Diabetes Mellitus and Insipidus in Two Sisters

SIR,—The article describing this extremely rare state of affairs (28 December, p. 1625) by a team from Great Ormond Street escaped my notice for a time, but since I have read it carefully I would like to ask for more information about the presence of diabetes mellitus. The presence of diabetes insipidus I grant clearly in both cases, but in Case 1 the finding of glycosuria, especially in a child with an abscess, is no proof of diabetes mellitus. It is said that further investigation showed that diabetes mellitus was present and that the girl was controlled on an unrestricted diet and 32 units of insulin zinc suspension. There is, however, no figure given of hyperglycaemia, which I think is necessary to establish firm proof of diabetes mellitus. Two years later after a further readmission the girl had considerable glycosuria. On a diet of 160 g. carbohydrates, with unrestricted protein and fat, up to 64 units of insulin zinc suspension were needed to eliminate the glycosuria. Again no blood-sugar figures are given. I should be glad to have the latter or ultimate diabetic treatment clarified.

Case 2, however, has obviously proved diabetes with blood-sugars varying from 250 to 360 mg./100 ml. before treatment. It is therefore Case 1 which requires proof, especially as the unique feature is describing two sisters with a similar rare combination of two conditions.—I am, etc.,

London W.1. R. D. LAWRENCE.

Acute Osteomyelitis

SIR,—I am grateful to Mr. Nigel H. Harris for his detailed attention (25 January, p. 237) to my paper on acute osteitis (21 December, p. 1561). Mr. Harris's thinking upon this subject still runs upon the tramlines of his previously expounded dogma, and it is natural that he should be hypersensitive. Nevertheless certain of his comments merit a reply.

(*a*) The term "chronic osteitis" was used to describe cases where primary treatment seemed to have failed—i.e., where infection recurred or continued, where sequestration was obvious on the radiographs (Figs. 2 and 3), or where a sinus developed. Acute osteitis does not lend itself to statistical analysis and any more subtle qualification would be misleading.

(*b*) The principal blood supply of normal cortical bone is from the medullary arteries.[1] In osteitis, if the medullary vessels are intact, then periosteum may be entirely stripped from the shaft without death of the bone (Fig. 4, Case 3 in my paper). If the medullary vessels are in jeopardy the cortex will depend upon a reverse flow from the periosteal vessels. Thus it can be conceived that operation will be of value to the cortical bone if all of the following circumstances prevail: (1) If there is massive medullary thrombosis. (2) If operation is performed at the moment when pus starts to strip off periosteum. (3) If no further elevation of periosteum occurs after operation.

Whether the medullary vessels thrombose probably depends upon the virulence of the organism and the duration and intensity of the infection—that is, thrombosis can be prevented by early diagnosis and early control of the infection by means of an antibiotic. If operation is performed before the infection has been controlled by the body defences or by an antibiotic then pus formation will continue in the bone, further periosteal stripping will occur (Case 1 illustrates this), and there is likelihood of wound breakdown and sinus formation. Even if operation can be timed for the crucial moment when periosteum starts to be imperilled it is likely to be of little benefit, and may be the first step on the way to chronic osteitis. When the infection is under control pus may be removed if sufficient quantity remains to upset the patient. There are two reasons for systemic reaction in acute osteitis—initial local infection and septicaemia, or later abscess formation; only the latter is a reason for operation.

(*c*) Mr. Harris has difficulty in defining "early treatment" and "premature surgery." These terms are relative, as applied to the individual. The only true assessment of results in acute osteitis depends upon critical retrospective analysis of each patient—was the diagnosis made early enough? (Why not?) Was full splintage applied? Was an effective antibiotic given from the beginning of treatment? (Why not?) And, What did operation do for this patient?—I am, etc.,

Perth. T. S. MANN.

REFERENCE

1 Brookes, M., *Brit. med. J.*, 1963, 2, 1064.

False-positive "Phenistix" Reaction

SIR,—I have recently investigated a 5-year-old boy where phenylketonuria had to be excluded. He was a very over-active lad, and on admission was placed on chlorpromazine. Urine specimen the following day was reported as having a positive "phenistix" reaction, and it was only then that my attention was drawn to an abstract in *Modern Medicine*, December 1963, of a paper by Dr. J. C. Scott.[1]

This abstract indicates that "phenistix" will show positive reactions in urine containing chlorpromazine, sulphonamides, etc., and although the colour change varied from that seen in a positive "phenistix" for phenylketonuria confusion might result.

It would be rare that infants a few weeks old would be receiving chlorpromazine, but in the somewhat older hyperkinetic child the use of this drug is not uncommon.—I am, etc.,

G. L. DAVIES.

Department of Child and Family Psychiatry,
St. Luke's Hospital,
Middlesbrough.

REFERENCE

1 Scott, J. C., *Scot. med. J.*, 1963, 8, 30.

College of Psychiatrists

Sir,—I have to report the result of a questionary on the above subject sent out in May and October 1963 to 1,147 senior psychiatrists resident in Great Britain and Northern Ireland by the Society of Clinical Psychiatrists. This Society is limited to consultants, senior hospital medical officers, senior registrars, and others of equivalent status. Its aim is to promote the interests of clinical psychiatrists. It has 224 members (including 8 medical superintendents).

In May 1961 the R.M.P.A. issued two memoranda on the future organization of psychiatry. It listed several possibilities and central to these were two alternatives: (1) The formation of a College of Psychiatry arising independently or out of the R.M.P.A. (2) Development under the "umbrella" of the Royal College of Physicians.

It was to these alternatives that the Society principally addressed itself when it held an open meeting in London in November 1962 to discuss the future organization of psychiatry.

It became clear that those who supported the formation of a College wished to see it evolve from the R.M.P.A. and not otherwise. Accordingly the questionary sent out in May 1963 by the Society of Clinical Psychiatrists to its 224 members was limited to two questions:

(1) Are you in favour of the formation of a College of Psychiatry developing from the R.M.P.A.?

(2) Are you in favour of the formation of a faculty within the Royal College of Physicians?

One hundred and seventeen (54%) replies were received: 76%, including 2% with reservations, favoured the formation of a college, 14% a faculty in the Royal College of Physicians. Other opinions were expressed in the remaining 10%. The result indicated that, as anticipated, there was outstanding support for the formation of a College of Psychiatry arising from the R.M.P.A.

The questionary was sent out in October 1963 to 923 senior psychiatrists not covered previously and resident in Great Britain and Northern Ireland. The names were taken from the R.M.P.A. 1962 year book. A memorandum stating the case for a College accompanied both inquiries.

The questionary, which was circulated in all to 1,147 senior psychiatrists in Great Britain and Northern Ireland, brought a total of 562 replies (49%). In what follows (1) and (2) refer to the two questions in the questionary (see above).

(*a*) Four hundred and forty-eight (80%) were in favour of a College of Psychiatry arising from the R.M.P.A. (1) and opposed to the formation of a faculty in the Royal College of Physicians (2).

(*b*) Sixteen (3%) recorded (1) "Possibly yes." (2) "No."

(*c*) Four (1%) recorded "Yes" to (1) or (2) or both with reservations.

(*d*) Forty-one (7%) were against a college (1) but favoured a faculty in the Royal College of Physicians (2).

(*e*) Nine (2%) were against a College (1) but recorded "Possibly yes" in regard to a faculty in the Royal College of Physicians (2).

(*f*) Forty-four (8%) were against either course.

A more detailed report which includes an analysis of status and qualifications, and regional scatter of voters, has been made and will be circulated to psychiatrists in the near future.—I am, etc.,

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*** A leading article appears at p. 511.—ED., *B.M.J.*