bowel was very much dilated and not contracting at all. On March 23 there was little change; no flatus had been passed through the colostomy. An intravenous pitressin infusion of 5 i.u. in 1 litre was administered in an eight-hour period. There was no response to this and the dose was doubled. Four hours later she experienced a colicky pain, and on March 24, following a total dose of 25 i.u. of pitressin in approximately 24 hours, her colostomy started to function. Since then her colostomy has functioned two or three times daily and her general state has improved considerably. The pitressin has been discontinued.

In view of the unfortunate death recorded in the earlier case mentioned¹ and our findings at the first laparotomy on our case, we feel that conservative measures, such as the administration of prosthigmine or

pitressin, would not alone have proved successful in relieving this patient's obstruction.—We are, etc.,

St. Thomas' Hospital,
London S.E.1.

DEREK R. GANDER.
H. BRENDAN DEVLIN.

REFERENCES

- ¹ Burkitt, E. A., and Sutcliffe, C. K., *Brit. med. J.*, 1961, 2, 1648.
- ² Ayd, F. J., *ibid.*, 1962, 1, 568.

Treatment of Macrolobulinaemia

SIR.—The letters of Dr. D'A. Kok (January 12, p. 120) and Drs. N. Conway and J. Miles Walker (February 16, p. 472) re-emphasized the beneficial effects of plasmapheresis in selected cases of primary macroglobulinaemia (Waldenström). This method may have to be applied in cases with bleeding diathesis or cryopathy, if alkylating agents and/or mercaptanes have been ineffective or too toxic.

Mercaptanes presently are the only drugs known to exert a depolymerizing and immunologically inactivating effect upon the 19S beta-2-M-immunoglobulins *in vivo*. At times these agents may produce adverse effects clinically. During a four-year period we have used mercaptanes in the management of 15 patients. One patient with primary macroglobulinaemia (Waldenström) developed urticaria following the oral administration of D,L-penicillamine. Agranulocytosis appeared in the same patient three days after cessation of a four week intravenous course of B₆-SH (Mono-mercaptopyridoxine-Merck) (total dose: 32.5 g.) followed by one day of oral administration (0.5 g.). This was complicated by pseudomonas septicaemia. Complete recovery ensued. In another patient with four living healthy children, one premature jaundiced infant alive after exchange transfusions, and four pregnancies terminating in Rh-erythroblastotic stillbirths, high Rh-antibody titres were demonstrated during the tenth pregnancy. She received D,L-penicillamine (500 mg. q.i.d.-p.o.) during the 50 days preceding delivery. After two weeks glossitis and severe anaemia with macrocytosis developed. The daily oral administration of 50 mg. of vitamin B₆ corrected the anaemia. It may be necessary to administer vitamin B₆ during the administration of D,L-penicillamine, since the L-form of this mercaptane has interfered with some of vitamin B₆-dependent transaminases of the liver according to Du Vigneaud and associates.¹

These observations suggest that mercaptanes may produce undesirable side-effects of various sorts (dermatitis, anaemia, agranulocytosis, etc.). Whether these are toxic or hypersensitivity phenomena is unknown. It seems probable that either or both mechanisms may be operative.

Characterization of these effects in humans is required. More effective but less toxic mercaptanes are desirable.—We are, etc.,

WILLIAM C. LEVIN.
STEPHAN E. RITZMANN.

Hematology Research Laboratory,
The University of Texas—Medical Branch,
Galveston, Texas, U.S.A.

REFERENCE

- ¹ Kuchinskas, E. J., Horvath, A., and Du Vigneaud, V., *Arch. Biochem.*, 1957, 68, 69.

Side-effect of Phenindione

SIR.—I was interested to read the recent correspondence by Dr. I. McLean Baird (March 9, p. 681) and Dr. H. A. Dewar (April 6, p. 947) about the appearance of a brownish-yellow discoloration of the