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SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Myocardial infarction: home and hospital treatment

SIR,—Dr H G Mather and his colleagues (17 April, p 925) are warmly to be congratulated on a number of points. They have attempted a randomised trial in so difficult a field as the care of acute myocardial ischaemia; they have persisted with it in spite of criticism; their methods have broken new ground in the use of experimental epidemiology; and their results have already had an international impact on attitudes to treatment.

Their total population of 1895 cases is, in fact, divided into four chief groups: 457 (24%) for whom hospital treatment was considered mandatory; 837 (44%) who were considered suitable for randomisation but elected hospital treatment; 151 (8%) who elected home treatment; and the remaining 450 (24%) who were randomised to home and hospital treatment. Their previous report[1] included case fatality rates among the "elective home" and "elective hospital" groups and demonstrated that the immediate outcome of a heart attack among these groups was very similar, regardless of the presence of hypotension, to those for patients allocated randomly to home or hospital treatment. It would be most helpful in the evaluation of the whole experiment if the investigators, through your columns, now published 300-day survival rates for the "elective home," "elective hospital," and "mandatory hospital" groups.

One of the implications of the authors' work is that some patients are best treated in a coronary care unit (CCU) while others will be better off at home. The question that still faces the general practitioner, who is the central figure in all of this, is what to do about any one particular patient. In their present report Dr Mather and his colleagues suggest that "on average, older patients and those without initial hypotension fared rather better under home care." Another factor may be distance from home or from place of attack to hospital. We found,[2] in a study of men admitted to the CCU at Oxford, that the "case incidence" of ventricular fibrillation and case fatality rates were higher for patients with homes in the surrounding towns and countryside than for those living in the city itself. Our results are tantalising for two reasons. Firstly, the numbers involved were rather small, so that, although the differences in rates were large, they could have arisen by chance. Secondly, we could not tell whether patients from outside the city, who had a lower rate of admissions per age-standardised population than the rest, were particularly severe cases to start with or whether the long ambulance journey had done them harm. So it would be helpful, too, if Dr Mather and his group could determine whether their data relating to their randomised and other groups support the idea that there is a relationship between length of journey to hospital and case fatality. They might also be able to provide information about whether there is a relationship between distance from hospital and the allocation of cases to each of the four major groups.

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[1] Mather, H G, *et al*, *British Medical Journal*, 1971, **3**, 334.
[2] Acheson, R M, and Sanderson, C F B, *British Heart Journal*. In press.

Dextropropoxyphene poisoning

SIR,—We should like to draw the attention of your readers to our recent experience of deaths following the ingestion of analgesic preparations containing dextropropoxyphene. The most commonly prescribed of these appears to be Distalgesic, each tablet of which contains 32·5 mg of dextropropoxyphene hydrochloride and 325 mg of paracetamol. The metabolic disturbances which may be induced by excess paracetamol are well documented, but the more immediate danger of acute respiratory depression due to overdosage with dextropropoxyphene appears to have escaped the attention of most doctors. Many seem to believe that preparations containing dextropropoxyphene are relatively innocuous and may be taken almost with impunity. They fail to appreciate the morphine-like narcosis which may follow overdosage.[1]

During the past three years we have