

strains and 11 antibiotics, with the findings of Dr. Stokes's and Professor Mary Barber's departments. In all, the participating laboratories reported on 3,386 tests, and only 114 of their results were classified as errors. On this basis, 97% of their reports were "correct". The clinicians who depend on us for vitally important information may find this figure more reassuring.—I am, etc.,

D. C. TURK

Department of Pathology,
Gibson Laboratories,
Radcliffe Infirmary,
Oxford

¹ Association of Clinical Pathologists Bacteriology Committee, *Journal of Clinical Pathology*, 1965, 18, 1.

Drink, Drugs, and Driving

SIR,—It has recently been reported¹ that the number of road traffic accidents involving charges being preferred as regards excessive alcohol levels have increased substantially. However, it may well be that this represents the tip of the iceberg as regards people whose driving is impaired; not only by alcohol, but by drugs, mainly psychotropic agents.

Generally speaking, it is only the patient and his family doctor who are aware of those driving under the influence of drugs (which is an offence at law). Many doctors advise their patients not to drive within the few hours after taking these agents.

It would seem that steps should be taken not only to dissuade people from driving under the influence of drugs, but to bring existing legislation into effect by requiring family doctors to provide details of current therapy of their patients involved in road traffic accidents.—I am, etc.,

T. C. MAYER

Ilford, Essex

¹ *Birmingham Post*, 17 June, p. 2.

Pericarditis after Myocardial Infarction

SIR,—I read with great interest the paper by Dr. U. Thadani and others (17 April, p. 135). I have studied a series of 195 patients with myocardial infarction treated in the coronary care unit during the course of a year. A pericardial friction rub was heard in 22 of the patients. In most of them the rub appeared on the second, third, and fourth day after the onset of symptoms and in three soon after cardiac resuscitation. It remained audible for one to three days in most of the patients, but in very ill patients it persisted for three to seven days. In none of the patients the rub recurred, so that none developed the postmyocardial infarction syndrome.¹ The site of infarction was anterior in 12, posterior in four, and anterior and posterior in six. The rest of the most important clinical and laboratory findings are given in the Table. As a group the 22 patients with pericarditis compared with 50 consecutively admitted patients without pericarditis had a worse prognosis, but this was due to the extensive infarction per se and not to pericarditis.

The interesting finding of this study is that postmortem examination revealed a considerable amount of haemorrhagic fluid^{2,4} in two patients who were receiving anticoagu-

	With Pericarditis (22 patients)	Without Pericarditis (50 patients)
	No. of Patients	No. of Patients
Anticoagulants ..	13	35
Arrhythmias and heart block* ..	18	34
Heart Block* (2nd and 3rd degree)	12	4
Severe Cardiac Failure ..	14	10
Cardiogenic Shock	6	1
Haemorrhagic Pericardial Fluid	2	0
Abnormal Chest x-ray ..	13	16
S.G.O.T. (units/ml. normal <100 units) ..	150-500 Mean 333	160-330 Mean 180
Mortality ..	4	6
Days of Hospitalization	46	28

There was no significant difference in admission delay, sex and age, and site of infarction between the two groups of patients.

*Most patients developed more than one arrhythmia.

lants (heparin and warfarin), and had died in cardiogenic shock. Both clinicians and pathologists agreed that the effusion had attributed to the development of the shock. It is suggested therefore that anticoagulants should be discontinued after the development of a pericardial friction rub in patients with myocardial infarction.

I am grateful to Dr. C. S. McKendrick for permission to report the results of this study.

—I am, etc.,

A. P. NIARCHOS

Coronary Care Unit,
Liverpool Regional Cardiac Centre,
Sefton General Hospital,
Liverpool 15

¹ Dressler, W., *Archives of Internal Medicine*, 1959, 103, 28.

² Goldstein, R., and Wolff, L., *Journal of the American Medical Association*, 1951, 146, 616.

³ Fell, S. C., Rubin, I. L., Enselberg, C. D., and Hurwitz, E. S., *New England Journal of Medicine*, 1965, 272, 670.

⁴ Miller, R. L., *Journal of the American Medical Association*, 1969, 209, 1362.

Marihuana Withdrawal Symptoms

SIR,—There are few references in the literature to reported cases of physical withdrawal symptoms from marihuana,^{1,4} while others have an open mind as to their existence.⁵⁻⁸ However, the literature is full of the mistaken impressions that they do not occur at all and hence I feel obliged to report my experiences in this regard.

During the winter of 1970, I accompanied a large group of men and women to an area of the South-west African desert. Here I encountered symptoms among three males and two females, aged 19-29 years, which I believe were indicative of marihuana abstinence.

The smoking of "pot" was prevalent among the younger adults in the camp and as supplies diminished I was presented with patients who had anxiety symptoms and restlessness coupled with acute abdominal cramps, nausea, sweating, increased pulse rate but no rise in temperature, low blood

pressure, and muscular aches. There was no loss of appetite, in fact the contrary was the case, with a craving for sweets and particularly chocolate. There was no enteritis which might have been due to dietary changes or local brackish water supplies, and no other illnesses. There were no viral infections in the camp; this was not a malarial district nor were there tick bites. The abdominal cramps did not appear to me to suggest a diagnosis of acute abdomen, or gynaecological or urinary infections or conditions, or spasm of biliary or urinary tracts.

I was unable to make a diagnosis at the time and the patients were treated with anti-spasmodics and bed rest. The symptoms persisted from one to three days. A short while later, on looking back, I realized that the disappearance of the symptoms had coincided with the arrival of a courier from the nearest sea-port who had brought with him a new supply of marihuana.

Some weeks later, at another area, I saw one more severe case in a 20-year-old woman with symptoms of similar pattern. She admitted that she had been partaking recently of too much "pot" and as she was proceeding home she had decided to make a complete break and thus had suddenly stopped taking it. I did not see her again, but learned from her friends some ten days later that her symptoms had disappeared, she was no longer taking marihuana, and in fact was extremely well. There was yet another much milder case which followed a like pattern.

I was satisfied that none of these patients had been on other drugs that might have given withdrawal symptoms. Hence it was not unreasonable that I came to the conclusion that these seven patients had in fact been experiencing acute physical withdrawal symptoms from the smoking of what is recognized in our country as a more potent type of cannabis than usually encountered in Europe or America.—I am, etc.,

A. D. BENSUSAN

Department of Medicine,
University of the Witwatersrand,
Johannesburg, S. Africa

¹ Williams, E. G., Himmelsbach, C. K., Wikler, A., Ruble, D. C., and Lloyd, B. J., *Public Health Reports*, 1946, 61, 1059.

² Bouquet, J., *Journal of the American Medical Association*, 1944, 124, 1010.

³ Fraser, J. D., *Lancet*, 1949, 2, 747.

⁴ Gaskill, H. S., *American Journal of Psychiatry*, 1945, 102, 202.

⁵ Bergel, F., and Davies, D. R. A., *All About Drugs*, p. 54. London. Nelson, 1970.

⁶ Cameron, D. C., *World Health*, 1971, April, p. 4.

⁷ Abdulla, A., *Schweizer medizinische Wochenschrift*, 1953, 83, 541.

⁸ Watt, J. M., *Bulletin on Narcotics*, 1961, 13, No. 3, 9.

Trauma to the Urinary Tract

SIR,—I should like to congratulate Mr. J. P. Mitchell on this excellent article (5 June, p. 567), with which I entirely agree. There is, however, one small point with regard to complete rupture of the posterior urethra which I feel he does not stress sufficiently and I hope he will not mind my drawing attention to it.

When repairing a rupture of the posterior urethra it is extremely important to approximate the two ends as nearly as possible by one or more sutures running from the prostatic capsule on either side to the triangular ligament below, so as to hold the