

REASONABLE NOTICE

SIR,—Your law report (Feb. 20) makes disturbing reading, for it looks as if a precedent has been set which may have far-reaching consequences.

Unless I am mistaken it means that any consultant or senior hospital medical officer can be given "reasonable notice" of termination of his appointment even though he is blameless as regards character and standard of work. In this case it seems that the only reason for the termination of the appointment was the "decreased numbers of patients" attending the hyperpietic clinic. Although some diseases are showing a decreased incidence, hypertension is certainly not, and it looks as if consultants and senior hospital medical officers had better acquaint themselves with the terms and conditions under which they have been appointed, and, above all, had better maintain good relations with their employing body. It will be a sad day for the National Health Service if this will have the effect of muzzling those who might be inclined to hold unpopular opinions or to air grievances about hospital working conditions.

For reasons which are apparent from the foregoing, I would prefer to sign myself

SENIOR HOSPITAL MEDICAL OFFICER.

INCREASED DISPERSAL OF SKIN BACTERIA INTO THE AIR AFTER SHOWER-BATHS

SIR,—In both your special articles (Feb. 27) it is reported that more bacteria are shed after a shower-bath. I think an explanation of this unexpected effect is needed.

Hare and his co-workers established that dispersing of staphylococci depends on shedding of skin-scales. One could speculate that showering only loosens the skin-scales and that after drying oneself they are more easily shed. If so, a second shower-bath might remove them. Perhaps another way to prevent the dispersal of skin-scales would be to coat the skin with an oil which makes them adhere. One might even do so before going into the operating-room, reserving a shower for afterwards.

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J. BORST.

ACQUIRED AGAMMAGLOBULINÆMIA IN SIBLINGS

SIR,—The report of Dr. Charache and his colleagues (Jan. 30), on what seems to be the first well-documented cases of acquired hypogammaglobulinæmia in siblings, is an important contribution to the pathogenesis of this disease.

Since our original observation in 1961 we have also found family bonds between one male and one female case of adult hypogammaglobulinæmia.¹

Recently it has been suggested² that the tonsils might be the mammalian equivalent of the bursa of Fabricius in the chicken, and the embryological source for the immunoglobulin-producing system—i.e., the large pyroninophilic lymphocytes of germinal centres, and plasma cells. Gross absence of the tonsils is a constant finding in congenital hypogammaglobulinæmia. None of our 9 adult cases, observed in Sweden, had a single episode of tonsillitis. One woman, studied at the University of Minnesota, volunteered that her tonsils became very large and then rapidly melted away at the onset of her repeated infections.^{3 4}

All these observations fit with the postulation of an environmental factor with tropism for the immunoglobulin-producing system in genetically predisposed individ-

uals. It is tempting to assume that this factor affected the described siblings at the same time, thus accounting for the simultaneous onset of their symptoms.

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FRANK A. WOLLHEIM.

DIRTY STREETS

SIR,—As a road orderly I view with concern the amount of rubbish that collects under parked cars and lorries, some of them left standing for many days. This must be a danger to health. Parking should be regulated so that each side of the road can be properly swept. Otherwise our mechanical sweepers and road-men have no chance to keep the streets clean and healthy.

New Barnet,
Herts.

CHARLES MEERS.

PERSISTENT ORAL DYSKINESIA IN TREATMENT WITH PHENOTHIAZINE DERIVATIVES

SIR,—Dr. Evans' article (Feb. 27) is the latest of a number which have appeared in recent years, attributing persistent abnormal movements, mainly of the face, tongue, and jaw, to treatment with phenothiazines.

By classifying these involuntary movements as extrapyramidal it becomes easy to implicate a class of drugs known to act chemically on the basal ganglia (as shown by the common occurrence of Parkinsonism in phenothiazine medication). One questions whether the evidence available supports this presumptive conclusion. The condition has an insidious onset which the patient has difficulty in recognising. The doctor similarly has difficulty in assessing the significance of the unusual movements, and he may well prescribe phenothiazines. If it is accepted that the brain may be damaged by low doses of these drugs, then their widespread use complicates retrospective clarification of the sequence of events. The channel of referral is important, for the condition may present to the dentist as an occlusal neurosis (bruxism) requiring extraction and dentures, to the neurologist as dyskinesia, and to the psychiatrist as the motor restlessness of agitated depression or the stereotyped movements of schizophrenia. Indeed, previous reports described these movements in diverse neuropsychiatric states, the common factor being previous treatment with phenothiazines. But one could easily postulate that tension states with dryness of the mouth and false teeth are common to all. It is yet to be explained why the patients affected are usually middle-aged edentulous women, but one might suppose that psychiatric disturbance in this group is associated with tension of the jaw muscles and dryness of the mouth, known to interfere with the retention of dentures. On this basis, generalised motor restlessness would be most conspicuous in the facial musculature.

The three cases reported by Dr. Evans illustrate these problems. In all of them the indication for phenothiazine treatment is unusual: depression, diabetes mellitus, and persistent jaw pain. One wonders whether the drugs had not been given originally for abnormalities of movement, the subsequent deterioration being either iatrogenic or due to the natural progression of the disorder. In the first patient, improvement was associated with sedation and a new, correctly fitting, set of dentures, suggesting that there was muscle tension together with local factors. In the second patient, diabetes mellitus, if associated with dryness of the mouth, may have contributed to the condition. I have treated an elderly edentulous patient with Parkinsonism and diabetes mellitus, in whom comparable mouth movements disappeared after the diabetes had been controlled. Two patients are at present under treatment in whom abnormal facial movements of the type described are a prominent feature of the mental state. Both are middle-aged edentulous women with personality difficulties and depressive illness. One received chlorpromazine, 25 mg. three times daily, for a brief period 5 years before the onset of the movements. Then a further short course of

1. Wollheim, F. A., Belfrage, S., Coster, C., Lindholm. H. *Acta med scand.* 1964, **176**, 1.

2. Cooper, M. D., Peterson, R. D. A., Good, R. A. *Nature, Lond* 1965, **205**, 143.

3. South, M. A. Personal communication.

4. Peterson, R. D. A. and colleagues. *Amer. J. Med.* in the press.