If the doctor looks for objective clinical signs he may obtain some more definite evidence of dependence. The constricted pupils, the injection scars, and other signs of pharmacological action of the drug in a patient whose history suggests narcotic dependence makes the evidence more definite. Studies in experimental animals support the validity of such evidence.^{2,3}

Dr. Ashcroft and his colleagues suggested that the chewing and teeth-grinding sign may be a comparable diagnostic sign in patients who are dependent on amphetamine.⁴ They indicated that there may be pharmacological evidence in rabbits which supports their clinical observation. The value of such pharmacological evidence for forecasting and interpreting drug action in man has been examined by Litchfield.⁵ He points out that almost all drug effects seen in man can be demonstrated to have a counterpart in animals, but it must be recognized that drug effects seen in animals cannot readily be translated into their counterpart in man.⁶ Dr. Walker is conscious of the difficulties of making a differential diagnosis between the clinical signs in patients who are tense and anxious and in patients who have the clinical features associated with dependence on amphetamine or amphetamine/barbiturate mixtures. Such difficulties do not, however, justify any suggestion that pharmacological findings are not valid for the interpretation of observations on the actions of drugs in man unless definite proof to this effect is produced.

Dr. Walker also suggests that a positive diagnosis of amphetamine dependence in practice is impractical unless biochemical facilities are available. It is of some importance to consider the meaning and implications of the term "diagnosis" in relation to drug dependence. Administration of nalorphine or substitution of dummy tablets for a narcotic drug induces the abstinence syndrome on the basis of which a definite diagnosis of drug dependence can be made. In the case of morphine, and to a lesser extent the barbiturates, toxicity is associated with withdrawal of the drug. Dummy tablets rarely, if ever, produce placebo effects. In the case of amphetamine, substitution of dummy tablets for an amphetamine/barbiturate mixture produced a placebo effect in 41% of patients who said they could and in 45% of patients who said they could not do without the mixture. All these patients were believed by their doctors on the basis of the history and general impression to be dependent on the mixture. Clearly, therefore, patients who were known to be taking purple hearts were not dependent upon the pharmacological action of the chemical compounds which are normally present in these tablets.^{7,8} The use of dummy tablets therefore provides a valuable clinical test of dependence on the pharmacological activity of a drug.

As Dr. Walker indicates, chemical tests for amphetamine, and for that matter most other drugs of dependence, are complicated to perform. In spite of this, laboratories such as this one, which perform these tests routinely, carry them out rapidly and reliably. In positive cases very small quantities of amphetamine can be detected in the urine. However, our experience indicates that whenever a drug is detected in the urine of animals or man it is most important not to depend on any one test alone for diagnosis of drug consumption whether it be clinical or chemi-

cal. Evidence from the history and the physical signs, and clinical tests for the pharmacological activity of the suspected drug, should be considered together with evidence from the chemical analyses of the urine, whenever this is possible, before a definite diagnosis of drug dependence is made.—I am, etc.,

CEDRIC W. M. WILSON.

Department of Pharmacology,
Trinity College,
University of Dublin, Ireland.

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Post-mortem Caesarean Section

SIR,—I was greatly interested in your article on post-mortem caesarean section (23 January, p. 204), because it so happens that I twice did the operation in India, and in both cases got a living baby.

The first was one of pelvic deformity where a spinal anaesthetic had been given, but I suspect that it had gone too high, because the patient ceased breathing, and in spite of every effort died before the operation. Having made sure that she was dead, I quickly whipped out the baby, which promptly yelled. (Nowadays, of course, it might be possible to resuscitate such a patient.)

The second case was more dramatic, a woman dying of pneumonia, with that terrible respiratory whoop that these patients get in the last stages. I was operating on another case when one of my assistants wheeled the dying woman into the theatre. I carried on with my operation. The whoop continued, but soon became a death-rattle, and, a few moments later, silence. I again did a very rapid caesarean and extracted a living but rather feeble premature baby which died the next day.

I thoroughly agree with you, it is no use fiddling about with lower-segment section, antiseptics, etc. (though this feels strange); the great thing is to get the baby out quickly, without damage and without panic.

I wonder if you are right in allowing "10 or 15 minutes" to elapse in attempts at resuscitation, with a maximum of 25 minutes? I should put the limit at five minutes or less. I do not think that if the foetal heart can be heard, or there are reasonable grounds for thinking that the baby is alive, precious moments should be wasted in making elaborate tests on the mother, still less in obtaining the permission of the relatives. After all, a competent surgeon is unlikely to be mistaken; incidentally, I believe that one of the quickest tests of death is to put a small drop of formalin on the conjunctiva, which promptly turns red if life is not extinct.

In skilled hands the time from making the incision to extracting the baby is less than a minute, and in the highly unlikely event of the incision's jerking the mother back to life she could be quickly anaesthetized with gas and oxygen, which would presumably be kept ready. Even so, a live baby is better than a moribund mother.

In 102 B.C. the alleged originator of the operation must have abided by some of your excellent principles, or of mine, and thereby changed the history of the world.—I am, etc.,

Bulawayo,
S. Rhodesia.

H. WILLIAMSON.

Plantar Warts and Athlete's Foot

SIR,—May I reply to Dr. C. Starkie's letter (13 February, p. 451) regarding barefoot gymnastics? In 1960 I did a survey on the incidence of plantar warts in Leicester schoolchildren (Annual Report, P.S.M.O., 1960). In the course of my research I requested from the advisers on physical education a list of all barefoot activities (gymnastic dancing, showers, and swimming) in all Leicester schools. The comparison of figures of plantar warts' incidence in different schools did not prove that barefoot work contributes to the frequency of occurrence. One school, for instance, which did not do any barefoot work at all, had an incidence of 61 per 1,000, and another, in spite of the many barefoot activities, had only an incidence of 9 per 1,000.

We all know that the numbers of verrucas in schoolchildren are constantly rising, but in my opinion we are still in the dark about the mode of infection and some more research is needed in this field.—I am, etc.,

School Health Service,
Leicester.

I. DUB.

Nursing Procedures

SIR,—At a time when the recovery of some patients in our hospitals is jeopardized by a shortage of trained nurses certain traditional time-consuming procedures should be reassessed for their usefulness.

Fluid charts are laborious to keep and under conditions obtaining in many wards of dubious accuracy. This statement is supported by discrepancies often revealed when daily "in" and "out" totals are added over a period of 10 days and the resultant figures assessed in relation to the clinical status. Whilst an accurately charted fluid intake is of great importance in some situations, in others only a measure of the total 24-hour urine output is required. This can most simply be obtained by funnelling of urine as soon as passed into a container, whose content is measured once in 24 hours with a plastic measuring jar. The progress of many patients with oedema fit enough to leave their beds for a few moments is best followed by daily weighing.

In this way many hours of valuable nursing time can be saved with the additional advantage of obtaining more accurate and relevant information.—I am, etc.,

H. J. GOLDSMITH.

Liverpool Regional Urological Centre,
Sefton General Hospital,
Liverpool 15.

What is a Therapeutic Community?

SIR,—Dr. S. Jacobson (20 February, p. 525) rightly points out that there are many therapeutic roads in social psychiatry leading to mental health. This being so, surely there