

Probable cases of *P foenicicci* intoxication have been described in children. Holden reported that a small boy became ill with tachycardia and mydriasis after eating *P foenicicci*,<sup>3</sup> but he was too young to describe adequately his subjective experience. Southcott describes a 2-year-old girl with pica who probably ate the *P foenicicci* that grew on her parents' lawn in Adelaide. She suffered from periodic attacks of hysterical behaviour with visual and tactile hallucinations; her symptoms were finally, fairly confidently, attributed to consumption of *P foenicicci*.<sup>4</sup>

Other species of *Panaeolus* have been recorded as being used for ritual purposes and causing accidental poisonings. In adults distortions of perception and laughing are prominent effects, but children may react more severely with convulsions.<sup>2</sup> Acute delirious and psychotic states and more prolonged "schizophrenia-like" conditions have been described after consumption of *Psilocybe semilanceata*.<sup>1</sup>

Publications exist in the United Kingdom and North America that give detailed descriptions of hallucinogenic mushrooms including *P foenicicci*. This is a common mushroom whose use for hallucinogenic and euphoric effects seems to be increasing. Furthermore, it has been suggested that this mushroom may often be collected and eaten in error for the more widely known *P semilanceata* (G Hadley, unpublished observations). It may produce acute perceptual distortions and have similar ill effects to LSD. There is also a risk of mistaking more-toxic fungi for these "magic mushrooms" and of young children eating adult doses.

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<sup>1</sup> Hyde C, Glancy G, Omerod P, Hall D, Taylor GS. Abuse of indigenous *Psilocybin* mushrooms: a new fashion and some psychiatric complications. *Brit J Psychiat* 1978;132:602-4.

<sup>2</sup> Pollock J. *Psilocybian mycetism* with special reference to *Panaeolus*. *J Psychedel Drugs* 1976;8:43-7.

<sup>3</sup> Holden M. A possible case of poisoning by *Panaeolina foenicicci*. *Bull Brit Mycol Soc* 1965;25:9-10.

<sup>4</sup> Southcott RV. Notes on some poisoning and other clinical effects following ingestion of Australian Fungi. *S Austr Clin* 1975;6:441-78.

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## Does increased movement protect smokers from postoperative deep vein thrombosis?

Clayton *et al* have shown that cigarette smoking is associated with a decreased incidence of postoperative deep venous thrombosis.<sup>1</sup> Pollock and Evans<sup>2</sup> have reported that among surgical patients cigarette smokers are younger and thinner than non-smokers and therefore less likely to suffer from postoperative deep venous thrombosis, but they concluded that this is certainly not the whole explanation. Coagulation studies have shown no difference between the blood of the smoker and the non-smoker.<sup>3</sup> We postulated that patients who are smokers may be protected postoperatively against deep venous thrombosis because they move more—possibly for a surreptitious cigarette in the bathroom.

### Patients, methods, and results

We tested this theory in 40 patients undergoing inguinal herniorrhaphy. We recorded their movement with a sensitive pedometer worn in their pyjama-coat pocket. All patients undergoing the operation wore the pedometer for 24 hours preoperatively and until the fourth day after operation. The patients were divided into smokers and non-smokers and their ages recorded. The median age of the non-smokers was 54.5 years (range 48-65), whereas that of the smokers was 47 years (range 33.5-53.5). This difference was significant ( $p < 0.025$ ). Smokers smoked an average of 22 cigarettes a day.

For the 24 hours before operation the median distance moved by the smokers was 2.01 km (range 1.77-2.25) and by the non-smokers 1.93 km (range 1.28-2.9). This difference was not significant ( $p = 0.52$ ). On the fourth postoperative day the smokers had walked 3.06 km (range 2.09-4.51) since the operation and the non-smokers 2.41 km (range 1.61-4.42). Again this difference was not significant ( $p = 0.68$ ).

### Comment

We conclude that there is no difference between the movements of smokers and non-smokers after operation and therefore that smokers are not protected from deep venous thrombosis by increased movement. The reason for the decreased incidence of thrombosis in smokers remains a mystery.

<sup>1</sup> Clayton JK, Anderson JA, McNicol GP. Effect of cigarette smoking on subsequent postoperative thromboembolic disease in gynaecological patients. *Br Med J* 1978;ii:402.

<sup>2</sup> Pollock AV, Evans M. Cigarette smoking and postoperative deep venous thrombosis. *Br Med J* 1978;ii:637.

<sup>3</sup> Clayton JK, Anderson JA, McNicol GP. Preoperative prediction of postoperative deep venous thrombosis. *Br Med J* 1976;ii:910-12.

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## Outcome of pregnancy after spontaneous abortion

A recent report from Liverpool<sup>1</sup> suggested that there may be a four-fold increase in congenital malformations in the pregnancy after a spontaneous abortion. Only a few cases were studied, and the authors called for studies from elsewhere. It has been generally accepted that a history of abortion, stillbirth, or neonatal death indicates an increased risk of subsequent obstetric problems.<sup>2</sup> In certain patients—for example, a woman who aborted a fetus with anencephaly—one would expect an increased risk of a further neural tube defect in subsequent pregnancies. No one to our knowledge, however, has suggested a risk of malformations in general on the scale found in the Liverpool study, and we thought that this warranted further investigation in a slightly different way.

### Patients, methods, and results

We studied the case notes of women who had delivered a baby at the old Bristol Maternity Hospital. The notes at the old hospital were conveniently filed according to the year of the mother's most recent delivery, and we selected a group of women whose final delivery was in either 1969 or 1970.

We excluded as malformations the following: clicking and dislocated hips, talipes, innocent systolic murmur, and undescended testicle. We included chromosome abnormalities, sacral dimples and sinuses, and hydroceles, so that our figures could be more easily compared with those of the Liverpool group.

We examined the records of 2633 pregnancies to see whether the outcome

Outcome of index pregnancy and outcome of subsequent pregnancy in 2633 patients. Results are given as number of cases with percentages in parentheses

Outcome of index pregnancy	No	Outcome of subsequent pregnancy			
		Normal	Spontaneous abortion	Mal-formation†	Anatomically normal stillbirths
Normal	2107	1824 (86.6)	213 (10.1)	51 (2.4)	19 (0.9)
Spontaneous abortion	440	304 (69.1)	120 (27.3)	10 (2.3)	6 (1.4)
Stillbirth	45	37 (82.2)	5 (11.1)	3 (6.7)	0
Major malformation*	41	30 (73.2)	9 (22.0)	1 (2.4)	1 (2.4)
Total	2633	2195	347	65	26

\*Major malformation included cases of spina bifida, hydrocephalus, anencephalus, congenital heart disease, malformations of the gut, and cleft palate.

†Live-born and stillborn babies were included in this category.