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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

McIlroy lives

SIR,—"It doesn't do me credit." So commented William McIlroy on reading his biography by Drs A N Bamji and C A Pallis (14 April, p 973). Like Bertrand Russell, he has had the rare privilege of reading and enjoying his obituary; he was amused by it and agreed that it was essentially accurate. However, while declaring himself an interesting chap, he took strong exception to being termed a "Munchausen," for at some stage in his peregrinations a medical student had introduced him to the tales of the legendary baron. We are happy to reassure his concerned biographers that he is as well as can be expected and in semi-retirement, no longer enacting his more complete performances.

Following admission to this hospital for a severe chest infection seven weeks ago, we have now, much to his satisfaction, transferred him to an old people's home. He was a model patient, helpful to the nurses, co-operative with the physiotherapist, and devoted to his books and the TV. Apart from confirming his burr holes, and noting the absent left shoulder joint and right hip prosthesis on *x*-ray, we managed not to investigate him any further—even before the notes of his previous stay here in 1963 were available. Incidentally, from these we can add at least three further hospitals to his impressive list.

He is undeniably a chronic invalid, his host of physical signs remaining unchanged and as dramatic as ever. Importantly, his tracheostomy (the source of his infection) makes his speech a major but useful obstacle to communication.

Unable to recall the authors of his obituary, he volunteered unsolicited that, in the 1950s, it was the Hammersmith Hospital which referred him to the Royal Marsden for radiotherapy (for his "syringomyelia").

Typical of these patients, he appears genuinely unable to explain his behaviour. "You tell me—I'm wonky in the head." He did, however, admit to feeling secure in hospital and preferring it to the usual alternative of a hostel for down-and-outs. He claims to have engineered admission in recent years in response to "nerves" and a feeling that he might do others harm.

It is tantalising to guess at McIlroy's future exploits, fortified by his notoriety. Perhaps, however, Drs Bamji and Pallis are right—he may just be fading away.

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**This correspondence is now closed—ED, *BMJ*.

Relief of postoperative pain

SIR,—It is widely agreed that a substantial number of patients do not obtain adequate relief of postoperative pain. Dr Jeremy J Church (14 April, p 977) has approached the problem by administering a continuous intravenous infusion of a narcotic analgesic. An increment of pethidine (0·3 mg/kg/h) is administered immediately after operation, and repeated hourly in the recovery room for four hours. The drip rate is adjusted according to the patient's response and the chosen increment is then administered hourly in the ward by a nurse, who in particular counts the respiratory rate before giving another dose. As a precaution against accidental overdose, only one increment is made available each hour in the drip-set.

This technique is an improvement on an intramuscular routine since it more nearly matches the patient's requirements to the dose of analgesic. However, it presupposes that a reasonably steady state is eventually reached. In a small clinical trial with a patient demand apparatus (Cardiff Palliator) in patients who