

repeated after one week. Four of the patients were postmenopausal; the other six were studied during the same phase of the menstrual cycle on both occasions.

Basal plasma prolactin levels were normal in all patients before and during treatment with diazepam. Metoclopramide produced a marked increase in plasma prolactin levels maximal 30 min after injection. An analysis of variance of the log transforms of the plasma prolactin levels showed no significant difference before and during diazepam treatment. The overall trend was also constant at each time before and during diazepam treatment. It is therefore concluded that diazepam does not affect basal prolactin levels or the release of prolactin in response to the dopamine antagonist metoclopramide. This finding compares with earlier reports, which showed that growth hormone production, pituitary-adrenal function,<sup>5</sup> and thyroid function<sup>6</sup> are unaffected by diazepam.

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<sup>1</sup> Sachar, E J, *et al*, *Neuroregulators and Psychiatric Disorders*, p 242. New York, Oxford University Press, 1977.

<sup>2</sup> Horrobin, D F, *Prolactin: Physiology and Clinical Significance*, p 32. Lancaster, MTP, 1973.

<sup>3</sup> Noel, G L, *et al*, *Journal of Clinical Endocrinology and Metabolism*, 1972, **35**, 840.

<sup>4</sup> Judd, S J, Lazarus, L, and Smythe, G, *Journal of Clinical Endocrinology and Metabolism*, 1976, **43**, 313.

<sup>5</sup> Harvard, C W H, *et al*, *Journal of Endocrinology*, 1972, **52**, 79.

<sup>6</sup> El-Hazmi, M A F, *Clinica Chimica Acta*, 1975, **63**, 211.

### Drug compliance and the elderly patient

SIR,—Recent correspondence and criticism in the press of drugs prescribed for the elderly and the ways in which they are taken have not identified the two most important problems that certainly seem to affect the ways the elderly patients on my list take theirs.

Firstly, the current child-proof container seems also to be elderly-patient-proof as well. Arthritic thumbs make it quite impossible for a substantial minority of my elderly patients to remove the lids from such containers. My own recent investigations of this problem revealed at least six containers of which even I couldn't remove the lid.

Secondly, no more than 45% of 187 elderly patients on my list were able to read the label on the container giving the instructions. The small size of the label and the illegibility of the writing made the job of decipherment difficult. Instructing the chemist to label the containers clearly and in large writing has had no effect. Individual chemists whom I have directly approached tell me that the cost of typing labels would be prohibitive.

Surely the Department of Health and Social Security could recognise that these two problems exist and instruct all chemists to test whether the elderly recipient of the prescription can actually open the container in which the drug has been placed and can actually read the chemist's instructions. These two simple steps would be an excellent starting point in

ensuring compliance. At the moment the situation seems contrived to ensure the opposite.

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### Pneumomediastinum in anorexia nervosa

SIR,—We read with interest the report by Drs Anita J Donley and T J Kemple (9 December, p 1604). Recently we saw a similar case in which vomiting seemed an important aetiological factor.

A 16-year-old schoolgirl was referred with primary amenorrhoea, weight loss to 30 kg (height 1.63 m), anorexia, and the psychiatric features of anorexia nervosa. When admitted she was found to have surgical emphysema of the neck, confirmed by chest x-ray, which also showed pneumomediastinum but no pneumothorax. This feature had not been noted at outpatient attendance six days before. A Gastrografin swallow radiograph was normal.

She admitted to feeling nauseated and full after small meals and to one episode of retching and vomiting, perhaps self-induced, following an excessive food intake shortly before she was first seen. In the absence of demonstrable lung disease we feel vomiting to have been the likely precipitating cause of the surgical emphysema and pneumomediastinum.

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### Toilet paper and spread of infection

SIR,—Dr R E W Fisher writes (28 October, p 1233) that "tiny sheets of toilet paper are disgusting and insanitary." It is not quite clear whether he objects to the size or the substance.

Several years ago, while I was working in the Middle East, a Moslem medical student followed me into an Armenian general store and saw me buy some rolls of strange pink paper. "Please, Mr Professor, what are those things?" he asked. "Toilet paper," I said. "What are they for?" he inquired politely. Patiently and rather patronisingly I explained that the sheets were used for personal cleansing after defecation. He was shocked in the extreme. "But, Mr Professor," he said, "in Iran we don't even clean our plates by rubbing them with paper?"

Since that time I have never been quite certain that the West was ahead in hygiene. It is worth noting, however, that the East is not particularly famous for the absence of dysentery.

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### Rapid diagnosis of *Mycoplasma pneumoniae* infection: a reminder

SIR,—A common problem both in general practice and in hospitals, especially at this time of the year, is infection with *Mycoplasma pneumoniae* (MP), particularly involving the chest. This year has seen a markedly increased number of reports of MP infections in the community.<sup>1</sup>

Diagnosis is often made in retrospect by serology when the decision about antibiotics has already been taken, perhaps wrongly.

Tetracycline and erythromycin are known to shorten the MP illness but are not ideal antibiotics for other forms of bacterial pneumonia. Ampicillin or amoxycillin, although often effective against the latter, are useless against MP and in fact may precipitate an exanthem in this infection.<sup>2</sup>

Agglutinins are found in well over 50% of patients with MP pneumonia, but testing for them is not easily performed, especially in general practice. A cold agglutinin screening test (CAST) done at the bedside has been previously reported as detecting titres of greater than 64.<sup>3</sup> In the past three weeks we have seen three patients with lobar pneumonia in whom this simple CAST was positive and allowed us immediately to start appropriate treatment for the MP infections that were later confirmed by serology. This test can most simply be done by adding a few drops of blood to the citrate in a commercial prothrombin tube (making a 50/50 mix) and then placing the tube in the ice tray in the freezing compartment of a refrigerator. After a few minutes the cooled tube is removed, tilted, and rotated, when obvious agglutination will be seen on the wall of the tube if the test is positive. This agglutination goes by warming the tube in one's hand. This test is also ideally suited to general practice, as few homes are without a freezing compartment and prothrombin tubes can be carried by the visiting doctor.

We feel that this test deserves more publicity as an aid to quickly identifying this common and treatable infection and thus reducing morbidity and possible hospital admissions.

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<sup>1</sup> Communicable Diseases Surveillance Centre (PHLS), 1978, unpublished.

<sup>2</sup> Cherry, J D, Hurwitz, E S, and Welliver, R C, *Journal of Pediatrics*, 1975, **87**, 369.

<sup>3</sup> Griffin, J F, *Annals of Internal Medicine*, 1969, **70**, 701.

### Intermittent ophthalmoplegia

SIR,—Drs W F Kelly and G F Joplin (2 December, p 1534) rightly stress the difficulty in the differential diagnosis of intermittent ophthalmoplegia and obviously in a short report are unable to supply all the clinical data to enable the reader to assess their statement that the patient was clinically euthyroid, although this appears very likely. However, the possibility that the patient was mildly hypothyroid without clinical signs (obviously closely considered by the writers) appears to remain.

This patient had had a previous partial thyroidectomy, has thyroid antibodies, and in addition a borderline high plasma thyrotrophin (TSH) concentration with an exaggerated response to thyrotrophin-releasing hormone. The "normal" levels of T3 and T4 recorded do not exclude the possibility of mild thyroid deficiency since the normal range is a statistical one and it is now accepted that tissue requirements for thyroid hormones vary from person to person. The findings given appear at least compatible with a patient whose thyroid function is compromised and whose T4 level is maintained at a level below the ideal for this patient but still (just) within the population normal range by an increase in TSH activity.

It is a cornerstone of the treatment of ophthalmic thyroid disease that the patient be