We should like to reiterate our opinion, and emphasize the fact, that intravenous regional anaesthesia is a very useful and safe method for operations on the extremities, particularly in unpremedicated, unprepared patients.—I am, etc.,

SHIRLEY A. FLEMING.

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REFERENCES

- ¹ Holmes, C. M., *Lancet*, 1963, 1, 245.
- ² Hooper, R. L., *Canad. Anaesth. Soc. J.*, 1964, 11, 247.

Eye Disease in Children

SIR,—I differ from Mr. K. Wybar, the author of "Eye Disease in Children" (22 May, p. 1361), with regard to the management of nasolacrimal duct obstruction, in that I would prefer to emphasize the importance of expression of the mucus or mucopus from the lacrimal sac rather than the instillation of antibiotic drops. Further, since probing is by no means free from trauma, I prefer syringing of the nasolacrimal duct in the first instance, since this simple procedure is often effective in itself.

With regard to the management of buphthalmos, it would have been better if the medical aspects of treatment had not been mentioned, since the treatment is surgical and any conservative treatment should be considered only as a temporary measure until such times as operation can be arranged.

These are only matters of emphasis with which I have no doubt Mr. Wybar will agree, and in no way detract from a useful and lucid article.—I am, etc.,

London W.1.

HAROLD JACKSON.

Aetiology of Cervical Cancer

SIR,—I would like to congratulate you on your leading article, "Cervical Cancer: Early Diagnosis or Prevention?" (22 May, p. 1327). This has now drawn general attention to the environmental and social factors in the aetiology of cervical cancer, which were revealed 10 years ago in Wynder's paper.¹ The implications for health education of the public were so obvious at the time that I have always been puzzled by the reluctance to make use of this epidemiological information, which is on the same footing as that which led to the discovery of the association between smoking and lung cancer.

I hope that what has often appeared to be almost a conspiracy of silence will now be ended.—I am, etc.,

A. J. DALZELL-WARD,
Medical Director,
The Central Council for Health
Education.

London W.C.1.

REFERENCE

- ¹ Wynder, E. L., *Brit. med. J.*, 1955, 1, 743.

Availability of Enteric-coated Aspirin

SIR,—The occurrence of gastro-intestinal bleeding following the ingestion of aspirin is well established. Enteric-coated aspirin tablets are known to cause occult blood in the stools but are unlikely to cause overt bleeding. It would seem that the enteric-coated tablet should be the preparation recommended in persons who frequently take

aspirin. Unfortunately enteric-coated aspirins are to be obtained only on medical prescription and are not available otherwise. This fact limits their usefulness.

While certain compounds of aspirin, notorious for their liability to cause erosion of the gastric mucosa, are widely advertised, it seems strange that this comparatively safe preparation of such a commonly used drug is unobtainable at the chemist's except on prescription.—I am, etc.,

Sheffield 10.

WILLIAM J. CLANCY.

Antidepressant Drugs

SIR,—Having returned after six weeks in the U.S.A., it is gratifying to find meanwhile that nobody has reported the occurrence of severe side-effects when both groups of antidepressant drugs are given combined under constant supervision, and in sensible dosage by mouth, and several people reported using these safely. The same result to this inquiry (23 January, p. 251) followed a similar inquiry in the *Lancet* in 1963.¹ It is to be hoped that the Food and Drug Administration in the U.S.A., the Witts Committee here, and the drug houses concerned will take note of this, and if possible modify their warnings accordingly.

It is also fascinating to read in the *Lancet*² that Professor Sheila Sherlock could only report two supposed deaths in her patients from Marsilid (iproniazid) jaundice in five years, but no fewer than 18 deaths were seen by her in ordinary infectious hepatitis in the same five years. Does anyone here still believe in Marsilid jaundice? Even many Americans are now beginning to think it was all a mistake, and want to be allowed to use the drug again.

One must also comment on the recent M.R.C. report on antidepressant drugs.³ This has resulted in another possibly misleading result *vis-à-vis* the ordinary general practitioner and general medical consultant, who now treat so many depressed patients.

We have all known for years now that in "Bedlam melancholia"—depressed patients so bad as to be willing to go and sit about for weeks in Bethlem, the Maudsley, or any other mental hospital—E.C.T. is still the best treatment; then come Tofranil (imipramine) and Tryptizol (amitriptyline); and Nardil (phenelzine) will generally help in such depressions only towards the end of a long attack. But if one is treating the general run of ordinary depressions attending a general hospital, such as St. Thomas's, or a general practitioner's surgery, exactly the reverse value of these drugs and E.C.T. is found to occur. Here phenelzine or Marplan (isocarboxazid) will help the majority of anxious and reactively depressed patients, who would never agree to go near a mental hospital. Amitriptyline and imipramine will mostly help only the severe depressions with symptoms of early waking, agitation, and indecision. In-patient E.C.T. will be needed in only a few of all the patients seen, especially if both groups of antidepressant drugs are sensibly combined first of all to try to avoid it. And if you don't wait too long in making up your mind what to use and in what order, most severely depressed patients can now be treated with combined drugs⁴ and E.C.T. as out-patients, and will not risk having to become Bedlam melancholias at all.

There is no psychiatric illness in which bedside knowledge and long clinical experience pays better dividends; and we are never going to learn how to treat depressions properly from double-blind sampling in an M.R.C. statistician's office.—I am, etc.,

WILLIAM SARGANT.

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REFERENCES

- ¹ Sargent, W., *Lancet*, 1963, 2, 634.
- ² Cook, G. C., and Sherlock, Sheila, *ibid.*, 1965, 1, 175.
- ³ *Brit. med. J.*, 1965, 1, 881.
- ⁴ Sargent, W., *ibid.*, 1965, 1, 251.

Bullous Lesions in Acute Barbiturate Intoxication

SIR,—We were interested to read the publication of Drs. G. W. Beveridge and A. A. H. Lawson (27 March, p. 835) on the subject of bullous lesions in acute barbiturate intoxication, and the communication of Dr. G. Warnock (1 May, p. 1188) on the same subject. The authors appear satisfied that such bullous lesions are specific for barbiturate intoxication. It would have been interesting to have figures for similar lesions in patients comatose from causes other than barbiturate overdosage. We wish to report two cases where bullous lesions were noted in association with coma due to neurological disorders in the absence of barbiturates.

Case 1.—An 88-year-old female, who lived alone, became weak in the left arm and leg and fell to the floor. On admission she was semi-comatose, and had a left hemiparesis. She had bullous lesions on the fingers and palm of the left hand similar to those described by Beveridge and Lawson. There was no evidence of barbiturates having been taken.

Case 2.—A 24-year-old female with a long history of psychiatric illness with depression and instability, and a former episode of paraplegia while in London, thought to be hysterical, was readmitted to a nearby psychiatric hospital with depression, weakness, and fatigue. She developed headache, vomiting, drowsiness, neck stiffness, and pyrexia, and lapsed into coma. There was no evidence of barbiturates having been administered. She was seen by one of us in view of the organic developments and transferred to the medical unit at this hospital. She was comatose and had a flaccid quadriplegia with areflexia. There were bullous lesions of $\frac{1}{2}$ –2 in. (1.3–5 cm.) in diameter over the greater trochanters, buttocks, posterior and lateral aspect of the thighs, which were apparently not purely pressure lesions. There was a lymphocytic cerebrospinal-fluid pleocytosis. C.S.F. protein was 55 mg./100 ml. and no organisms were grown. There was also a transient hypokalaemia. Porphyrins were absent from the urine. L.E. cells were absent. There was a previous history (1962) of evacuation of a subdural haematoma in London but angiography during the recent illness showed no evidence of any recurrence. The diagnosis is still obscure but thought to be a viral encephalitis with polyneuritis. No barbiturates had been given at any time during the illness, so far as we can ascertain, neither at home nor in the psychiatric or general hospital.

Neither of the two patients reported here had taken barbiturates. The only thing in common was that the patients were comatose or semicomatose. In Case 1 the lesions were on the hemiplegic side, whereas in Case 2 they were bilateral, chiefly on pressure areas.

It is well known that vasomotor reflexes are impaired in coma states and that local

vasodilatation may occur, as in the well-known *tache cérébrale*. Although localized bullous lesions are sometimes seen in barbiturate coma, evidence is presented to show that these are not necessarily specific for barbiturate intoxication, and it is suggested that such lesions may occur in states of coma unconnected with barbiturates and indeed with any drug.—We are, etc.,

DENIS M. FREEMAN.

General Hospital,
Warrington, Lancs.

Publicity for Hazards of Monoamine-oxidase Inhibitors

SIR,—I feel I must bring to your notice the disturbingly serious position in which many patients are placed by not being warned of the adverse reactions which may follow the administration of monoamine-oxidase inhibitors.

I find that the patient often falls between two stools, as the psychiatrist at the hospital thinks the general practitioner will give the necessary precautions and the general practitioner assumes that the "specialist" has already done so.

It is, of course, common that certain drugs can potentiate each other with dangerous results, but it seems to me an entirely different situation when such common articles of diet as cheese, Marmite, Bovril, or broad beans could result in episodic hypertension with the possibility, however remote, of an ensuing subarachnoid haemorrhage.

It may well be that many doctors are not aware of these hazards, and I feel there should be some arrangement made whereby the patient could never obtain these drugs from any dispensary or chemist without these dietary precautions being printed on the label.—I am, etc.,

London N.W.9.

MURRAY N. COX.

Treatment of the Climacteric Syndrome

SIR,—Drs. F. Osmond-Clarke and M. Murray (8 May, p. 1249) spoil a good case by omitting all reference to the one counter-argument—the danger of oestrogenic haemorrhage. It is an aphorism that adequate hormone-replacement therapy of any type carries a high risk of undesirable side-effects, and it is particularly true for oestrogen treatment of the climacteric. Reactionary bleeding, provoked by overdosage, is very common and is indeed becoming the most frequent type of post-menopausal haemorrhage. It is this, and not the fear of carcinogenesis, which is the basis for the gynaecologist's reluctance to prescribe oestrogens as freely as he otherwise would.

The ideal, of course, as Drs. Osmond-Clarke and Murray advise, is strict regulation of oestrogen administration by frequent control via vaginal-smear cytology. But this involves considerable expertise, and does not always accurately reflect the true blood-oestrogen level.¹ For the present, therefore, it is advisable to limit treatment to the minimum with frequent interruption and the complete avoidance of implants and other forms of so-called "depot" therapy. Perhaps the best way of avoiding oestrogenic bleeding is to use one of the oestrogen-

testosterone combinations, of which the original—Mixogen—is the best.—I am, etc.,

London W.1.

ALBERT DAVIS.

REFERENCE

- ¹ Charles, D., Bell, E. T., Loraine, J. A., and Harkness, R. A., *Amer. J. Obstet. Gynec.*, 1965, **91**, 1050.

Injury by Thermometer

SIR,—Dr. S. K. Dikshit's unfortunate experience (22 May, p. 1377) prompts me to write about that of one of my patients, a middle-aged lady.

She was staying in the South of France, where she contracted an acute upper respiratory infection. Her clinical thermometer had been left at home, so she bought one of the larger Continental-style rectal thermometers. She was not accustomed to these instruments and pushed the thermometer in until about half the shaft was within the rectum in addition to the bulb.

Some hours later she had an urge to empty the bowel and passed a considerable quantity of bright red blood. Proctoscopy at the local clinic revealed ulceration of the rectal wall and incidentally some small internal haemorrhoids which did not appear to be the source of bleeding. The sigmoidoscope was passed to 15 cm. but revealed no further lesion. On her return to this country the investigations were repeated, and the lesion was found to have healed completely.

Temperature-taking in the rectum would appear to be a hazardous procedure for those with little knowledge of the anatomy of that part.—I am, etc.,

London S.W.9.

A. MELINEK.

Rapid Estimation of Urea

SIR,—I was interested in reading the paper of Professor D. N. Baron and Dr. G. Hughes (23 January, p. 233). The authors have made reference to my work with Urograph¹ and I would like to clarify their comments in the discussion. Firstly, I would draw attention to the fact that our study was using the original Urograph marketed in Canada by the Warner-Chilcott Co., which required only 0.1 ml. serum for a determination. It would appear that Professor Baron and Dr. Hughes were using what is marketed as "the new, improved Urograph," which requires 0.2 ml. serum for a determination. Secondly, we have measured the height of the blue column, since these were the manufacturer's instructions and we were evaluating the product on this basis. Thirdly, it is an error to say that we found "the Urastrat method was not accurate (confidence limits +27%)." A more careful examination of our data would reveal that the confidence limits of $\pm 27\%$ referred to the precision or reproducibility of the test, not the accuracy.—I am, etc.,

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J. E. LOGAN.

REFERENCE

- ¹ Logan, J. E., *Canad. med. Ass. J.*, 1963, **89**, 341.

Pyloric Antral Mucosal Diaphragm

SIR,—We were interested in Dr. N. Conway's Medical Memorandum "Pyloric Antral Mucosal Diaphragm" (10 April, p. 970) and consider a patient seen by us recently of interest. Our case supports Mr. J. A. Rhind's view (15 May, p. 1309) that the condition

will be found by surgeons examining their operative specimens. In this patient the lesion was not detected by barium meal or at operation, and it was only after the specimen of gastric antrum (excised for other indications) was opened on completion of the operation that the mucosal diaphragm was recognized. The presence of a healed prepyloric ulcer close to and proximal to the site of the mucosal diaphragm makes one wonder whether this ulcer was secondary to stasis caused by the diaphragm.

A.B., born 1910, was investigated in March 1965 for episodes of abdominal pain and vomiting that had been getting worse over the past five years. Barium meal had demonstrated a chronic ulcer crater of the greater curve of the pyloric antrum. There was resting juice in the stomach and the radiologist reported considerable initial pylorospasm. At operation (29 April 1965) there was evidence of a healed antral ulcer. There was no constriction of the sero-mucosal coats. Vagotomy and antrectomy was performed. On opening the specimen there was a mucosal diaphragm with a $\frac{1}{4}$ in. (0.3 cm.) lumen 1 cm. distal to the scar that marked the site of the healed antral ulcer. The mucosal diaphragm was not palpable from the outside.

—We are, etc.,

Walton Hospital,
Liverpool 9.

N. O. K. GIBBON.
W. B. ASHBY.

Foster Parentship

SIR,—Often the foster mother has problems which may also occur in ordinary or adoptive families, but the impermanence of fostering and the child's earlier rejections may preclude a happy outcome. All children need opportunity to come to terms with their ambivalent feelings towards their parents. The parent also needs support in learning to understand the child's development, and in patiently accepting and turning to good account his changing moods. This opportunity and support can be partly met, for the under-fives anyway, in a pre-school playgroup. Several hundred of these exist, about 130 of which are affiliated to the National Association of Pre-School Playgroups (known as P.P.A.). This is a voluntary association set up in 1961 to promote public interest in the educational needs of young children, and to press for the fulfilment of the provisions for under-fives recognized in the 1944 Education Act. P.P.A. has drawn up a code of high standards for its members' guidance. P.P.A. stresses the vital role the mother plays in the child's first sallies into the wider world. The playgroup supervisor usually has a rota of mothers to help her. Each mum, therefore, learns a good deal about handling children, makes new friends, discovers that her problems are not unique, and gains real satisfaction from taking part in a little community project. Most groups are run by parent committees and are non-profit-making.

Encouragement of foster parents to participate in such groups could be rewarding in terms of improved parent-child and family-neighbourhood relationships. Experienced supervisors can usually judge when a child needs the additional help of a child guidance clinic. The neighbourhood would also be taking some responsibility for the well-being of its "at risk" members, instead of delegating this to outside agencies. Most playgroups, however, have long waiting-lists, and