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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 now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

An Easy Death—An Uneasy Argument

SIR,—Dr. S. L. Henderson Smith (3 May, p. 276) may be right in stressing that excellent hospice-type care of the dying may not render all discussion of the issues of euthanasia quite obsolete, even though it might greatly decrease the number of instances in which the question might arise. It is unfortunate, to some extent, that the issues of good terminal care and active euthanasia should have become muddled in some minds to the point that they may begin to appear as alternatives. Doctors and laymen may justifiably disagree on questions of "assisted suicide" or "arranging dying" (the number of circumlocutions this debate is spawning is awesome). But we should not disagree on the importance of drastically improving the standards of terminal care received by the majority of dying patients, nor should we allow the euthanasia debate, however spirited or sincere, to interfere with the attempt to achieve this more universally applicable objective.

Dr. Smith would also be advised to avoid seriously misleading abuse of statistics, lest the rest of his arguments be regarded as similarly ill-founded. The "continuing occurrence of suicides in those suffering from terminal conditions" does, verily, continue; but in the experience of most of those associated with the care of the dying it is an uncommon event and seldom seen in the context of optimal terminal care. That 18% of "successful" suicides are associated with organic illness is barely relevant, unless Dr. Smith wishes to equate organic illness with terminal illness, surely an excessively gloomy attitude. The proportion of the population of completed suicides suffering from what would generally be acknowledged as a terminal illness is uncertain, but available data suggest that it is low. The majority of the 18% so glibly quoted would be suffering from such conditions as rheumatoid arthritis, peptic ulcer, or asthma.—I am, etc.,

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Paradoxical Effect of Pindolol

SIR,—Clinical experience has shown that for some beta-blockers there seems to be a dosage ceiling beyond which further increase in dosage is unprofitable.[1]

In the case of pindolol increase in dosage may actually cause a rise in blood pressure. We first noted this in a man aged 56 with malignant hypertension. He responded well initially to cyclopenthiazide and a small dose of pindolol (rising to 15 mg daily), but when the dose was further increased to 25 mg daily in an attempt to achieve completely normal blood pressure the pressure in fact rose. Reduction in the dose of pindolol led once again to a fall in blood pressure.

Subsequently we looked for this phenomenon in patients with poorly controlled blood pressure (in this case >160/110 mm Hg lying) on relatively high pindolol dosages. While taking a high dose of pindolol nine patients had a morning test, during which five lying and standing blood pressure and pulse readings were taken by trained technicians. The dose of pindolol was then reduced and a further morning test was done after an interval of 1-4 weeks. In all nine patients the blood pressure fell (see table); the pulse rate did not alter significantly.

Pindolol has a considerable sympathomimetic effect,[2] but its beta-blocking effect is so powerful that it is usually used at a low dosage compared with most other beta-blockers. The sympathomimetic effect is thus usually not excessive. However, it may be that in some patients the sympathomimetic effect tends to predominate when the dose rises above a certain level. Collins and King[3] found a rise in blood pressure in 8% of patients treated with pindolol in a multicentre study (dosage in these cases was not

Effect of Lowering Dosage of Pindolol in Nine Patients

	Pindolol High Dose	Pindolol Reduced Dose	Change
Mean dose (mg/24 h)	48	19	
Range (mg/24 h)	27·5-67·5	7·5-30	
Lying:			
Systolic B.P. (mm Hg)	196	179	−17*
Diastolic B.P. (mm Hg)	120	108	−12‡
Pulse (/min)	76	75	− 1
Standing:			
Systolic B.P. (mm Hg)	176	160	−16*
Diastolic B.P. (mm Hg)	115	106	− 9†
Pulse (/min)	79	76	− 3

*P<0·002. †P<0·01. ‡P<0·05.