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While the principles of freedom of choice are important, the current trend of increasing motorcycle accidents must be diminished.

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<sup>1</sup> Andrew, T, and Milne, D, *Injury*. In press.

<sup>2</sup> Department of Transport, *Road Accidents Statistics*, Circular 4/26, 1976.

<sup>3</sup> Bieber, R, *Californian Highway Patrol Report*, 1977.

### Severe hyponatraemia in hospital inpatients

SIR,—Drs S J Iqbal and P J Ojwang (3 March, p 618) continue to take us to task for having put diuretic-induced hyponatraemia under a “depletional” heading.

We can only reiterate that we ourselves pointed out uncertainties about the pathogenesis of diuretic-induced hyponatraemia in our original paper (4 November 1978, p 1251). As we found that no urinary biochemical measurements distinguish groups of patients otherwise easily distinguished on clinical and radiological grounds, we would prefer to rely on the latter in an emergency. Hence, although we do not feel that our “objectives about patient management” are really different from those of Drs Iqbal and Ojwang, we must beg leave to differ on how to achieve them.

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### Brain failure in private and public life

SIR,—Dr William Goody's lecture on brain failure in private and public life (3 March, p 591) will be of great interest to those who, like myself, are approaching completion of the average life span. Few will quarrel with his main theses—that brain failure is common and has many causes and is (for those escaping other causes of death) ultimately inevitable, that it is more dangerous to the community when it occurs in an influential person, and that it should be prevented if possible. But his list of symptoms and signs of brain failure calls for comment.

Such symptoms and signs may indeed be indicators of commencing brain failure, but surely many of them are no more than evidences of temporary inefficiency of brain function. Incompetence over familiar tasks, for instance, and transient loss of concentration are common enough at all ages, and surely may be no more than signs of fatigue—due, for example, to lack of sleep, a prolonged spell of enforced concentration, or anxiety from some unrelated cause. I am sure that I cannot be alone in having frequently experienced some symptom or sign such as Dr Goody has instanced and inwardly lamented, “I am growing old”—only to recall with a relieved start that I had just that symptom as a child or as a student. I think that the point is worth making, because if we accepted Dr Goody's list as indicative of brain failure I suspect that we would most of us sink into a state of apprehension and depression, which would perhaps be conducive to accelerated brain failure. Granted that Dr Goody referred to

his signs and symptoms as “intermittent,” saying that the more frequently they occur the more one must be concerned about them; but my own advice to anybody feeling such concern would be to try the effect of a holiday.

Dr Goody suggests compulsory retirement for politicians and other leaders and decision makers at an earlier rather than a later age to prevent the serious consequences of their brain failure. I think I would rather see a system that debars the elderly in influential positions from decision making while retaining them in an advisory capacity so that their experience can be utilised.

LIONEL BACON

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SIR,—Dr W Goody in his article (3 March, p 591) fails to make it clear what he means by brain failure. The term was originally taken to mean, and is still used to describe, syndromes characterised by impaired social functioning due to an inability to learn, because of a decline of intellect associated with impaired memory. This clinical picture is seen in both acute and chronic organic psychiatric syndromes, but not in neurosis, depression, psychopathy, or functional psychosis, all of which have different treatments and prognoses. Dr Goody, however, seems to indicate that he considers them to be causes of brain failure.

He also states that normal aging ultimately gives rise to brain failure. Society is protected for the most part from people becoming incompetent owing to the failure of the aging brain by compulsory retirement. Compulsory retirement at a fixed age is a crude way of assessing whether a person is fitted to a particular post and is very unfair on the individual whose mental ability is quite adequate, despite his age. Dr Goody complains that people in public life often escape compulsory retirement and that society should be protected from their failing brains, and, to such ends, he advocates investigating the brains of the members of the House of Commons and others, using computerised axial tomography. Unfortunately, he does not say to what degree changes shown by such a scan would reflect an impairment of mental ability. If this knowledge is not forthcoming, this method could prove as arbitrary and unfair as compulsory retirement at a fixed age.

Society can probably best guard against unsuitable and incompetent people holding public office, not by invoking medical investigations and opinions, which would be unacceptable to many people, but by devising rules such that people could be easily relieved of public posts if found wanting by their peers.

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### Whooping-cough vaccination

SIR,—I feel I must take issue with Dr Alastair G Ironside (3 March, p 619), whose argument seems to be that in whooping cough herd immunity is irrelevant to the vulnerable pre-vaccination babies and that prophylactic erythromycin for two weeks is a practical alternative.

He bases his opinion on an unspecified comparison of infant mortality between two “outbreaks,” one in a “well-vaccinated” population and the other in an “unvaccinated”

one. I feel that this is such an important argument that such opinions must be backed by facts and figures or at least a reference. Those of us, as GPs left with the task of advising our new parents about the best course to take, need to be very sure of our facts. This is an area where “maybe” won't do and I feel it is quite wrong to ask the parents to decide unless they too are in full possession of the facts. So perhaps Dr Ironside would support his opinion, and I for one will revise my policy if he can.

Treating at-risk contacts with erythromycin may well be feasible for a physician's child but how does Dr Ironside think we can get our parents to treat a well child for two weeks with an antibiotic customarily given six-hourly, when it is widely accepted in general practice that it is difficult enough to get them to complete a five-day course for an ill child? Surely, inefficient as it is, a vaccination programme is more likely to succeed—given that we can prove that vaccination protects more than it injures and then present the case simply and with one voice to the public.

DAVID TURNER

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SIR,—Dr A G Ironside (3 March, p 619), while acknowledging that there are no controlled trials available, recommends the use of erythromycin for preventing whooping cough in young household contacts of cases.

Your readers may be interested to know that my college is currently undertaking a controlled, double-blind trial of this procedure. The study is being conducted by the college's Epidemic Observation Unit, which is based in the University of Surrey and is financed by the Medical Research Council.

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### Difficulties in diagnosing meningococcal meningitis

SIR,—It is surprising that in their short report “Difficulties in diagnosing meningococcal meningitis in children” Drs Oliver R C Smales and Nicholas Rutter (3 March, p 588) do not refer to immunological methods of establishing the diagnosis of meningococcal infection. It is known that counter-current immunoelectrophoresis (CIE) on cerebrospinal fluid (CSF) is superior to Gram staining in establishing the diagnosis of meningococcal infection and has the advantages that it is (a) rapid, (b) simple, (c) less affected by prior antibiotic therapy, and it enables the organism to be grouped.<sup>1</sup>

Used in conjunction with Gram staining and culture the method increases the number of positive diagnoses made. Moreover, antigen can be detected more often in serum than organisms by blood culture. In particular, in one study of 14 patients with acute meningococcaemia (children with the clinical picture of meningococcal meningococcaemia but with no clinical or laboratory evidence of meningitis) antigen was detected in every patient while blood culture was positive in six out of 11 patients tested.<sup>2</sup>

Finally, patients with group A meningococcal meningitis in whom antigen was detected in blood had a worse prognosis and higher