I think that it is worth while drawing attention to the similarity of these two cases, thus amplifying the answer given by Dr. Pallis to the question about the frequency of sinus thrombosis in Behçet's syndrome.—I am, etc.,

H. C. MASHETER.

Department of Clinical Investigation,
Parke, Davis & Co.,
Hounslow, Middlesex.

REFERENCES

- ¹ Masheter, H. C., *Proc. roy. Soc. Med.*, 1959, **52**, 1039.
- ² Cosgriff, S. W., Diefenbach, A. F., and Vogt, W., *Amer. J. Med.*, 1950, **9**, 752.

Diagnosis of Amphetamine Addiction

SIR,—Whilst agreeing with many of the comments expressed by Dr. P. G. M. G. Walker on the difficulties of the diagnosis of amphetamine addiction (6 February, p. 384), we cannot share his confidence in the value of the methyl-orange test (described by Connell in his monograph¹), as a possible solution to this problem. Over the past nine months we have carried out a routine estimation of urinary amphetamine by this method on all patients under 60 years on admission to this psychiatric unit. In 159 consecutive admissions amphetamine substances were reported in the urine in 82. An intensive investigation of drug administration, prior to admission, was then carried out in these cases, but ingestion of amphetamines was confirmed in only 12 cases. In the remaining 70 cases the positive test for urinary amphetamine was a non-specific reaction to a psychopharmacological or general medical drug—e.g., phenothiazines, amitriptyline, chlorthalidoxepoxide, ephedrine. Connell drew attention to this possibility (page 91), and recommended the use of a paper chromatographic method when this dilemma is encountered.

The widespread use of psychopharmacological drugs which produce false positives in the methyl-orange test now seriously limits its value as a routine screening procedure in the diagnosis of amphetamine dependence, as originally suggested by Connell. A more specific test for urinary amphetamine is required for clinical practice.

We hope to report our own experience of the methyl-orange test and the routine procedure in more detail, in the near future.—We are, etc.,

J. JOHNSON.

Oldham and District General Hospital,
Oldham, Lancs.

G. MILNER.

REFERENCE

- ¹ Connell, P. H., *Amphetamine Psychosis*, Maudsley Monograph No. 5, 1958, Part 2.

SIR,—Of course Dr. P. G. M. G. Walker (6 February, p. 384) is right; since these patients are completely untrustworthy and inveterate liars the diagnosis of amphetamine addiction (like that of other addictions) rests upon demonstrating the drug in blood or urine. It is clearly as important to establish whether amphetamine is or is not the cause of a patient's symptoms as it is to determine, say, the protein-bound iodine in a patient whose symptoms could be due to hypo-

thyroidism. In the case of amphetamine detection this presents no difficulty to the well-equipped, well-staffed laboratory, though in some addictions—e.g., cocaine—the problems of detection are greater.

The difficulty Dr. Walker has experienced in getting investigations of his patients carried out are, therefore, not due to lack of methods but to the fact that facilities for executing any but the simplest of routine pathological investigations are just not available to the majority of psychiatrists and their patients. Laboratories in general hospitals are so undercapitalized, overworked, and understaffed as to be unable to undertake additional work for patients without apparent somatic disease.

Clinical pathology has until recently played comparatively little part in the diagnosis and treatment of patients with psychiatric illnesses, and has been used almost exclusively to detect coincidental "somatic" disease; which, every so often, turns out to be causal. There are, however, problems which arise in relation to the psychiatric patient—drug addiction, for example—which do not apply to the patient with somatic disease. With a greater understanding of the role of metabolic lesions in the causation of psychiatric disorders and the enlightened interest of psychiatrists in this aspect of their patients' illness the need for clinical, and particularly chemical, pathological facilities will increase, and, if experience in general hospitals is anything to go by, at an alarmingly rapid rate.

Our own experience is that over the past three years the number of requests to undertake investigations on patients suspected of drug-taking, causing psychiatric illness, has increased enormously, and that whereas it was formerly virtually confined to the detection of amphetamine it now extends over the whole field of addiction.

While illnesses due to drug addiction comprise only a small percentage of the patients referred to psychiatrists, the load on existing laboratory facilities is—as Dr. Walker remarks—already more than most can bear; I shudder to think what chaos will occur, when—as I am confident there will be—objective tests for the recognition and identification of the commoner psychiatric disorders become available. It is important that consideration is given to this matter by the relevant authorities now, and not to wait until the problem is actually upon us.—I am, etc.,

Area Laboratory,
West Park Hospital,
Epsom, Surrey.

VINCENT MARKS.

Hazards with Monoamine-oxidase Inhibitors

SIR,—A further danger of treatment with monoamine-oxidase inhibitors (M.A.O.I.) has come to our notice. We have recently seen two patients who have developed severe reactions after taking Procol while on M.A.O.I. drugs. This is a widely advertised preparation on direct sale to the public as a remedy for the common cold. It contains phenylpropanolamine hydrochloride 50 mg. and isopropamide iodide 2.5 mg. The former drug is a sympathomimetic amine with ephedrine-like effects and the latter is a long-acting anticholinergic.

The first patient was a 25-year-old female who had been on phenelzine 15 mg. three times a day for some months for depression. She developed nasal congestion and took one tablet of Procol, a drug she had used often, prior to taking phenelzine, without ill-effect. During that evening she had also eaten a portion of processed cheese, but this was her usual habit and had not caused any reaction on previous days. Within one hour of the ingestion of Procol she developed severe throbbing headache and vomiting. After another hour she became unconscious and went into status epilepticus, having at least nine major fits. Full consciousness was not recovered for about 12 hours. There was no previous, nor subsequent, history of epilepsy. She gradually recovered over a fortnight and a subsequent electroencephalogram was normal. Since this episode she has been on phenelzine again with no ill effects.

The second patient was a 48-year-old female taking mebenazine (Actomol) 5 mg. three times a day. She too had taken Procol in the past, before being on mebenazine, without ill effect. On this occasion, within two hours of taking one tablet of Procol, she developed severe frontal and occipital throbbing headache with vomiting. Bradycardia of 48 beats/min. was recorded by the general practitioner. The headache gradually disappeared over the next 48 hours. In both patients the blood-pressure shortly after admission was somewhat raised—being 150/100 mm./Hg in the first patient and 160/90 mm./Hg in the second.

It seems likely that the explanation of the symptoms of both patients is an encephalopathy following the combination of a M.A.O.I. and a sympathomimetic amine (phenylpropanolamine) contained in Procol. There are other tablets on sale to the public which contain phenylpropanolamine—for example, Mu-Cron, Eskornade, Dristan, and Capriton.

The M.A.O.I. drugs can be very dangerous when combined with certain other drugs and even some foodstuffs. We would again make a plea that all patients given these drugs should be strongly warned against taking any medication not first approved by their doctor.—We are, etc.,

C. M. TONKS.

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University of Leeds,
Leeds 2.

A. T. LLOYD.

Combining the Antidepressant Drugs

SIR,—In this practice in 1959, 17 patients attempted suicide. Nine of these were provided with the means by us. Six were successful. Four patients died due to barbiturate overdosage. We referred 41 patients to psychiatrists, and 11 were admitted to hospital.

In this practice in 1964 three patients attempted suicide. We referred only four patients to psychiatrists, and three were admitted to mental hospitals.

Since 1960 we have prescribed no barbiturates. We have prescribed the antidepressant drugs more and more frequently as our confidence grew. In four years 11 attempts at suicide with massive overdosage of antidepressants have all ended in failure. Only three were admitted to hospital. Four cases have given us special cause for thought. One case on Tofranil (imipramine) and one case on Nardil (phenelzine) have developed jaundice. Both cases occurred when sporadic cases of infective jaundice were seen in the area. One case developed dependent oedema, and, in spite of stopping the Nardil (phenel-

zine), with which she was being treated, the oedema recurred at irregular intervals. The fourth case was a girl aged 21 under the care of St. Thomas's Hospital, who was on Tofranil (imipramine), Marsilid (iproniazid), and Largactil (chlorpromazine). Her mother had charge of the tablets. She was admitted to hospital in coma. Blood and urine samples showed no evidence of drug overdosage. When she recovered she denied to hospital staff that she had taken anything other than the normal dose. The mother confirmed this. Yet, after discharge from hospital, the girl told us that for weeks she had been palming the nightly chlorpromazine tablet, and had taken 40 tablets before lapsing into coma.

We have at this time over 50 patients on various antidepressants, and though some of them can hardly stand up because of hypotensive effects they are all finding life worth living.

It is the family doctor who should be prescribing these drugs, certainly singly, and it is hoped, as we gain more experience, in combination. It is the writing of physicians, pathologists, toxicologists, and committees with little clinical experience of handling the antidepressants that is making it difficult for us to accept the much more authoritative statements of those who think, teach, and practise as Dr. Sargent does.

Our patients do not die from antidepressant drugs, either singly, in combination, or in massive overdosage. They sometimes die by their own hands without them.—I am, etc.,

London S.W.11.

B. HYNES.

Anti-folic-acid Drugs

SIR,—In "To-day's Drugs" (30 January, p. 302) your expert says, with respect to antifolics, "The effect these substances have on the germinal chromosomes is unknown, but may be harmful, and they certainly should not be given to women in the child-bearing age."

Are we to deduce from the above that antifolics can safely be given to men in their procreative years?—I am, etc.,

CELIA LUTWAK-MANN.

Molteno Institute of
Biology and Parasitology,
Cambridge.

** We have shown Dr. Lutwak-Mann's letter to our expert contributor, who replies: "Methotrexate may well be harmful to both men and women, and it was not implied that antifolics could safely be given to men. The whole comment on their use was meant to be critical."—ED., *B.M.J.*

Doctors' Dilemma

SIR,—During a meeting of the Medical Disciplinary Committee of the General Medical Council held on 25 and 26 November 1964 it was reported that a charge of infamous conduct in a professional respect was being heard in the case of a doctor who held the degree of M.B. from an Indian university. The charge alleged that he used the designation M.D. on his printed notepaper or appended it to his signature in communications to persons in the United Kingdom and pretended that he possessed a degree of Doctor of Medicine granted to him by the

University of the State of New York or by some other university, whereas he had, in fact, obtained no such degree.

To my mind this raises a rather tricky problem which may concern itself more with a question of semantics than of false pretence. In Canada and the United States the general public assumes that any person licensed to practise medicine is in possession of an M.D. degree. Most correspondence from lay as well as professional bodies addressed to us appends the initials M.D. after our names. Indeed, such official bodies as the American College of Surgeons, which is fully aware of my academic qualifications, made out my certificate of Fellowship describing me as ———, M.D. I think the appellation M.D. is considered to mean as much Medical Doctor as the possession of a university degree of that nature.

Personally, I take pains in using my correct degrees when signing official documents and letters to other doctors. This is probably of particular importance when making out narcotic prescriptions and when signing official documents. However, when writing letters to employers, school principals, or other lay bodies, the initials M.B., B.S. may often be meaningless on the local scene. This difficulty is of course overcome by calling myself Doctor ——— on my stationery, and I know that most practitioners in the United Kingdom use a similar title on their letterheads and on their prescription forms. Since, however, very few graduates of British medical schools are, in fact, in possession of the degree of doctor in any faculty of any university, this description is equally false as

using the appendage M.D. to designate my status in this country.

Surely the time has come for British universities and universities of other Commonwealth countries to adopt the otherwise worldwide system of awarding the degree of Doctor of Medicine to their medical graduates. The description of Bachelor of Medicine and Bachelor of Surgery perhaps with the additional information of physician and surgeon that many United Kingdom practitioners display on their stationery must be highly misleading and confusing to the general public.—I am, etc.,

Oakville Medical Centre,
Oakville, Ontario.

J. A. LOEB.

Arcus Senilis

SIR,—I read with great interest the study of arcus senilis by Dr. G. M. McAndrew and Dr. D. Ogston (13 February, p. 425). I would like to point out that the occurrence of this corneal deposit is much influenced by exposure of the cornea to changes in temperature and perhaps to trauma from dust, etc. I have noted that a marked arcus (grade 4) is sometimes to be seen in a young man who has led an outdoor existence or who has worked in front of a furnace. Lastly, and perhaps most conclusively, I have on a number of occasions seen a unilateral arcus in a patient with a residual Bell's palsy. I have felt that failure of closure of the eye was in this case somehow responsible.—I am, etc.,

London W.1.

L. P. E. LAURENT.

Portable Anaesthetic Apparatus

SIR,—It has probably occurred to many anaesthetists that the Boyle circle Mark III would form an admirable self-contained portable anaesthetic apparatus if it were connected to a supply of oxygen and fitted with a simple vaporizer.

When I was giving closed-circuit Fluothane (halothane) anaesthesia in Malaysia recently the Malaysian Oxygen Company was also

impressed with the suitability of this device and produced a stand for a Mark III circle system to which was attached a small oxygen cylinder, reducing valve and flow meter, and Goldman vaporizer. This equipment is illustrated in the accompanying illustration. I have now used it for most types of surgery where spontaneous breathing is appropriate, and it appears to be a cheap, simple, and safe