effective and free of side effects. During the past six years, we have not had to resort to orbital decompression in Graves exophthalmos; this includes 3 patients with papilloedema.

P DANDONA
C W H HAVARD
4 January 1985

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From Dr William Kelly and others
Middlesbrough General Hospital, Cleveland

Dear Sir, We read with interest the paper by Weetman, McGregor and Hall (November *Journal*, p 936). Graves' ophthalmopathy is certainly a difficult management problem, and there is no treatment which is simple, safe and effective. We are concerned about the continuing reports from Weetman and colleagues of the benefit from cyclosporin A, since this is contrary to our own recent experience and that reported by others (Brabant *et al.* 1984, Howlett *et al.* 1984).

We have studied a 45-year-old female with infiltrative eye disease. Ophthalmic disease was assessed by computerized tomography scans, exophthalmometers, fields of binocular single vision, Hess charts and clinical assessment. Graves' disease with exophthalmos was diagnosed at age 41 years. All symptoms improved with carbimazole 15 mg 3 times daily and Hypromellose eye drops. Carbimazole was stopped after 12 months, but she relapsed 2 years later and was given radioactive iodine therapy.

She became biochemically hypothyroid, and L-thyroxine 0.2 mg daily was commenced from age 44. One year later her eye condition worsened, with severe exophthalmos, chemosis and double vision, and she was referred to us. Serum thyroxine was 146 nmol/l (normal 60–160) and serum TSH was 1.3 mu/l (normal <6). Tendon reflexes were normal and the pulse rate was 72/min. Exophthalmos using a Rodenstock measurement was 23 mm in each eye (15 mm in each eye 5 years previously). Upward and outward movements of both eyes were impaired, and there was prominent lid-lag, with red conjunctivae and periorbital oedema. Opticrom (sodium cromoglycate) eye drops were commenced without clinical benefit. Predsol eye drops relieved conjunctival irritation, but had no effect on exophthalmos or eye movements. Cyclosporin was gradually increased to 10 mg/kg/day and serum levels were measured. She was assessed clinically every 2 weeks for 10 weeks, when objective tests were repeated. There were no changes in the Rodenstock measurements, Hertel meter readings, intraocular pressures, lid-lag, periorbital oedema, fields of binocular single vision, Hess charts or visual acuity. There were no renal or other side effects during treatment. Eleven weeks after stopping cyclosporin, there were no further clinical changes, including exophthalmometer readings.

Weetman *et al.* (1983) initially reported improvement in the ocular symptoms of 2 patients with Graves' ophthalmopathy following cyclosporin A; their recent paper (November *Journal*, p 936) includes these first 2 patients, and the group now reports benefit in 5 of 6 patients with Graves' ophthalmopathy. However, no objective measurements of exophthalmos are given, and if cyclosporin A does reduce the size of the extraocular muscles – as Weetman *et al.* claim – then it is surprising that this is not evident, for example, by simple tests such as a decrease in exophthalmos or increase in the fields of binocular single vision. Failure of cyclosporin A therapy in treating Graves' ophthalmopathy has now been demonstrated in 7 cases, combining our results with those reported by Brabant *et al.* (1984) and Howlett *et al.* (1984).

Cyclosporin A is a very useful drug to prevent rejection of transplanted organs; it would be a pity, however, if it acquired an undeserved reputation for efficacy in the treatment of Graves' ophthalmopathy.

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ABDUL RASHID
7 January 1985

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Cardiopulmonary resuscitation: standards among junior hospital doctors

From Dr P J Trafford
Senior House Officer
St Helens Hospital, Merseyside

Sir, it was important for Dr Casey to draw attention to a hospital problem which refuses to go away (November 1984 *Journal*, p 921)! I would like to report the methods used at two hospitals