Dobbs and Fleming have succeeded in using history, symptoms, and dipstick tests to distinguish between the "urethral syndrome" and urinary infection where many others have failed.[8] However, our own experience with these criteria has been disappointing.

Ditchburn and Ditchburn's use of microscopy[9] is commendable, and we have also recommended it.[10] However, some patients without significant bacteriuria have pyuria and some with significant bacteriuria have few if any leucocytes in their urine.[11] Further, not all medical students are taught to use a microscope well enough to be able to recognise leucocytes in urine. Thus, the use of the microscope would require postgraduate training in many cases.

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Requests for organ donation

SIR,—Ms Luisa Dillner's news item on organ transplantation suggests that "junior doctors are getting better at approaching relatives" for consent to organ donation, thereby implying that in some intensive therapy units this stressful task is left to junior medical staff.[1] This practice is inappropriate and unnecessary as such doctors may not possess the necessary skills, knowledge, and experience.

There is seldom any urgency to diagnose brain stem death or to request organ donation; with proper supportive care the onset of asystole in brain dead subjects can be delayed. Formal testing of brain stem function and consultation with relatives should therefore be unhurried and undertaken only when senior staff are available. This complies with the recommendation in the United Kingdom that the diagnosis of brain stem death should be made by two senior doctors.[2] The approach to relatives for organ donation is best made by the same doctors, preferably immediately after the tests.

Increasing public awareness of conditions such as the persistent vegetative state make it common, and appropriate, for informed relatives to ask probing questions concerning the patient's prognosis. Such inquiries may not be handled well by inexperienced junior staff. Reports such as that of the confidential inquiry into perioperative deaths have emphasised the need for consultants to support junior staff in difficult or demanding situations.[3] Without this, junior staff cannot be expected to learn how to perform these tasks or to develop a sense of responsibility for their own future practice.

HIV infection must now be excluded in potential donors.[4] The lag period to seroconversion may make it necessary to inquire into the lifestyle of the donor as well as to request an HIV test. This has many distressing implications and may, regardless of the result, have lasting effects on the surviving family. This sensitive task is possibly more demanding than requesting organ donation itself and should not be left to junior medical staff.

Finally, if patients are to be admitted to intensive therapy units before brain stem death solely for elective ventilation and subsequent organ donation,[5] experienced senior medical staff must participate in the negotiations.

In the two intensive therapy units in Portsmouth the relatives are always approached by a consultant in the unit, usually immediately after the absence of brain stem function has been confirmed. The nurse caring for the potential donor and the duty registrar in the unit are always involved. Adherence to this policy has ensured that potential organ donors are not overlooked and has resulted, with a few understandable exceptions, in the donation of all those organs deemed suitable for transplantation.

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Assault after ingestion of antidepressant

SIR,—We were interested in Ms Clare Dyer's report from the Court of Appeal of murder during mania after ingestion of amitriptyline.[1] We have a 46 year old inpatient who assaulted his daughter and wife the day after taking 75 mg of amitriptyline.

The man does not have a history of violence or criminality, but from the age of 16 he has experienced bouts of severe sleeplessness, irritability, overactivity, poor concentration, and worrying each spring. His mother has a closely similar history. At 21 he had an episode of considerable overtalkativeness and jocularity followed by several weeks of mild disinhibition.

This year he was sleepless for some weeks. For three days he did not sleep at all, and he developed delusions that his daughter was illegitimate and his wife unfaithful. One night he took three tablets of amitriptyline 25 mg, which had been prescribed two years earlier, which he believed to be sleeping tablets. He woke at 4 am to find himself overactive and his thoughts racing and subsequently experienced his mind being "pushed out by another mind." Later he picked up a large pair of scissors and stabbed his daughter repeatedly. She sustained a pneumothorax. He then felt an urge to gouge his wife's eyes out and made some attempt to strangle her, although she was not injured.

The police found him standing on his bed over two ornamental bayonets, which he made no attempt to use. On arrest he was shouting "God rules." Later he thought that he had killed his family. Surprisingly, he was not charged but taken to a local hospital. He had to be restrained from attacking nursing staff, but his symptoms settled over four days with small doses of chlorpromazine and did not recur.

The datasheet for amitriptyline warns that "psychotic manifestations, including mania and paranoid delusions, may be exacerbated," and it is well known that antidepressants can cause mania.[2] In view of these two cases, it may be that severe and uncharacteristic violence may be precipitated by amitriptyline in those with a predisposition to manic-depressive illness. A similar suggestion has been made about fluoxetine ("The Prozac file," *Dispatches*, Channel 4, 1990 Dec 19). Perhaps other such cases are known to readers.

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Tattoos

SIR,—Messrs N S G Mercer and D M Davies point out that tattoo artists may provide a service to remove tattoos by injecting tannic acid into the area to induce a partial thickness burn.[1] We have treated several patients recently who have received this costly treatment and have suffered full thickness burns. These patients presented many weeks after being treated with tannic acid with inflamed full thickness burns that required formal tangential excision and split skin grafting to obtain satisfactory healing.

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SIR,—Although I found the editorial on tattoos[1] and the research paper from Drs Hall-Smith and Bennett[2] of great interest, I was left with the feeling that both articles failed adequately to address the possible solutions to this prevalent but forsaken problem in young people.

As most of those affected have been shown to be children of school age it would not seem too difficult for doctors to arrange for appropriate education in the matter of tattoos and their sequelae to be given at school, both primary and secondary. The messages may be transmitted by committed teachers, but it is possible that the greatest positive effect may follow the same educational message being promoted in the school by a plastic surgeon, dermatologist, or local general practitioner.

A health promotion policy aimed at adolescents at school could well fall within the context of paid promotional clinics by the family health services authority, and in any group practices the sum of all attending patients of any doctor may be included in the list of clinic attenders. A greater long term benefit may be seen by taking an active health promotion policy, in schools, aimed at susceptible adolescents and conducted by some of those who are likely to bear the brunt of this particular patient group who, once they are out of their teens, may decide that they have made a mistake.

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