demand expertise. If this is lacking then expert supervision should be at hand. When this is not available, as in practical terms it may not be, then how much wiser it is to stop well short of that critical force. A trial of forceps therefore should still be a laudable and well-recognised procedure, and a "failed forceps" never regarded as an obstetric failure, unless the danger force is exceeded. No amount of experience will always predict the outcome of every instrumental delivery.

Perhaps in the electronic age we could design a special type of strain gauge attached to the forceps handles. Failing this, a change in some attitudes towards trials of forceps, and in particular failed forceps, could certainly help.

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Silver poisoning associated with an antismoking lozenge

SIR,—Dr D MacIntyre and others described a case of argyria associated with an antismoking lozenge, Respaton, containing silver acetate and ammonium chloride (23-30 December, p 1749), and we wish to report a second case due to the same preparation.

A 63-year-old Englishman complained of gradual change in the colour of his skin. His only other symptoms were slight giddy feelings and tiredness, apparently originating from his being told that he looked "off colour." On examination the striking feature was a bluish-grey colour of the skin exposed to light—on the face, a V-area of the neck, and the hands. The fingernails had a bluish shade. There was no pigment line on the gums but the patient was edentulous. The rest of the examination showed no abnormalities. Ophthalmological assessment revealed no abnormal eye pigmentation. A skin biopsy was taken from a pigmented area of the neck. Haematoxylin and eosin stain showed fine black granules in the region of the basement membrane of glands and hair follicles. After treatment of the sections with Lugol's iodine solution and sodium thiosulphate, followed by restaining with haematoxylin and eosin, the granules were no longer visible, confirming the presence of silver. Silver concentrations in the hair, estimated by neutron activation, were normal, as were the results of all other investigations.

Our patient had taken Respaton lozenges continuously for two years but he denied exceeding the manufacturer's recommended maximum dose of six lozenges per day, unlike the patient previously described. Nine months after diagnosis his pigmentation remains unaltered, despite discontinuing the lozenges; his smoking habit persists.

Although the only adverse effect of chronic silver absorption is generally accepted to be cosmetic, these cases raise the question of whether silver containing preparations should be freely on sale to the public.

We would like to thank Dr R Millis for the histology and Professor T Clark for permission to publish this case.

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Treatment of tuberculosis

SIR,—I was very interested in the admirable letter from Sir John Crofton (6 January, p 52) on the treatment of tuberculosis. I was surprised and alarmed to learn that "deviations from the well-established rules of antituberculosis chemotherapy are still not too uncommon in some areas of Britain, especially among orthopaedic surgeons, urologists, and gynaecologists." So far as gynaecologists are concerned, there is no justification whatever for this failure to conform to current therapeutic practice. During the past 25 years many articles have been published on the treatment of gynaecological tuberculosis, emphasising that it is essential to employ the same drug courses as those used in the treatment of pulmonary tuberculosis.

During the past 28 years, I have made a special study of tuberculosis of the female genital tract and more than 600 patients with this condition have been under my care. Throughout this period, all drug programmes have been planned in consultation with Dr R J Cuthbert, consultant chest physician at Southern General Hospital, Glasgow. In addition, he or one of his colleagues has examined every patient at the start of treatment and all patients with drug reactions of any kind. Even with these precautions a substantial recurrence rate has been found with every drug programme except the most recent ones incorporating ethambutol and rifampicin, where the period of follow-up is too short for comparison with the earlier regimens. The lowest recurrence rate encountered to date has been 12·3%, the drugs employed being streptomycin, para-aminosalicylic acid, and isoniazid, administered for 18 months or two years.

Recurrence of gynaecological tuberculosis may be found several years after the conclusion of drug treatment. The longest gap between treatment and recurrence in my own series was 19 years. The view that a patient can be regarded as cured after one or two negative post-treatment examinations is incorrect. Indefinite follow-up of all such patients is essential, and failure to carry it out is not in the interests of the patients and is an indication of ignorance on the part of those adopting this view.

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Contribution of poor blood pressure control to strokes

SIR,—There appear to be several confusing statements in the article on stroke and hypertension (9 December, p 1605) by Dr P Kennedy and Dr B Hoffbrand, who claim that the incidence of unsatisfactory blood pressure control in patients suffering "hypertensive" strokes is 62%. However, a closer look at the published figures reveals that 35 patients out of 65 had a high blood pressure reading at the time of the stroke; this gives an incidence of 53·85%. Moreover, if the three patients who were found to be hypertensive only at the time of the examination are excluded—as this rise in blood pressure may have been secondary to the stroke[1] then the incidence drops to 49·23% (32 patients); and finally, if the 12 patients who "had their blood pressure well controlled before the stroke" are also excluded then we are left with only 20 patients whose blood pressure was poorly controlled, and the incidence of unsatisfactory blood pressure control in patients who suffered strokes is 30·77%. If only hypertensive patients are considered, then 20 out of 35 had an unsatisfactory blood pressure control—an incidence of 57·14%; this incidence would rise to 65·71% if the three newly discovered hypertensive patients are included.

Regrettably, we are not given any information regarding the aetiology of the strokes. Do the authors assume that if the blood pressure is elevated soon after the stroke then hypertension is directly responsible for the event? Drs Kennedy and Hoffbrand also state that "these findings provide evidence that more effort needs to be paid to ensuring adequate treatment of patients already known to have hypertension than to finding new cases." This we find puzzling as the morbidity and mortality associated with hypertension is now well recognised, even in the older population,[2 3] and a stroke may be the first manifestation of hypertension. Finally, we feel that the dangers of overtreating hypertension in the elderly or reducing their blood pressure too rapidly should have been mentioned.[4] It would have also been appropriate to emphasise the need to check at regular intervals the functions of the target organs while hypertension is being reduced, otherwise clinicians might fall in the trap of treating a blood pressure reading rather than the patient.

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[1] Marshall, J, *Medicine*, 1978, **34**, 2018.
[2] Kannel, W, *et al*, *Stroke*, 1976, **7**, 327.
[3] Shekelle, R, Ostfeld, A, and Klawaus, H, *Stroke*, 1974, **5**, 71.
[4] Jackson, G, *et al*, *Lancet*, 1976, **2**, 1317.

**We sent a copy of this letter to Dr Kennedy and Dr Hoffbrand, whose reply is printed below.—ED, *BMJ*.

SIR,—Drs R Hamdy and M A Nasar have misread our paper. We did not assess our patients' blood pressure status on sphygmomanometer readings at the time of their stroke but by the stated criteria, including clinical history, chest *x*-ray and electrocardiograph, and previous hospital notes. Only 35 patients were hypertensive by these criteria, not the total of 65 patients, which was the total number admitted with stroke during the period of the investigation. The percentages are of the 32 patients (of this 35) who had been diagnosed as hypertensive before their stroke, and are correct as published.

The purpose of our paper was to present evidence of poor blood pressure control in a large percentage of patients known to have hypertension who suffer a stroke. Even if space had permitted, a discussion of the management of hypertension and the aetiology of stroke would have been hardly appropriate.

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Health risks from keeping cats

SIR,—I am surprised that your expert's answer (16 December, p 1700) about the dangers of cats to health did not include any mention of toxoplasmosis. Congenital toxoplasmosis is a serious and often fatal neonatal illness in which there is choroidoretinitis, cerebral calcification, psychomotor retardation, hydrocephalus, and convulsions. *Toxoplasma gondii* is a protozoon which recently was de-