but the radiological appearance of her cervical spine will remain the same.

I would encourage doctors first to examine the function of the cervical spine, and to follow this up by the examination of the whole upper limb to seek (a) evidence of nerve-root damage (or its absence), and (b) an alternative cause of pain in the arm.

Many people feel that the term "cervical spondylosis" should not be used as a clinical diagnosis. I therefore hope that Dr. Nichols will give us further details, as trials of this kind are so valuable, but only if the terms of reference are clear.—I am, etc.,

London W.1.

R. C. B. BARBOR.

Accidental Strychnine Poisoning

SIR,—In view of the frequency with which strychnine must be prescribed in tonic mixtures, it is perhaps surprising that overdosage from this source is so rarely reported. The following case may serve to remind one of the potential dangers of "harmless mixtures," and perhaps also that bizarre symptoms in a patient with a previous psychiatric history do not always imply relapse.

A girl of 21 was referred for psychiatric opinion, having been seen at the general practitioner's surgery the same evening behaving oddly and complaining of bizarre symptoms of a "hysterical" type. She had a previous history of hospital psychiatric treatment.

Two weeks previously she had obtained a bottle of tonic from the doctor, but had taken little. On the day in question she was due to see him again, and felt she should not waste it. Rather than throw it away, she drank the rest (some 7 fl. oz. (198 ml.)) before her tea, at about 5.30 p.m. By about 6 p.m. she felt rather peculiar, "tired and heavy-headed." Her muscles felt stiff. She called a friend and the two of them went to the surgery, getting there at about 7.15 p.m. She found it hard to walk. They sat down, but when her turn was called she felt unable to rise. She tried, and after a couple of steps fell and went very stiff. Her back arched. She remained fully aware of her surroundings. After a few seconds she was able to sit up, but felt she did not have complete control of her limbs. She felt excited and peculiar. Things seemed more vivid than usual. Everyone seemed to be shouting. She felt "all alone in the middle of a lot of people."

She was given a letter, and seen by the psychiatrist at 9.30 p.m. By then the stiffness was wearing off. She still felt excitable and overactive and showed pressure of thought. She had had no more spasms, but showed a tremor and hyperreflexia of all limbs. It was at this stage that she admitted to taking an excess of tonic. As it was by then over four hours since ingestion, and as her symptoms were abating, she was simply sedated. She was unable to sleep that night, and the following day continued to feel excited and mildly depersonalized. After 48 hours her symptoms had completely gone and she felt well.

It may not be commonly realized that an ordinary 10 oz. (284 ml.) bottle of glycerophosphate tonic contains $1\frac{1}{2}$ gr. (72 mg.) of strychnine, which is over twice the quoted M.L.D. It also contains 25 gr. (1.6 g.) of caffeine. After strychnine overdosage symptoms appear in 15–30 minutes. There is enhancement of all forms of sensation. Twitching of the muscles occurs, and the chest feels tight. Convulsions may occur and if uncontrolled may cause death in five or six spasms from asphyxia. If the patient survives for three hours he will probably recover. It was

fortunate that this patient did not asphyxiate on the surgery floor.

The dangers of exceeding medication in what may to the patient appear a harmless bottle of medicine should be emphasized to all those to whom it may be prescribed.—I am, etc.,

M. T. HASLAM.

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The Catarrhal Child

SIR,—It is with considerable interest that I read Dr. D. H. Garrow's article (20 March, p. 773). Had he concluded his article by omitting his section on "T's and A's," I feel sure that many E.N.T. surgeons would have agreed with most of his observations. To launch forth, however, in the concluding section with a tirade against the operation, suggests that Dr. Garrow has little idea of what criteria of selection are now used by his own colleagues.

One could not agree more with the observation that the operation is useless for coughs, colds, rheumatic fever, etc., that inspection of the tonsils is in general unrewarding, and that injection of the anterior pillar is a sign of no significance. These are not now, and have not been for some years, the criteria under which this operation should be considered.

Three absolute and one relative indication are used in this area. I do not suggest they are infallible or even the best but it will be seen that they differ widely from the list Dr. Garrow enumerates: (1) Recurrent acute follicular tonsillitis, three or more attacks in a year. (2) One attack of quinsy. (3) Where the size of the tonsils is so large that they meet in the midline and obstruct reasonable breathing or eating. The relative indication is where recurrent acute otitis media is preceded or accompanied by acute tonsillitis and established nasal blockage. The operation will, it is generally agreed, give a 70% success rate in preventing further otitis media.

To suggest the operation may lead to phobias, enuresis, abdominal pain, personality changes, etc., is rubbish.—I am, etc.,

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Amersham and High Wycombe Areas.

Iatrogenic Vertebral Arteriovenous Fistula

SIR,—Dr. K. G. Heymann (3 April, p. 924) has misunderstood our paper on iatrogenic vertebral arteriovenous fistula (13 February, p. 429). Although after arteriography our patient "started to tolerate the noise more easily" she was still well aware of it and objectively the thrill and bruit were unchanged, and indeed still are unchanged. We felt that the increased tolerance to the noise was a psychological adjustment which had gradually developed with the passage of time. Heymann's own patient¹ had an abnormal vertebral artery, but, as he stated, "the nature of the malformation is in doubt." In the patient recorded by Kravenbuehl² a right-sided external carotid fistula was present, the

noise disappeared after angiography, only to reappear three days later. Neither of these patients is therefore strictly comparable with our own and indeed in Heymann's patient the bruit and thrill never entirely disappeared. We accept the total abolition of the bruit in the vertebral arteriovenous fistula described by Faeth and Dueker³ and agree that thrombosis in the fistula may have been precipitated by angiography.—We are, etc.,

HUGH GARLAND.

J. T. LAMB.

JOHN PEARCE.

Leeds 1, Yorks.

REFERENCES

- ¹ Heymann, K. G., *Brit. J. clin. Pract.*, 1964, 18, 99.
- ² Kravenbuehl, H., *Münch. med. Wschr.*, 1961, 103, 2185.
- ³ Faeth, W. H., and Dueker, H. W., *Neurology (Minneapolis)*, 1961, 11, 492.

Indomethacin and Peptic Ulcer

SIR,—Dr. Olle Lövgren and Dr. Erik Allander (10 April, p. 996) must indeed have been fortunate to have found such a low incidence of side-effects from capsules of indomethacin. In my own experience, headache, vertigo, or nausea occurs in at least 50% of patients receiving this drug, even with the modest dosage of 25 mg. thrice daily. In addition, two of my patients have developed an acute toxic psychosis which was almost certainly due to indomethacin.

Apart from these unpleasant side-effects, I have not so far observed anything to suggest that this drug has an "anti-rheumatic effect"—whatever that may mean. In my experience, it appears to have only an analgesic effect, and this in a minority of patients suffering from rheumatoid or osteoarthritis, and is much inferior in its effect to phenylbutazone in this group of diseases.—I am, etc.,

London W.1.

A. C. BOYLE.

Punch-drunk Syndrome

SIR,—Dr. Macdonald Critchley is still trying to spread gloom and despondency among sports medical officers with the bogey of the "punch-drunk" syndrome (see report on Plenary Session on Exercise and Sport (17 April, p. 1,061)). The latter may have existed 40 years ago when professionals boxed 20 to 25 rounds, or in the bare-knuckle prize-fighting days of the late nineteenth century. The pathological signs he described might equally have occurred in men of the same social background, education, and alcoholic habitus who had never boxed.

He states he has seen over 100 cases of the punch-drunk syndrome in boxers. I challenge him to produce three to-day, when boxing is strictly controlled medically and the number of rounds considerably reduced. In 36 years of vetting amateur boxers I have seen only one case of cerebellar atrophy, in an Army instructor who boxed all and sundry eight hours a day for five days a week.

As to participants in other sports showing signs of the syndrome, I have seen a number of Rugby League football players who were much more "groggy" than the average boxer.—I am, etc.,

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