can be more convincing to a patient than the more callous approach of a seasoned practitioner who has seen it all before.

(2) The doctor should stress to the patient that the presence of a student may actually improve the care he is getting. The patient can be told that the melding of seasoned experience and up-to-date scientific knowledge that his physician and student when acting in concert bring to a clinical situation can work only to his advantage. This calls for an admission of humility on the part of the physician, but this too is a welcome thing to many patients.

(3) The patient should be informed that students have to learn and that medical education is only part book learning. The practice of medicine, and general medicine in particular, is something that must be learned in the field. A certain altruism on the part of the patient can and must be cultivated.

Finally, at the end of the interview a few minutes can be spent with the patient in a tactful way to determine if he held back on any information because of reluctance to be candid in the presence of a third party. Occasionally important facts come to light and the patient has been served.

Obviously what I am talking about cannot be done in an office which has a rapid turnover; but then perhaps those offices are not ideal for the training of medical students. If encouraged and made to feel a part of the health care team our students will grow into more sensitive and caring physicians.—I am, etc.,

DAVID ELPERN

Family Medicine Institute,
Augusta General Hospital,
Augusta, Maine

### Isolation System for General Hospitals

SIR,—I suggest that some of the recommendations of the Control of Infection Group at Northwick Park Hospital (6 April, p. 41) seem to be examples of the first of Todd's[1] list of the main errors of medicine—basing treatment on theory. Or, as Chapin[2] might have put it, that the group do not always distinguish clearly between how diseases might be spread and how they are in fact spread.

As cubicle isolation is expensive in resources, it is important to record observations which indicate when it is not necessary. I therefore report that in the infectious disease unit at this hospital during the past 27 years patients with hepatitis (in its icteric stage), meningitis (of all forms), encephalitis, erysipelas, herpes zoster (in adults), leptospirosis, psittacosis, brucellosis, glandular fever, malaria, pneumonia, and non-infective disease have commonly been nursed together in open wards without evident ill effects. Though the Northwick Park group do not recommend isolation in the five last-mentioned conditions, I include them in the record because when treated in infectious disease units elsewhere the patients are commonly nursed in cubicles—for lack of any other accommodation.

These observations suggest the possibility of great saving in gowns, gloves, time, and other expenditure.—I am, etc.,

H. G. EASTON

Ruchill Hospital,
Glasgow

1 Todd, J. W., *Lancet*, 1970, **1**, 665.
2 Chapin, C. V., *The Sources and Modes of Infection*. New York, Wiley, 1910, *cited by* Taylor, I., and Knowleden, J., in *Principles of Epidemiology*, 2nd edn., p. 117. London, Churchill, 1964.

SIR,—Those of us who have been concerned with the control of infectious diseases will have been impressed by the article on isolation in general hospitals (6 April, p. 41). The Control of Infection Group at Northwick Park Hospital are to be congratulated.

However, the implication that cases of suspected smallpox should ever be confined in such a unit is a cause for concern. Whenever smallpox is suspected direct admission to a special smallpox hospital should be the rule. Any attempt to contain the patient locally while the diagnosis is confirmed is to be deprecated since it can result in needlessly contaminating part or all of the general hospital, with grave disruption of general medical services during the subsequent inevitable closure.—I am, etc.,

M. F. H. BUSH

Ipswich

### Accidental Poisoning in Children

SIR,—In the debate on the adjournment in the House of Commons on 18 March Dr. David Owen, Under Secretary of State for Health, said that medicines were chiefly responsible for hospital admissions in cases of poisoning in children under 5 and that aspirin was the largest single cause (30 March, p. 652). It seems likely that of the 16,000 children admitted to hospital for accidental poisoning each year about 5,000 are due to the specially flavoured "junior" aspirins.

A personal study of over 300 such cases has shown that these children practically invariably finish the opened packet which usually contains 50 tablets (total of 4 g). Dr. Owen says that he is prepared to examine anything which could reduce the risk of accidental poisoning. One of the simplest and most practical measures would be to forbid the sale of "junior" aspirin in packages of more than a dozen (1 g). This amount is very unlikely to give rise to toxic effects and would make the admission of the child to hospital unnecessary.—I am, etc.,

W. P. SWEETNAM

Department of Paediatrics,
Royal Infirmary,
Huddersfield

### Rebound Migraine

SIR,—I would like to draw attention to a syndrome which can develop in patients taking ergotamine preparations for the relief of migraine and which can easily go unrecognized. Four patients were encountered personally over a six-month period in whom migraine or migrainous neuralgia had initially responded to ergotamine but who had then developed daily headaches while taking the drug every day. The headaches were similar to those for which they had first sought treatment, but there were often slight differences in their character, situation, or timing. They were improved for an hour or more by a dose of ergotamine, but as its effects wore off they invariably recurred and were relieved again only by another dose. When all ergotamine preparations were stopped the headaches subsided within a few days.

Infrequent accounts of this situation have appeared before.[1-4] The terms "ergotamine tolerance," "ergotamine withdrawal headaches," and "ergotamine-induced headaches" have been used to describe it, but these are not satisfactory descriptions. Ergotamine tolerance has never been proved[5] and it is misleading to call these "withdrawal" headaches since they are at their worst while the drug is being taken and disappear, sometimes immediately, when it is stopped. Though they are undoubtedly induced by ergotamine the situation is more complex than this, for they continue to be relieved by it as well. I suggest that the syndrome should be called "rebound migraine," which evokes the continuous fluctuation of symptoms in relation to ergotamine intake. The probable underlying mechanism is a recurring cycle of vasoconstriction → vasodilatation with headache → vasoconstriction,[1] based on a primary followed by a rebound response to each dose of ergotamine.

This syndrome may be much commoner than is generally realized. The diagnosis should be considered in any migrainous patient who has intractable headaches while taking substantial amounts of ergotamine every day; such headaches may be occurring because of rather than in spite of the drug. Withdrawing the ergotamine can lead to complete relief, but the patient must be given to understand that this may take several days and that the trial period of abstinence has therefore to last at least a fortnight.

A fuller account of this condition will be published elsewhere.—I am, etc.,

N. J. LEGG

National Hospital for Nervous Diseases,
London W.C.1.

1 Peters, G. A., and Horton, B. T., *Proceedings of the Staff Meetings of the Mayo Clinic*, 1951, **26**, 153.
2 Friedman, A. P., Brazil, P., and von Storch, T. J. C., *Journal of the American Medical Association*, 1955, **157**, 881.
3 Lucas, R. N., and Falkowski, W., *British Journal of Psychiatry*, 1973, **122**, 199.
4 Rowsell, A. R., Neylan, C., and Wilkinson, M., *Headache*, 1973, **13**, 65.
5 Brazeau, P., in *The Pharmacological Basis of Therapeutics*, ed. L. S. Goodman and A. Gilman, 4th edn., p. 893. London, Collier-Macmillan, 1970.

### Polyarteritis after Influenza Vaccination

SIR,—We would like to draw attention to a patient who developed acute polyarteritis of a fulminating type following administration of a dose of inactivated influenza vaccine.

The patient, an Englishman aged 46 with a family history of diabetes mellitus but no family history of allergy or asthma had suffered from mild bronchitis for most of his life. In 1968 bronchial asthma was diagnosed and this required intermittent courses of steroids. In 1972 he was investigated and found to be sensitive to house dust and house dust mites. There was no history of any other allergy and in particular no intolerance to eggs. Respiratory function tests showed moderately severe airways obstruction with a reversible component. He was started on long-term steroids and was well controlled with disodium cromoglycate and 2·5 mg of

prednisolone twice daily. At no time did he receive any sulphonamide preparation. While on this dosage of prednisolone he received, in October 1973, an injection of 1 ml of Admune subcutaneously, which he had had in the previous year. Within 10 days he began to suffer from myalgia, which affected all muscle groups, and arthralgia. His weight began to fall and this was associated with general malaise and anorexia. Clinical examination was unhelpful apart from a maintained pyrexia of 38-39°C and generalized muscle wasting.

Investigations showed a haemoglobin of 11·0 g/100 ml; E.S.R. 33 mm in 1 hr; serum electrolytes and urea normal; W.B.C. 22,000/mm³ with 6,300 eosinophils/mm³; serum creatinine phosphokinase 17 mU/ml; antinuclear factor negative; L.E. cells not seen. Both latex and Rose-Waaler tests were weakly positive. Urine contained protein 10 mg/100 ml, but no blood at any time. His blood urea then rose to 74 mg/100 ml and alkaline phosphatase to 22 King-Armstrong units. Serum asparate aminotransferase was 44 IU/l. and serum hydroxybutyric acid dehydrogenase 36 IU/l. Protein electrophoresis showed a low albumin level with increased $\alpha_2$-globulin. An electromyograph showed small motor units consistent with myopathy. Muscle biopsy was performed and this showed necrotizing arteritis. Tests for antinuclear factor then became positive but serum complement was 132 mg/100 ml (normal 82-150 mg/100 ml).

He was started on 40 mg of prednisolone daily and made good symptomatic improvement. His temperature came down to normal, as did his blood urea, liver enzymes, eosinophil count, and E.S.R. However, his muscles became more wasted and despite the addition of azathioprine and anabolic steroids he continued to deteriorate. His weight had in fact fallen from 11 stone (70 kg) before his illness to 6 stone (38 kg). In the last two days of his life he developed macroscopic haematuria and ultimately died of bronchopneumonia. Necropsy revealed extensive polyarteritis of his muscles. His heart showed areas of microinfarctions and both his kidneys showed severe glomerulonephritis with epithelial crescents.

We think that the time relationship of the onset of his illness to the immunization makes Admune the likely cause of this acute fulminating collagen reaction.—We are, etc.,

C. F. P. WHARTON
R. PIETRONI

Orpington Hospital,
Orpington, Kent

## Dangerous Patients

SIR,—Your leading article (23 March, p. 527) is welcome in drawing attention to the difficulties in making recommendations regarding dangerous patients in the light of current attitudes in mental hospitals towards mentally disordered offenders. However, there are further issues raised which you have failed to follow through in your argument.

You have indeed protested time and again about the shortage of beds in secure hospitals. However, in jumping to the next conclusion that the requirements for admission to a special hospital should be widened both you and the Royal College of Psychiatrists are rejecting the responsibility of mental hospitals to provide secure accommodation for at least a percentage of patients. It hardly solves the problem by shifting all responsibility to special hospitals and then expecting them to carry the opprobrium and also "like Janus of ancient mythology, to look in two directions at the same time: forward towards a therapeutic community . . . and backwards towards the security of a prison."

It is to be hoped that the community will come to recognize the consequences of the "open door" policy when pursued to its limit and begin to question whether the problem is solved by exchanging mental hospital beds for special hospital and prison beds.—I am, etc.,

N. F. HILLS

Department of Corrections,
West Perth,
Western Australia

SIR,—The harbouring in the general psychiatric hospital of potentially dangerous patients may not be quite so intractable under present legislation as your leading article (23 March, p. 527) implies.

In the event of such a patient becoming also uncooperative, it is open to the hospital to secure the almost immediate help of either my colleague, Dr. Patrick McGrath, or one of his Broadmoor Hospital colleagues. As the result of telephoned information an immediate bed could be secured for the patient's transfer to Broadmoor under the provisions of section 63(3) of the Mental Health Act (which takes up for section 60 detainees the provision of section 41(1a) of the Act). Alternatively a Broadmoor consultant could visit rapidly the detaining hospital and give an opinion on disposal, with transfer into security if deemed appropriate.

My Broadmoor colleagues prefer the extra grip afforded by an indefinite time restriction order under section 65 of the Act; but I do not believe they would consider it a sine qua non. It is, however, open to the general psychiatric consultant to insist on this. He can thus refuse inpatient admission under section 60 from magistrates' courts but require that, if psychiatric disposal is thought suitable by the bench, the patient be remanded to crown court for the addition of the indefinite restriction order.—I am, etc.,

SEYMOUR SPENCER

Oxford

## Epilepsy and Driving

SIR,—The *British National Formulary* has rightly become a respected publication, but unfortunately there is an error on page 82 of the 1974-76 edition which is causing confusion to doctors when advising their patients about epilepsy and driving.

The passage in the *B.N.F.* reads:

"Under recent regulations in the U.K. an epileptic may be eligible for a driving licence but, if controlled by drugs, he must not alter the regimen unless he is prepared to give up his licence for three years; if he subsequently has a fit during daytime he must wait a further three years, even if medication is resumed, before applying for a licence."

In fact the relevant regulation[1] is as follows:

"An applicant for a licence suffering from epilepsy shall satisfy the conditions that—(*a*) he shall have been free from any epileptic attack whilst awake for at least three years from the date when the licence is to have effect; (*b*) in the case of an applicant who has had such attacks whilst asleep during that period he shall have been subject to such attacks [while asleep but not whilst awake] since before the beginning of that period; (*c*) the driving of a vehicle by him in pursuance of the licence is not likely to be a source of danger to the public."—We are, etc.,

T. A. BETTS
M. ESPIR
F. B. GIBBERD
R. H. E. GRANT
P. M. JEAVONS
A. RICHENS
C. W. M. WHITTY

British Epilepsy Association,
London W.C.1

1 *The Motor Vehicles (Driving Licenses) Regulations 1970*, 22(2). London, H.M.S.O., 1970

## British Academy of Psychopharmacology

SIR,—Further to the letter from the steering committee (2 March, p. 391) the inaugural meeting of the British Academy of Psychopharmacology was held on 22 April and the academy formally constituted.

As a result of the steering committee's letter we received 129 letters supporting the formation of the academy and one letter against its formation. The inaugural meeting was attended by 45 interested individuals, many of whom had travelled considerable distances to attend the meeting. Letters of congratulation and support were received from the presidents of the International, American, German, and Turkish Colleges of Psychopharmacology.

Professor Max Hamilton was elected first president of the academy, and Dr. Alec Coppen president-elect. Other officers and a council of 10 members were also elected. It was decided that one of the main objects of the academy would be to provide a means of integrating the many disciplines involved in psychopharmacological research, though there would be some emphasis on clinical psychopharmacology. To this end applications for membership will be considered from interested individuals, and any of your readers who may like further details are invited to write to me.— Iam, etc.,

DAVID WHEATLEY
Honorary Secretary,
British Academy of Psychopharmacology

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## Withdrawal Symptoms after Stopping Phenelzine?

SIR,—In the past month two of my patients have suffered similar symptoms related to the withdrawal of phenelzine.

The first is a man in his thirties with a rather long-standing neurotic depression who has benefited from phenelzine without making a full recovery. Because of residual symptoms I decided to give him a course of electric convulsion therapy and I thought it wise to stop the drug meanwhile. However, within a day of doing so he was suffering from a severe frontal headache which lasted for several days and, more significantly perhaps, shivering and a feeling of intense cold which lasted well over a week. He said he felt just like Frank Sinatra