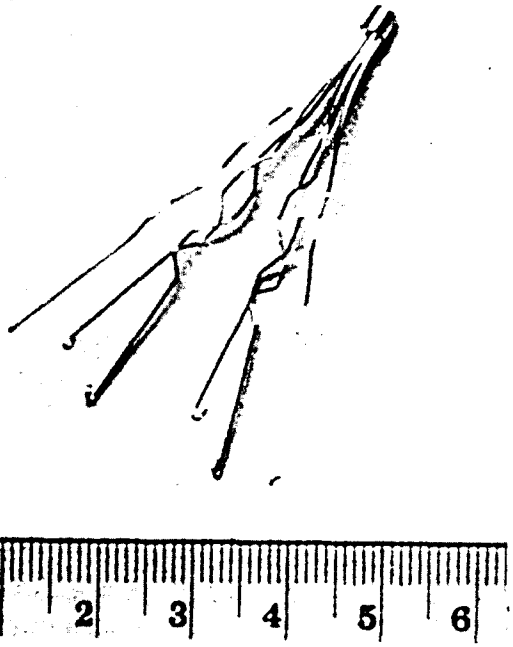

Figure: **Percutaneous modified-hook stainless steel Greenfield filter**

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Fortunately, such accidents must be very rare. The use of metal mesh gloves during all necropsy procedures would reduce the risk of such injuries, but the fine anchoring points of the filter could penetrate the metal meshwork. Although patients with Greenfield filters are given cards that identify the device and date of insertion, it would seem prudent to develop an identification bracelet system or some sort of screening before necropsy, as well as better education of pathologists and anatomists of this rare but potentially serious hazard.

Jerrold L Abraham, Lazar J Greenfield

*Department of Pathology, SUNY Health Science Center, Syracuse NY 13210, USA; Department of Surgery University of Michigan, Ann Arbor, MI

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Contents of "ecstasy"

SIR—The risk of adverse reactions to 3,4-methylenedioxymethamphetamine (MDMA) ('ecstasy') is widely known.[1] However, it is still not clear how some can use this drug regularly without harm, whilst others die or have a severe toxic reaction.[2] A range of tablets or capsules are sold as 'ecstasy'. Under a Home Office licence, we have recently analysed 'ecstasy' tablets which were handed in to the Leeds Addiction Unit under an amnesty. The tablets came from all parts of the UK.

Tablets were weighed, crushed, dissolved in deionised water and extracted in chloroform before analysis by gas chromatography with samples eluted over a temperature gradient of 155–195°C. The most common tablets handed in were 'doves' (n=7), small white tablets embossed with a dove-shape on one side. The only hallucinogenic amphetamine they contained was MDMA (concentration range 88–140 mg per tablet); one dove tablet had a trace of caffeine. Four other tablets contained MDMA (concentration range 2–105 mg per tablet) and caffeine (concentration range 0·02–39 mg per tablet). A 'rhubarb and custard' contained MDMA (94 mg), amphetamine (0·8 mg), and methamphetamine (1·8 mg). Four tablets contained 3,4-methylenedioxyethamphetamine (MDEA), a synthetic analogue of MDMA in concentrations from 94 mg to 125 mg per tablet; one of these tablets had a trace of caffeine.

Six tablets handed in had no hallucinogenic substances; two contained mixtures of amphetamine (5·9 mg and 19 mg per tablet) and caffeine (10 mg and 3·8 mg, respectively); three had varying proportions of caffeine (range 0·07–0·13 mg) and paracetamol (range 55–216 mg); whereas one tablet had no detectable stimulant drug. Reports of unusual or unexpected effects may be explained by the presence of non-stimulant substances in the ecstasy tablets. We identified ketamine (concentration range 185 mg–197 mg per tablet) in two tablets known as 'Strawberry Milkshake' and 'White Lightning'. Ketamine is licensed for use for general anaesthesia (parenteral 10 to 100 mg/mL), and oral doses (500–700 mg) have been used for sedation before dental procedures,[3] but this drug is more widely known as a veterinary anaesthetic. Adverse effects associated with ketamine include vivid dreams, hallucinations, and delirium.[4]

Our survey indicates that 'ecstasy' tablets are not always what they purport to be. There is no quality control in the illicit drugs market and consumers need to be made aware of this absence.

Kim Wolff, Alastair W M Hay, Kellie Sherlock, Mark Conner

*Research School of Medicine and Department of Psychology, University of Leeds, Leeds LS2 9JT, UK

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Salbutamol in the treatment of asthma

SIR—Sympathomimetics are the mainstay of asthma therapy, yet there is evidence that regular or excessive use can be associated with increased morbidity and mortality.[1,2] A possible explanation for these associations is airway hyperresponsiveness resulting from use of beta-agonists. In the guineapig, hyperresponsiveness follows administration of fenoterol[3] or salbutamol (attributed in particular to actions of the *L*-isomer of salbutamol).[4] We have had the opportunity to compare effects of racemic salbutamol and its constituent enantiomers *D*-salbutamol and *L*-salbutamol (Sepracor Inc) on asthmatic airways, and we included the measurement of hyperresponsiveness in our protocol.

Volunteer asthmatics with mild airway obstruction, and without previous glucocorticosteroid therapy, were recruited into a double-blind, placebo-controlled, parallel group study. One week before administration of test drugs, pulmonary function was defined and 40 subjects with an $FEV_{1\cdot0}$ greater than 80% and hypersensitivity to inhaled methacholine (PD_{20} <1000 μg) were randomly assigned into groups of ten. Bronchodilator therapy did not differ significantly between the groups and was withheld for 24 hours before study. On the study day, subjects inhaled either racemic *D,L*-