Adynamic Ileus and Nortriptyline

SIR,—In their short paper on this topic (2 April, p. 841) Drs. G. Milner and N. F. Hills assert that nortriptyline possesses more dangerous anticholinergic properties than do imipramine and desipramine. They do not produce any evidence about the relative toxicity of these drugs when administered in their normal dosage, but they did observe ileus when nortriptyline was given (1) in full adult dose to a child of 14½ years, (2) in the standard dose of 75 mg. daily to an 81-year-old admitted to hospital after having taken an overdose of barbiturates, and (3) when a standard dose was given in conjunction with 150 mg. daily of chlorpromazine to a woman complaining of abdominal pain.

The part played by nortriptyline in the induction of these patients' ileus is far from clear, but there is no doubt that nortriptyline is a potent drug with anticholinergic properties. It is to be used with discretion in the elderly, and is probably best administered to such patients in reduced dose initially.

The recommended adult daily dose is 75 mg., which may be raised to 100 mg. daily if necessary, above which level anticholinergic side-effects are likely to become troublesome. Drs. Milner and Hills state categorically that "the usual adult dose" is 150–200 mg. daily, but it is fervently to be hoped that their opinion on this point at least will be taken with reservation.—I am, etc.,

W. H. LYLE.

Dista Products Limited,
Liverpool 24.

Contact Lenses and Oral Contraceptives

SIR,—A 33-year-old short-sighted married woman who had worn corneal contact lenses uneventfully 12 hours a day for three years began sequential oral contraceptive therapy with Oracon, in which ethinyloestradiol, 0.1 mg., daily for 16 days, is followed by dimethisterone, 25 mg., plus ethinyloestradiol, 0.1 mg. daily for five days. After 10 days' therapy in the first cycle she noted improvement of acne vulgaris of her face and chest, but because she developed minimal ankle oedema, slight weight gain, fullness of the face and breasts, and increasing prominence of pre-existent mild varicose veins, she discontinued the drug. These effects were all probably oestrogen-induced; the side-effects diminished and the acne vulgaris relapsed after the oestrogen therapy was stopped.

A few days after stopping the ethinyloestradiol she began to notice photophobia in direct sunlight. After this had continued for three weeks, unaccompanied by redness of the eyes or lacrimation, she was examined by an ophthalmologist, who detected unilateral corneal oedema and superficial corneal opacities, staining with fluorescein. Her use of contact lenses was prohibited; the photophobia disappeared within 36 hours, and after three weeks slit-lamp examination of the cornea revealed complete recovery. She was then able to resume wearing her contact lenses for 12 hours a day uneventfully.

During the previous three years regular slit-lamp examinations had shown that her contact lenses were of a correct "fit," and no corneal staining with fluorescein had been detected. There was no obvious local cause for the attack of corneal oedema here described, which was coincident in time with side-effects due to fluid retention induced by oestrogen. It would be of interest to know if oral contraceptive therapy has been associated with disturbances of contact-lens wearing in other patients.—I am, etc.,

G. A. CARON.

University of Oregon Medical School,
Portland 1, Oregon.

Causes of Death in Primitive and Emerging Populations

SIR,—In the medical literature dealing with epidemiology, geographical pathology, environmental health, etc., regret is often expressed over our lack of knowledge of patterns of morbidity and mortality in primitive and emerging populations. Unfortunately, information in this field is likely to remain defective for many years. The reason is not far to seek. The following illustrates the difficulties prevailing.

In an attempt to assess the proportion of deaths of Johannesburg Bantu adults that could be ascribed to nutritional causes, death certificates for 1963 were examined. Of persons dying from 45 years and onwards it was dismaying to find that no less than 23% were attributed to senility or unknown causes (Classification B.45, 780–795). For the total Johannesburg Bantu population—that is, all ages—the figure was 21%. Yet in this city health services for non-whites are of a higher standard than any in Africa.[1,2] Current Bantu infantile mortality rate is about 60, lower than that of any other city in this continent, and lower, too, incidentally, than current figures for Portugal and certain Central and South American countries.[3] Why then is the cause of death of about every fifth Bantu uncertain or unknown? The proportion among the rural population, of course, is higher. To afford perspective it should be added that the corresponding percentages obtaining for total populations elsewhere are as follows: United Kingdom, 1.3; South Africa (Whites), 4.8; Greece, 18.0; Yugoslavia, 25.1; Ceylon, 22.4; El Salvador, 28.3.[4]

Locally (and presumably elsewhere) the salient reason for the lack of knowledge is that many Bantu die without the attention of a doctor in their terminal illness. This is by no means attributable wholly to poverty, but, at least in the case of adults, due rather to the tacit acceptance of the inevitability of death, which is part of their philosophy. It is conjectured that the proportion of adults dying from unknown causes could be reduced perhaps considerably by investigating from next of kin the antecedents of those who died in relation to hospital or other treatment prior to death. To throw light on this possibility we are seeking to assess the extent of the reduction possible by inquiring into the causes of death of 100 random adult Bantu stated to have died from senility or unknown causes.

The present situation, understandably, on the basis of death certificates precludes the making of satisfactory comparisons of prevalences of particular causes of death in Bantu compared with whites. At present it is therefore possible that diseases in Bantu believed to be common may be commoner than current figures suggest, and, moreover, that diseases deemed to be rare may be less so. For the study of inter-racial prevalence of diseases valuable information is likely to accrue only from two avenues of approach—namely, from post-mortem studies of persons dying from traumatic causes and from clinical observations on truly representative groups, together with other appropriate examinations (*x*-ray, E.C.G., laboratory studies, etc.).—I am, etc.,

ALEXANDER R. P. WALKER.

South African Institute for Medical Research,
Johannesburg, South Africa.

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2 Malkin, C., ibid., 1965, **2**, 1078.
3 *Epidem. vit. Statist. Rep.*, 1965, **18**, 352.
4 Ibid., 1964, **17**, 532.

Battered Baby Syndrome

SIR,—I wonder how many doctors share Miss E. C. Sumpter's experience with these babies and their families (26 March, p. 800)? Our own, at the Whittington Hospital, differs considerably. We have certainly not found that the parents "usually seek immediate medical help and almost invariably appeal for the child's admission to hospital." On the contrary, the baby is sometimes not brought to the hospital until several days after the injury, and babies have been brought to our casualty department with a "lump" which turns out, on *x*-ray, to consist of well-calcified callus round a fracture. Nor, in our experience, are the problems "essentially different from those of the overtly neglected or ill-treated child." Several of the babies we have seen have been both neglected and "battered."

It is true that some of the babies seem otherwise well and come from apparently good homes, but we have been struck by the proportion of the families that are already known to their general practitioners, health visitors, and various social agencies as having many problems. What possible excuse is there for the consultant and social worker to confine their investigations within the hospital, as Miss Sumpter suggests, when these other professional persons are likely to have much relevant and important information?

Miss Sumpter finds the problem of whether to inform the police simpler than most of us. It may be true that "women police officers and C.I.D. officers are compassionate, well-informed people with considerable knowledge of human motivation" even off the television screen and without Miss Sumpter's rose-tinted glasses, but should doctors then be less compassionate? The N.S.P.C.C. has for years been involved in dealing with such families and pride themselves that they now very rarely prosecute. The doctor performs his civic duty perfectly adequately by informing the children's department of the local authority, which has quite specific responsibilities in such circumstances. Then inquiries can be made and decisions taken as matters, not of punitive justice, but of social case-work. The doctor, by contributing his specialized knowledge, can cooperate in the attempt to end the intolerable situation in which the baby and the parents find themselves.

I agree that these children are in "constant and mortal danger" whilst they are in their homes. The important thing, therefore, is for general practitioners, casualty officers, paediatricians, and others who may see them to know about the syndrome and to admit any