girl collided with a schoolmate while playing and fell, hitting the right temporal region of her head on a piece of concrete. She did not lose consciousness but almost immediately noticed double vision on looking to the right. No other symptoms developed, but the diplopia persisted and she was admitted to hospital. Physical examination revealed no abnormality apart from an isolated right lateral rectus palsy which was confirmed by orthoptic testing using a Hess chart. In particular there was no superficial bruising, tenderness, or evidence of upper respiratory tract infection. Skull *x*-ray was normal, but in view of the unusual nature of the injury computerised axial tomography of the head was undertaken; this likewise showed no abnormality. She was kept in hospital for four days and after discharge was seen regularly as an outpatient; by 14 weeks after the injury recovery of right lateral rectus function was complete.

The course of events in this child leaves little doubt that the rectus palsy was the result of the trauma, but whether the injury was to nerve or muscle can only be speculative. The anxiety generated for both child and parents not only by the symptoms, which were distressing, but also by the investigations and the concern of the medical attendants was considerable. With hindsight or the knowledge of similar cases much of this might have been prevented.

I am grateful to Professor J K Lloyd for helpful criticism, advice, and permission to report this case.

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[1] *British Medical Journal*, 1968, **2**, 190.
[2] Knox, D L, Clark, D B, and Schuster, F F, *Pediatrics*, 1967, **40**, 560.
[3] Yarzagaray, L, *Surgical Clinics of North America*, 1973, **53**, 59.

Adultproof childproof containers

SIR,—For how much longer have patients to suffer their pills and tablets being dispensed in bottles that are difficult enough to open in a good light and infinitely more so in an artificial light and by the elderly with frail hands? All because, we understand, some parents are careless enough to leave screw-cap bottles within the reach of small children. Accidental poisoning in this way must be a minute fraction of the countless prescriptions dispensed and it is thought that the time has come to take a more balanced view of the matter, reverting to the old screw-on type with a warning from the doctor to parents with small children to act responsibly in the matter.

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Circumoral paraesthesiae and labetalol

SIR,—Tingling of the scalp has been described in three patients related to the use of oral labetalol.[1 2] One of 22 patients I have treated with this drug has experienced persistent circumoral paraesthesiae reminiscent of that reported by some patients receiving parenteral streptomycin.

A 39-year-old West Indian has been treated with labetalol 600 mg twice daily for moderately severe essential hypertension since May 1977. Within two weeks of beginning the drug he developed a persistent perioral numbness "as if I had had a tooth removed under a local anaesthetic." The numbness gave way to circumoral tingling, which diminished after the dose of labetalol had been reduced to 400 mg twice daily. The drug was stopped twice because of this symptom and on both occasions the paraesthesiae ceased. The discomfort was still present after eight months of treatment but ceased after sotalol hydrochloride was substituted. Placebo labetalol has not been used. There has been no scalp tingling or formication.[3]

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[1] Hua, A S P, Thomas, G W, and Kincaid-Smith, P, *Lancet*, 1977, **2**, 295.
[2] Bailey, R R, *Lancet*, 1977, **2**, 720.
[3] Scowen, E, *Lancet*, 1978, **1**, 98.

Fall in admission rate of old people to psychiatric wards

SIR,—The informative paper by Dr K Shulman and Professor Tom Arie (21 January, p 156) draws attention to the diminishing intake to psychogeriatric hospital beds in the face of lack of evidence of decreasing demand. Your correspondents Dr J Todd and Dr I M Pullen (4 February, p 299) relate this to the steady reduction of psychiatric beds in mental hospitals and the increased length of stay (mainly due to decreased mortality) of those admitted to psychogeriatric beds respectively. Dr Shulman and Professor Arie incline to the view that "scandals" in mental hospitals widely publicised in official reports and thence through the mass media have caused a growing reluctance on the part of psychiatrists to admit the demented. No doubt all these opinions are valid and simply indicate that psychogeriatric accommodation as a whole has been upgraded, that it is extremely unwise for any psychiatrist not to go along with the upgrading programme, but that with present financial stringency it has been found impossible, while improving quality of accommodation, to maintain quantity.

The burden of looking after the elderly demented unable to gain admission to a psychogeriatric ward inevitably falls to the lot of those unsuited and ill-equipped to deal with the problem. Thus the Annual Report of the Health Advisory Service for 1976[1] states: "The absence of a satisfactory service for the elderly severely mentally infirm means that general practitioners, physicians, and geriatricians frequently must carry the responsibility for problems which are not theirs." One might add to the list the hard-pressed staff of the social services' residential homes for the elderly. I regularly visit a dozen or so of these homes in my own catchment area and I am constantly appalled at the numbers of ambulant severely demented residents, whose behaviour may encompass anything from using flower pots as latrines to getting into the beds of residents of the opposite sex. In one of the homes residents have recently organised a petition of protest to the Department of Health and Social Security. In another with one of the much-praised but seldom provided elderly mentally infirm (EMI) wings I sympathised with the matron in not being allowed to lock the intervening door from the main block only to be told that it didn't really matter as many residents in the main block showed far more disturbed behaviour than those from the EMI wing.

If one can criticise the psychiatrists over the present state of affairs it would be for their complete failure to press a campaign for a substantial increase of long-stay beds for the elderly alongside their compliance in the programme of upgrading of accommodation involving reduction of beds. The situation is not helped by the DHSS's adherence to a "norm" (2·5-3 psychogeriatric beds per 1000 population over 65), which is a considerable underestimate of demand and even of the actual existing provision in many areas of the country. It was therefore most refreshing to read[2] of the report published by the Scottish Division of the Royal College of Psychiatrists "firmly recommending that the NHS should provide . . . institutional care for elderly demented patients and that local authorities should be freed from this responsibility." No doubt it suits the Treasury admirably if financial responsibility is shifted in the reverse direction, but at what cost to the reputation of old people's homes, the comfort of their sensible residents, and the strain on their attendant staff?

We have just emerged from an era in which the stigma of the workhouse deterred potential residents from entering council homes for the elderly. There now seems a danger that these often excellent establishments will be branded by the general public, including the elderly, as places where only the feeble-minded are sent.

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[1] Department of Health and Social Security, *National Health Service: Annual Report of the Health Advisory Service, 1976*, London, HMSO, 1977.
[2] *British Medical Journal*, 1978, **1**, 1.

Imbalanced ventricles and cardiac failure

SIR,—With reference to your leading article on cardiac failure (11 February, p 324) a method for causing a temporary shift of blood away from the pulmonary circulation in acute pulmonary oedema is the application of venous tourniquets to all four limbs. I have found this useful in general practice on several occasions. It acts rapidly and gives a "breathing space" for drugs to become effective.

P D S THOMAS

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Serum IgE, lymphomas, and atopy

SIR,—I read with interest the paper by Dr P L Amlot and Mr L A Green on atopy and IgE concentrations in Hodgkin's disease and other lymphomas (11 February, p 327) and would like to make two points.

In the past three years three patients have presented to this department with generalised pruritus, and an underlying diagnosis of Hodgkin's disease was made. In two patients histological examination revealed nodular sclerosis (clinical stage II and IV) and in the third mixed cellularity (stage III). All three patients had had significant weight loss. None was atopic, but they all had markedly elevated serum IgE levels (the patient with stage IV nodular sclerosis having a level of 4675 U/ml). These limited data are thus in accordance with the authors' findings.

The authors state in their introduction that "with one exception, no valid study so far has shown any differences in serum IgE concentrations between people with cancer and those without." This is not true. In mycosis fungoides, a predominantly cutaneous

lymphoma, increased levels of serum IgE (often very high) compared with controls have been reported by at least two groups of workers.[1 2] In the four patients with mycosis fungoides seen in this department during the past two years the serum IgE levels have all been raised (range 979—>5000 U/ml). As with Hodgkin's disease, the pathogenesis of these high serum IgE levels (in the presence of normal levels of IgG, IgA, and IgM) is at the moment unclear.

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[1] Tan, R S H, *et al*, *British Journal of Dermatology*, 1974, **91**, 607.
[2] Mackie, R, *et al*, *British Journal of Dermatology*, 1976, **94**, 173.

Consultant physician to outpatients

SIR,—How refreshing to read Dr John Todd's paper on the role of the consultant physician (18 February, p 417).

Most general practitioners would agree with him that patients have "problems" rather than a diagnosis. But he should not be too modest in assessing the importance of the general physician. It is true that the general practitioner can nowadays fairly fully investigate the great majority of his patients. However, I can think of many cases—the young unstable diabetic; the patient with rheumatoid arthritis or epilepsy which is not controlled by one's treatment; the anxious patient who will not accept one's reassurance; the case when one fears that perhaps an essential clinical finding has been missed; and one could go on—when the second opinion of the skilled general physician is of inestimable help to the family doctor. Here surely is the true *métier propre* of the consultant physician.

One might perhaps add a plea that the patient is then returned to the care of his own doctor with the opinion of the physician and not kept attending at hospital follow-up clinics. This second opinion reassures greatly both patient and general practitioner.

The only sad point in Dr Todd's enlightened article is the comment that he has retired.

H M S NOBLE

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Recording events in clinical trials

SIR,—Dr D C G Skegg and Sir Richard Doll (10 December, p 1523) use the example of gastrointestinal bleeding developing during intravenous ethacrynic acid treatment reported by the Boston Collaborative Drug Surveillance Program (BCDSP)[1] in support of their thesis that all events, attributable to medications or not, be reported during clinical trials. I do not believe that the report cited illustrates the value of blind data-gathering or adverse event-reporting. Even putting aside the demonstrated fact that some of the patients began bleeding before administration of ethacrynic acid and the resulting partial retraction of the relationship by the authors of the report[2] there have been no further new cases discovered by the BCDSP according to a recent review of their data[3] and no corroboration from the Israeli[4] or Canadian[5] event-gathering associates of the BCDSP. Furthermore, there has been no independent confirmation of the "relationship" in the English literature. An article in French[6] discusses five cases of gastrointestinal haemorrhage in seriously ill patients with renal failure who received intravenous ethacrynic acid; the authors believed that a causal relationship would be difficult to prove.

Dr Skegg and Sir Richard Doll may be correct that uncritical reporting of undesirable events during clinical trials will uncover important adverse effects early. The example that they chose is a poor one, however. Their proposed system makes clinical trials more complex and later interpretation of event-reporting difficult and may uncover many false leads, as the BCDSP has done. Unexpected benefits and unexpected undesirable effects have both been discovered during clinical trials. Careful, inquisitive, imaginative investigators and monitors will continue to make such observations. Adding uncensored event-collecting to current procedures, if based on the example cited, seems of questionable value, however.

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[1] Stone, D, *et al*, *Journal of the American Medical Association*, 1969, **209**, 1668.
[2] Slone, D, *et al*, *Journal of the American Medical Association*, 1969, **210**, 347.
[3] *Drug Effects in Hospitalized Patients*, ed R R Miller and D J Greenblatt. New York, Wiley, 1976.
[4] Levy, M, *et al*, *Israel Journal of Medical Services*, 1973, **9**, 617.
[5] Borda, I T, *Canadian Medical Association Journal*, 1976, **114**, 517.
[6] Talbot, P, and Lemieux, G, *Union Médicale de Canada*, 1971, **100**, 792.

Arthritis associated with psoriasis

SIR,—We were interested to read your recent leading article on the treatment of psoriatic arthritis (4 February, p 262). Your contentious statement dismissing gold in the treatment is at variance with our experience. We are currently looking at the records of some of our patients with psoriatic arthritis—that is, patients with psoriasis who are seronegative and anodular—and are impressed with the efficacy of chrysotherapy. Our custom is to start patients on gold when it has become apparent that non-steroidal anti-inflammatory drugs are not controlling disease activity. Out of over 50 patients so far studied, 14 have been given long-term gold therapy. In three of these it was stopped (*a*) because it was ineffective, (*b*) because of possible worsening of the psoriasis, and (*c*) because the patient became scared of gold.

We hope to publish full details of our study in due course.

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Drug compliance in diabetics

SIR,—Dr A Melander and his colleagues presented very interesting data on serum levels of tolbutamide and chlorpropamide in diabetics (21 January, p 142). However, a very important factor was not mentioned—namely, patient medication compliance.

In a study of outpatients at an urban hospital compliance was measured by pill counts and urine assay.[1] Since we found urine assay to be a sensitive but non-specific compliance indicator, scores were derived based on pill counts obtained in the home. Two of the drugs analysed were tolbutamide and chlorpropamide. For tolbutamide 23% of patients took less than 20% of prescribed dose, 8% took 20-49%, 38% took 50-79%, and 31% fell into the "compliant" range of 80-109%. The corresponding figures for chlorpropamide were 14%, 22%, 14%, and 29%; 21% of these patients took more than 140% of the prescribed dose. Unfortunately, blood glucose determinations did not always correspond to the exact date of compliance measure. Nevertheless, no correlation was found between compliance and fasting blood sugar.

Dr Melander's blood level results thus appear to confirm the erratic compliance which we found among diabetics treated with oral hypoglycaemic drugs. The authors' suggestion of "suboptimal dosage" may be in fact suboptimal compliance.

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[1] Eshelman, F, Fitzloff, J, and Troyer, W, *Clinical Trials Journal*. In press.

Treatment costs in the USA

SIR,—The discussion in your correspondence columns about the cost of medical care in the United States (10 December, p 1542) is largely on a hearsay basis. To acquaint your readers with the actual facts of the situation I am giving my own fee schedule.

I have a high-class family practice in a prosperous suburban area on the south shore of Long Island, 60 miles from New York City. I see about 30 patients in an eight-hour day in the office—slightly less than four patients an hour.

My initial office visit charge for a new patient is $40. This is for taking a complete history and doing a comprehensive physical examination—eyegrounds, ears, mouth, throat, blood pressure, heart, chest, breasts, abdomen, pelvic examination and taking a cervical smear, rectal examination, testing the stool for occult blood, and dipstick urine analysis. Blood is taken for complete blood count and chemistry, but the fee does not include the laboratory charges. Repeat visits are $18 and at that time ears, throat, blood pressure, heart, chest, breasts, and abdomen are examined routinely each time, as well as a dip stick test of the urine at each visit. Routine procedures such as syringing the ears would be included in the fee. The charge for a home visit is $25.

When considering these charges one must also consider incomes in the area. My senior office aide is paid $5.25 an hour plus 25% for a private pension plan—a total of $6.56 an hour. This is the equivalent of $7000 a year at the current rate of exchange for a 40-hour week.

At a postgraduate course for family doctors six months ago on talking around I found that the charge for an office visit for a family physician varied from a high of $20 to a low of $8 in different parts of the US, the lowest fees being in the rural areas. A better picture of medical costs is the fact that the total percentage of the gross national product spent on medical care in the US is about 7½%. The percentage of the national product spent on medicalc are in the countries of Western Europe is about 7½-8½%. The exception is