his general condition did not improve he was transferred to the ward and given 500 ml of 5 per cent dextrose intravenously. The blood pressure and the pulse rate remained unchanged. He was infused with another 500 ml of 5 per cent dextrose without much benefit. He was conscious throughout this period, and was kept under observation without any further treatment. His blood pressure gradually improved and six hours later was 100/70 mm Hg with a pulse rate of 100 per min. He remained under observation for the next 24 hours and was discharged with a blood pressure of 120/80 mm Hg and a pulse rate of 92 per minute.

As acupuncture point Fengchi (G B 20) is also recommended in the treatment of hypertension,[4] stimulation of this point probably was responsible for the hypotension on this occasion and therefore was avoided in the subsequent treatment. The 10 day course of acupunture was completed successfully without further incident.

Fourteen other patients were treated for chronic sinusitis without the stimulation of acupunture point Fengchi (G B 20) and none of these patients showed evidence of hypotension; further evidence that stimulation of the acupuncture point Fengchi (G B 20) in this patient might have been responsible for his hypotension.

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Fatal but Clinically Undiagnosed Tuberculosis

Sir,

I was interested to read this article by Dr R. M. Whittington (June *Journal,* p. 343). This disconcerting state has been recognized previously with miliary tuberculosis, both in the UK[1] and in Canada.[2]

The Canadian experience showed two groups amongst 48 patients with miliary tuberculosis. In 18 patients the diagnosis was made only at autopsy. In this group there was a particularly high incidence of concomitant disease. In addition, tuberculin testing, bacteriological search for acid-fast bacilli and chest radiography were frequently neglected. Members of this group were considerably older than those in the group in which the diagnosis was made before death. The disease was characteristically insidious in onset, frequently with non-specific symptoms. Fever was a common presenting symptom. Several patients presented with a fulminant illness which, although diagnosed, was not affected by anti-tuberculosis therapy and was rapidly fatal.

Thus, with all forms of tuberculosis, continued vigilance is necessary. This is especially important in the elderly patient who has other chronic illness.

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Prescribing Oral Contraceptives in Oxfordshire

Sir,

This paper (April *Journal,* p.201) provides some interesting insights into doctors' attitudes towards the varieties of oral contraceptive available. When asked to name their three most commonly prescribed brands, 68 per cent of general practitioners and 42 per cent of family planning doctors gave the low dose oestrogen/high dose progestogen Eugynon 30 or Ovran 30, making them second in the league. Although there is no direct evidence, I suspect that this means that a substantial number use them as their first choice for most women.

On the other hand only 14 per cent of general practitioners and no clinic doctors named a brand containing 50 micrograms of oestrogen. This shows that there is still great preoccupation with the oestrogen component and comparative neglect of the progestogen. The Presidents of the two relevant Colleges have stated, 'We are unable to determine from present evidence whether oral contraceptives containing lower doses of oestrogen offer any advantage over those containing 50 micrograms'[1] and I doubt if they have changed their minds. However, 90 per cent of prescriptions for combined pills are for those containing 30 micrograms of oestrogen.

Clifford Kay ably demonstrated in 1980 that it is the progestogen which is responsible for both hypertension and arterial disease.[2] Plowright and Adams' prescribing survey was conducted later that same year. Low oestrogen/high progestogen were in vogue at one time as progestogens were found to reduce blood cholesterol. However, we now know that what they reduce is the protective HOL fraction and this helps to account for the rise in arterial disease. This means that although the low oestrogen/low progestogen pills like Microgynon and Ovranette may continue as first choice, if a second choice is required (for example for breakthrough bleeding) then it should be a high oestrogen/high progestogen pill, such as Eugynon 50 or Ovran as the high oestrogen tends to offset the adverse effects of the progestogen upon blood lipids.

I hope that we can see a diminution in the prescription of low oestrogen/high progestogen pills in coming years.

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Prestel for the General Practitioner

Sir,

Mr Ewan Davis (June *Journal,* p.383) rightly indicates the potential of the Prestel database to family doctors. The service will undoubtedly become increasingly useful as more information comes 'on line', particularly from local health authorities, drug information services and pharmaceutical companies.

One problem not mentioned concerns the cost of telephone calls to the Prestel link. Prestel computers are based in London and Birmingham. Communication from users in other parts of the country is either by calling the computer direct, or more usually by communicating via a local dataplex link which involves calling a more local number at local call rates. Unfortunately practices which are not in

London or Birmingham and are not within local call distance of a dataplex link incur considerable telephone costs when making trunk calls to gain Prestel access.

It is unfortunate that British Telecom's pricing policy discriminates against rural areas. Communications are particularly important for general practitioners working in these areas; it seems a pity that they will be discouraged from using this useful medium.

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Withdrawal from Benzodiazepines

Sir,

I have started a support through withdrawal scheme for people coming off benzodiazepines. The enormous amount of suffering I see makes me wonder how much information on the toxic effects of these drugs, and illness caused by their withdrawal, reaches the doctors. The pharmacological manuals grossly understate the dangers of tolerance, dependence and withdrawal that have been demonstrated so clearly after the use of these drugs. This is not only after long-term use at high dosage, but also after very short-term use (two weeks), on a normal therapeutic dose.

We must look urgently for the most effective treatment, since a quarter of benzodiazepine users will become severely physically dependent. Widespread dependence, as much as overprescribing, must be the reason for the enormous use of these drugs.

The withdrawal syndrome has many unique features and needs to be treated as a new disease. In acute withdrawal, psychosis, convulsions and suicides are a great deal more common than the literature would suggest. The physical symptoms, many of which are not typical of anxiety, are the worst aspect of the illness. Some of the symptoms are belated and are not associated with the drugs by patient or doctor. Rebound insomnia is a persistent symptom. Unfortunately, and so often, doctors prescribe another benzodiazepine for night sedation when the patient complains of this.

Psychological dependence is less of a problem. Many users report craving for the drugs, but at the same time feel revolted by them, and angry that they have to take them to avoid withdrawal symptoms.

Thousands of people could not possibly invent the bizarre symptoms caused by the therapeutic use of benzodiazepines and reactions to their withdrawal. Many users have to cope, not only with a frightening range of symptoms, but also with the disbelief and hostility of their doctors and families. It is not uncommon for patients to be 'struck off' if they continue to complain about withdrawal symptoms. Even when doctors are concerned and understanding about the problem, they often have little knowledge of withdrawal procedure, and even less about treatment. The drugs newsletter on benzodiazepines issued in this region will help them. Is anything being done elsewhere?

Banning benzodiazepines would be unrealistic; there is nothing to replace them. But I would urge doctors to seek more information about them, and to listen to what their patients are saying. Release and self-help groups all over the country have done wonderful work, but why should people need to form groups for an urgent medical problem? This is drug-induced disease, not drug abuse.

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DATES FOR YOUR DIARY

British Psychological Society

Dr C. P. Elliott-Binns, general practitioner, will speak on 'Back to square one: the Hippocratic approach' at an open meeting of the British Psychological Society Section of Medical Psychology and Psychotherapy.

The meeting will be held on Wednesday 28 September at 20.00 in room 97, Tuke Building, Bedford College, Regents Park, London NW1.

Paediatric Symposium: Child Health Surveillance

This symposium will be held at the Royal College of Physicians of Edinburgh on Wednesday 16 November 1983. The speakers will include people working in general practice, paediatrics and community medicine. Further details can be obtained from the Royal College of Physicians of Edinburgh, 9 Queen Street, Edinburgh EH2 1JE. (Tel: Edinburgh (031-225) 7324).

CIS/MARU Symposium

The next symposium on premises will take place at College Headquarters on 2 November 1983. The two previous seminars were aimed at architects but the next seminar has been organized for general practitioners. Anyone interested in attending should contact Annie Murray, Central Information Services, The Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. (Tel: 01-581 3232).

10th British Congress on the History of Medicine

The History of Medicine Society of Wales will be hosts for the Congress of the British Society for the History of Medicine on 'Child Care through the Centuries' at the picturesque Clyne Castle, Swansea between 6 and 8 April 1984.

Speakers have been invited from many fields to cover a variety of subjects from the earliest textbooks on children's diseases to the latest ideas on the care of the newborn. The programme provides for discussions on the social, scientific and clinical aspects of the care of the infant and young child.

Those interested in attending the conference should write to Dr John Cule, Abereinon, Capel Dewi, Llandysul, Dyfed SA44 4PP, and details will be sent to them in December 1983.

How valuable is Your Time?

A symposium on Organization in General Practice is being held on Saturday 22 October 1983 at Whipps Cross Hospital, London. The symposium is approved under Section 63 and further details can be obtained from The Secretary, Medical Education Centre, Whipps Cross Hospital, London E11 1NR.