

Colchicine

Indications. Treatment and prophylaxis of acute gout. During initial therapy with allopurinol or uricosuric drugs in chronic gout.

Dosage. Acute attack, 1 mg initially (orally) then 0.5 mg every 2-3 hours until pain is relieved or diarrhoea occurs or until a total dose of 10 mg is reached. A course of therapy should not be repeated within three days. Prophylaxis, 0.5-1.5 mg orally, nightly or alternate nights. Dosage should be increased at the earliest possible sign of an impending acute attack. Combined therapy, with allopurinol or uricosuric drugs 0.5 mg two or three times daily. Not suitable for use in children.

Contraindications. Pregnancy.

Precautions. Reduced cardiac, renal, or hepatic function.

Warnings and adverse effects. Gastrointestinal symptoms are most likely to occur in patients with peptic ulceration or spastic colon.

Probenecid

Indications. Gout and hyperuricaemia. As an adjunct to therapy with penicillins and certain cephalosporins—for example, cephalothin, cephalexin and cephaloglycin.

Dosage. URICOSURIC THERAPY: Usual adult dose 500 mg daily for one week followed thereafter by 1 g daily. Daily dosage may be increased by 500 mg every four weeks up to a maximum of 2 g daily. When acute attacks have been absent for at least six months and serum urate concentrations are normal, dosage may be reduced by 500 mg daily over a period of months to the minimum effective dose. Paediatric dosage not established. PENICILLIN AND CEPHALOSPORIN THERAPY: General, ADULTS 2 g daily. Smaller dosage for elderly patients with suspected renal impairment. CHILDREN over two years—25 mg/kg body weight (or 0.7 g/m² body surface) initially; followed by 40 mg/kg (or 1.2 g/m²) daily (or adult dosage if weight is over 50 kg). Gonorrhoea—single dose of 1-2 g, with adequate doses of either oral ampicillin or ampicillin derivatives.

Contraindications. History of blood dyscrasias or uric acid stones. Acute gout. Concurrent administration of salicylates.

Precautions. Administration during pregnancy. History of peptic ulcer.

Warnings and adverse effects. In the treatment of hyperuricaemia, ensure adequate fluid intake and alkalinisation of urine. Plasma concentration of sulphonamide is increased after prolonged concurrent therapy with probenecid. Reducing substances may appear in the urine.

Sulphinpyrazone

Indications. Chronic and recurrent acute gout. Hyperuricaemia.

Dosage. 100-200 mg daily increasing to 600 mg (rarely 800 mg) daily over first week, or until serum urate concentrations are within normal limits. Subsequent dosage should be reduced as necessary to maintain normal serum urate concentrations. Sulphinpyrazone should be given daily in divided doses with meals or milk. In some cases a single dose may suffice. Paediatric usage not established.

Contraindications. Active peptic ulcer. Severe hepatic disease. Sensitivity to phenylbutazone or other pyrazoles. Concurrent administration of salicylates.

Precautions. Administration during pregnancy. Use with caution in patients with healed peptic ulcer, impaired renal function or nephrolithiasis. Concurrent therapy with other plasma protein-binding drugs—for example, anticoagulants, sulphonamides, and hypoglycaemic agents—may necessitate a modification in dosage.

Warnings and adverse effects. May precipitate an attack of acute gout. Gastrointestinal bleeding may occur. Ensure adequate fluid intake and alkalinisation of the urine during initial stages of therapy. Invalidation of results of renal function tests involving PAH, PSP, or other organic acids may occur. Blood dyscrasias may occur suddenly even after a small dose. Blood count should be monitored both before and regularly during treatment.

Letter from . . . Chicago

Oblomov's syndrome

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British Medical Journal, 1978, 1, 1467-1469

We spent two days on the beautiful island of Fiji, with its lush tropical vegetation, its towering palm trees, and its colourful flowers. We swam in the warm ocean, lay in the sun, drank Fijian beer, and rode with the natives on the bus from Nadi to Lautoka. We owed this unexpected tropical holiday to the striking Australian air controllers, and learnt on landing at Sydney's Mascot airport (and submitting to the traditional anti-sheep-disease spraying) that the controllers had walked out because one of their "mates" had hurt his back lifting a chair at work. Unable to stand for long periods he would have accepted a lower paid clerical job, but the union insisted on retirement with full superannuation privileges; so that the man, caught

between management and the unions, eventually had to resign from his job. But that was some time ago. . . .

Lately the air controllers have again been in the news, this time at Chicago's O'Hare, the world's busiest airport, where 750 000 planes land each year, and where the controllers play a perpetual game of chess in the dark, in front of a radar screen, with blips representing circling planes as chessmen. The stress and responsibility are enormous; and periodic computer failures aggravate their ulcers, headaches, insomnia, and nightmares—so that many live on aluminium hydroxide gel (Maalox) and diazepam and drink themselves to sleep, and few last longer than five years in their jobs. So they want better working conditions, more pay, fewer hours, a back-up computer, and less stress.

Teachers too think that their occupation is making them sick, at least in the Chicago public schools, where violence and lack of discipline remain unresolved issues, and where union leaders claim that the stress of teaching has caused "a major health problem." At least 12% of all teachers have ulcers, colitis, neurodermatitis, or hypertension, and many others are said to suffer from mental fatigue, anxiety, depression, low self-esteem, and lack of sociability. Administrative problems such as

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overcrowding, lack of books and supplies, and involuntary transfers aggravate the situation—but other occupations also have their share of stresses and strains. According to the National Institute for Occupational Safety and Health the most stressful jobs are those of labourer, secretary, inspector, clinical laboratory technician, and office manager, followed by foreman, administrator, waiter, and machine operator. And while the experts are concerned about the deleterious effects of stress they also point out that stress results in some of the most productive and satisfying work, and that without it we might not even bother to get out of bed in the morning.

Such presumably was the case of Ilya Ilych Oblomov, the hero of Ivan Goncharov's nineteenth century novel, the man who refused to get out of bed. Dressed in a faded loosely-flowing dressing-gown and oblivious to the preoccupations of the outside world, he spends his days lying in bed, impervious to the pleadings of a procession of friends who want him to change his ways. The estate is bankrupt, the landlord threatens to evict him—Oblomov decides he must work out a plan but never quite gets around to it. He had expected much from life as a young man, but, finding his first job in an office trivial and meaningless—just pushing useless papers and writing silly reports—he had resigned in disgust and taken to his bed. Later in the story he gets up, goes into society, falls in love, plans to marry—but the thought of having to straighten out his affairs is too much for him—so he relapses into his former state and lives out the rest of his slothful life on a comfortable sofa. In this he differs from the many others who, though perhaps leading what Henry Thoreau called quiet lives of desperation, cannot afford the luxury of premature retirement; unless perhaps at times of illness and severe depression, when they too may refuse to get out of bed, a clinical state that Dr Wladyslaw Wermut of Gdynia has designated Oblomov's syndrome.¹ But some depressed individuals, rather than taking to their beds take their lives—and lately much attention has been paid to the problem of suicide in adolescents, children, and even infants.

In 1975, the last year for which statistics are available, there were 4736 suicides in the 15-24 year age group and 170 confirmed suicides in younger children, some as young as 5 years. Modes of death include self-strangulation and jumping out of the window or in front of a car. Many of these children are depressed and constantly sad; they may feel unloved or rejected; or they may wish to rejoin a parent who has died. Some exhibit classical features of depression, such as insomnia, loss of appetite, and weight loss, and some feel constantly guilty about things they have not done. A few appear to be quite aware of their intention and announce their wish to commit suicide and die, but there is some question whether the younger children actually understand the finality of death. In some cases there is just a desire to avoid the pain of living.

Another solution for those who cannot cope is alcoholism—often institutionalised in the three-Martini lunch for the affluent and in skid rows for the down-and-out. Indeed, it has been said that the modern skid row provides one of the most sheltered and secure ways of living—for those who do not mind the stench of the flophouses, the rags, the rows of empty whisky bottles in the lobbies, the icy winters, and the hopelessness.

In Chicago's famous skid row on Madison Street the missions are still active, providing counselling, clothes, cheap hotels, and "soup and salvation." The police are no longer the enemy, now that they take the drunks to detoxification centres instead of the old police drunk tank. But ten years ago the city decided to rehabilitate the area and began systematically to tear down many of the flophouses. Later, with rising unemployment, the number of alcoholics and addicts began to increase and spill over into other areas. So that in a city with rapidly shifting populations the granddaddy of skid rows now boasts little grandchildren in various other parts of the city, where people who can't take the pressure can disappear to be left alone, take a drink, or just live.

Among the middle classes alcoholism is less conspicuous. It is least apparent in women, yet it takes on the proportions of a hidden epidemic, since at least one-third of America's 10

million alcoholics are women and since most of them hide their inclination in the kitchen, the bedroom, or the closet. Statistics indicate that almost one-half of alcoholic women are housewives, the others being executives, clerical workers, or semi-skilled working women. As expected, the causes are loneliness, anxiety, inferiority feelings, or unresolved conflicts about their sex roles. The consequences are often more serious than with men. The husbands will usually leave them; in pregnancy there is a risk of a deformed or retarded baby; while later the family tends to fall apart, and cirrhosis is said to be more frequent in alcoholic women than in men. Women also seek help less often and much later, with doctors and family members often helping them hide rather than encouraging them to seek help. And with the number of women drinkers growing at twice the rate for men, the "hidden epidemic" remains an unresolved problem in this society.

Empty hospital beds

If Oblomov's syndrome merely represents a single man's disinclination to leave his bed, it pales into insignificance in comparison with the more widespread reluctance of doctors and administrators to give up the thousands of hospital beds that lie empty or are believed to be inappropriately used. The aetiology of this epidemiological syndrome is partially iatrogenic, and has been facetiously related to the number of children the doctor has to put through college, as well as to his ability to cope with the high expectations of a demanding and litigious public. Other factors include the degree of anxiety exhibited by the patient and his family; the kind of insurance and whether it will pay for outpatient tests; the distance the patient must travel to the hospital; the time of the day (or night) or week when the symptoms arise; the complexity of the case; the availability of the patient's old record; and the doctor's degree of familiarity with the patient's history. Doctors are often accused of admitting patients unnecessarily; but arrangements for efficient outpatient work-up are not always available, and a stay in hospital remains a time-honoured method of unravelling a puzzling case. Moreover, increased efficiency in the outpatient clinic may not necessarily prove cheaper than inpatient care, since it is the personnel required that constitutes the greatest expense. But be that as it may, current evidence suggests that America suffers from a surfeit of hospital beds.

Estimates of the problem vary, from earlier studies suggesting an excess of 60 000 beds, to Mr Ralph Nader's 1975 estimate of 100 000 excess beds plus 250 000 used for unnecessary admissions. In November 1976 an 11-member study group of the Institute of Medicine, a branch of the National Academy of Sciences, recommended closing 7-10% of the nation's 970 000 beds within five years and reducing the ratio of hospital beds per 1000 population from the present 4.4 to 4 by 1981 to stop rising hospital costs. And a report prepared under contract for the Health, Education, and Welfare Department suggested that a gradual 20% reduction in the supply of beds would not endanger the health of the American people.

Acting presumably on these premises, HEW secretary Joseph Califano last September issued his department's guidelines for the 205 local health planning agencies, requiring the elimination of 10% of the nation's beds (including 7000 of Chicago's 18 000 beds), with a reduction of the overall ratio to 4 or even 3.7 per 1000 population. The guidelines, to be put in effect fully by 1984, were expected to save \$2 billion a year in maintenance of unused beds; but they were thought to be too Draconian, provoked a deluge of 50 000 mostly negative letters, and had to be revised. New guidelines were reissued in February, again proposing a maximum of 4 beds per 1000 persons and an average occupancy of at least 80% for all hospitals in an area. In addition there was to be at least a 75% average occupancy rate and 1500 births annually for hospitals providing care for complicated obstetrical problems; no more than four neonatal care beds per 1000 live births; a minimum of 20 beds

for paediatrics units in urban areas and an occupancy rate of 65% to 75%; at least 200 open-heart procedures a year for adults and 100 open-heart operations in paediatrics; at least 300 cardiac catheterisations annually for adults and 150 for children; a service area of at least 150 000 people or treatment of at least 300 patients with cancer annually for megavoltage radiation therapy units; at least 2500 procedures a year for each computerised tomographic scanner; and plans consistent with already established procedures for suppliers of endstage renal-disease services. These final regulations took effect on 24 March, but it remains to be seen how they will be implemented.

Finally, the medical student subterranean newsletter has announced the appointment of Dr Vladimir Dracula as professor of haematology and director of a vastly expanded regional blood bank at the medical centre. Dr Dracula, who pioneered

revolutionary techniques in blood transfusion, recently donated \$2 million to the medical centre. His appointment was cited as evidence that the medical school did not discriminate on the basis of ethnic origin in its tenured appointments. Other critics of Dr Dracula's appointment, however, pointed out that the professor's knowledge of medicine was limited by its allegiance to the sixteenth century doctrine of vitalism. These remarks were thought to be rather biting, but then Dr Dracula had a few biting replies of his own. The critics subsequently obtained positions on the night shift of the doctor's expanding staff.

Reference

¹ Wermut, W, *Journal of the American Medical Association*, 1975, **231**, 26.

If I Had . . .

Hypertension

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British Medical Journal, 1978, **1**, 1469-1470

Let me begin by assuring the reader that I regard myself as a fairly healthy 38-year-old, and that I am (as most hypertensive patients would be) completely asymptomatic. My specialty has shown to me the frailty of human flesh, and this, together with the consequences of living in an inflationary age, forces me to seek further insurance, and I am instructed to attend an eminent specialist for examination.

Circumstances of diagnosis

On the day of my appointment everything seems to go wrong: my outpatient clinic is overbooked, a colleague's wife becomes unwell and has to be seen immediately, and, having run from the nearest available parking space two blocks away, I arrive 10 minutes late for my appointment. A receptionist of mature years and frosty complexion indicates, by asking was I unaware that her good boss was an extremely busy man (a fact which I accept without demur), that no favouritism is shown to medical colleagues in this establishment. The learned physician himself is in a tizzy, and mutters that, because he is late for an important meeting, the examination will of necessity be rapid. After mumbling apologies, I deny a propensity to fits, asthma, mental and nervous disease, miscarriages, and syphilis, and with diminishing ardour defend my family honour. Fumbling with shoelaces in one hand, and a half-opened fly in the other, I fall on the couch and feel the sphygmo cuff tightening around my biceps. "Good God," mumbles he, "ever had blood pressure,

boy?" "No," I reply, terrified. "Any of the family ever die from strokes?" "No, honestly," I assure him.

After a few more clinical manoeuvres, one of which displays his sartorial panache with a tape measure, I am faced with the dreadful prospect of peeing on demand into a receptacle that at best would hold one-third of my bladder capacity after a hike across the desert. Another estimation of my blood pressure, and I am shown the door with the assurance that the insurance company will be contacted without delay.

Consequences of diagnosis

This day has been an extremely important one in my life. I have been labelled *hypertensive*. If this has been discovered early I must be forever grateful to the insurance company, because, given that effective management is instigated before cardiovascular damage has been done, my prognosis is good. On the other hand, it is possible that the condition has been misdiagnosed—a point to which I shall return. In either event the consequences will be similar: I shall hear from the insurance company that my proposal is acceptable, but at an increased premium. In effect, I have been classified, and labelled, as hypertensive—and this has similar consequences to a poor credit rating. I will always find it difficult hereafter to obtain insurance, and mortgage and pension options will likewise be affected. My employment prospects are unlikely to be influenced by the diagnosis—but were I an airline pilot or a train driver my occupation would be in jeopardy.

In short, life will never be quite the same again. I am not saying that this should not be so, but would it not be rather terrible if all of this happened because the insurance doctor and I were both in a great hurry when our paths briefly crossed?

On being told of the diagnosis, and before seeking another opinion, I would attempt to mollify the diagnosis by applying my own clinical logic. Without being aware of the actual level of my blood pressure, I would argue that the diagnosis was based on a casual reading in circumstances that although a little contrived are not by any means unrealistic. I would point to

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