

CORRESPONDENCE

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Isolation in the Control of Dysentery

SIR,—It is a pity that Dr. R. G. Hendrickse should state without qualification in his otherwise excellent paper on dysentery (17 March, p. 669) that patients with the disease should be isolated until negative cultures are obtained. Because isolation is impossible in many homes, this policy would result in the admission to hospital of large numbers of patients, mainly small children, most of whom would have only mild symptoms, if any. But the expense and disruption entailed would be misplaced because in dysentery, as in other endemic infections, the family should be regarded as the infected unit, most of its members being infected although only a few develop symptoms.²⁻⁴

On recovery, the stools may still be intermittently positive even though as many as 12 consecutive negative specimens have been obtained.³ Fortunately, symptomless excretors are not important in the spread of the disease⁵ and it does not seem to matter if they are allowed to go to school.⁶

I suggest that patients with diarrhoea should stay out of circulation from the com-

munity at large, most of them being treated at home, segregated as far as possible. On recovery, stool cultures should be taken only from those from institutions or nurseries, or who deal with food. Other patients should be told that although it is never possible to be certain of freedom from infection, they will not be a danger to anybody if they are careful about personal hygiene.—I am, etc.,

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¹ Easton, H. G., *Lancet*, 1955, 2, 241.

² Macleod, R. C., *British Medical Journal*, 1955, 2, 255.

³ Macleod, R. C., *Monthly Bulletin of the Ministry of Health and Public Health Laboratory Service*, 1958, 17, 2.

⁴ Ross, A. I., *Monthly Bulletin of the Ministry of Health and Public Health Laboratory Service*, 1955, 14, 16.

⁵ Ross, A. I., *Monthly Bulletin of the Ministry of Health and Public Health Laboratory Service*, 1957, 16, 174.

⁶ Ministry of Health, *Report of the Chief Medical Officer for the Year 1956, Part II, on the State of the Public Health*, London, H.M.S.O., 1957, p. 56.

Antibiotic Levels in Tissue Fluid

SIR,—Mr. G. D. Chisholm and his colleagues (10 March, p. 569) seem to have overlooked the influence of blood flow to their artificial organ (a Silastic "tissue cage" implanted beneath the skin of a dog) in determining the course of drug equilibration in the "tissue."

At first sight their observation of a long time constant, in some instances exceeding an hour, for antibiotic equilibration appears to have considerable practical significance. However, reference to their previous experiments with radioactive sodium¹ also shows a long equilibration time. This might be primarily determined by a relatively low

blood flow to their model organ, which has substantial dimensions (about 9 ml). Has this flow been measured—for example by using isotope-labelled microspheres? Is the flow per 100 g comparable with that of normal tissues? Alternatively, what is the time constant for equilibration of an inert substance (such as xenon) in the model tissue, and how does this compare with that of antibiotics?

Until these questions are answered it would be premature to conclude that blood concentrations of antibiotics are a misleading guide to tissue concentrations or that the

latter are unpredictable. It would seem more likely that the results depend on the choice of an unusual tissue model.—I am, etc.,

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¹ Calnan, J. S., Pflug, J. J., Chisholm, G. D., and Taylor, L. M., *Proceedings of the Royal Society of Medicine*, 1972, 65, 715.

Glomus Tumours

SIR,—Your interesting leading article (10 March, p. 565) on this unusual condition stimulates me to mention its vascular presentations. When occurring in the hand of a young woman with wasting, coldness, and congestion Raynaud's disease may be misdiagnosed. In the toe of an older patient arteriosclerotic ischaemia may be suspected. In both situations sympathectomy may have been considered and this can lead to referral to a vascular surgeon.

A test that I have found most useful when the well-localized tenderness that is so characteristic of glomus tumour has already been found is the inflation of a proximal sphygmomanometer cuff above systolic arterial pressure. This relieves pain and reduces the tenderness quite conspicuously. From the good description of the surgical anatomy in the first paragraph in your article it is easy to see why this test can be so effective.—I am, etc.,

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SIR,—Your leading article (10 March, p. 565) is welcome in that light is shed on a rare tumour. However, you fail to emphasize that subungual glomus tumours are invariably minute, measuring millimetres rather than centimetres in diameter. The pain from them