

Tuberculin Jelly Test

SIR,—The modification of the tuberculin jelly test which I described in a recent article in the *Journal* (July 15, p. 141) was developed to enable the useful range of the test to be extended into the teens and possibly beyond. As several cases have been brought to my notice of severe reactions in very young children in whom this modified technique has been employed, may I say that I would not advise its use, and do not think it necessary, in children under 5 years of age? Their skins are so sensitive that the original jelly test without flour-paper should be quite adequate. If flour-paper is used then some severe reactions may result.—I am, etc.,

London, N.W.3.

W. POINTON DICK.

Transmission of Kala-azar

SIR,—As pointed out by your correspondent, Dr. B. J. Bouché (November 4, p. 1060), the sandfly theory has been severely mauled in the past few years. As there have been no serious attempts at resuscitation since September, 1945, I think we may assume that it is dead and has been decently, if unobtrusively, buried by its friends. May we hope that the obituary notice will duly appear in the next generation of textbooks?—I am, etc.,

Sheffield.

R. H. MALONE.

Four Brothers with Duodenal Ulcer

SIR,—Although a familial history of peptic ulcer is quite usual, I have recently encountered a remarkable tendency to chronic duodenal ulceration in the male members of one family. Of nine children seven are male, all of whom are miners by occupation. I have myself in the course of the last fifteen months carried out a partial gastrectomy in three of the brothers for chronic duodenal ulceration. In each case the ulcer was on the first part of the duodenum, was extremely chronic, and in two of the three was associated with severe pyloric stenosis: in fact, the first brother to come under my care was admitted as an early case of alkalosis. Besides these three who have been treated by partial gastrectomy, one has been operated upon for a perforated duodenal ulcer some twelve years ago, and yet another is at present undergoing investigation elsewhere for severe indigestion, and has been told he is suffering from "stomach trouble." Of the two remaining brothers, one is symptom-free, and the other has mild indigestion, but has not thought it worth his while to seek medical advice. Therefore, of the seven male members of this family, three have had gastric resections for severe duodenal ulcer, one has had a perforated duodenal ulcer, one is at present under treatment for gastric trouble, one has slight symptoms, and only one is completely free. Both sisters are fit and well, as are the parents and near relatives. The ages of the seven brothers range from 31 to 53.

It would appear as though the tendency to duodenal ulceration in this instance is not hereditary. The fact that they are all miners (even allowing for the increased instance of peptic ulceration among miners) would not seem to account for such a high percentage of duodenal ulceration; nor have the three cases upon which I have operated exhibited any signs of undue apprehension—indeed, they have all three been excellent patients, and were certainly not of the anxious worrying type so commonly associated with a duodenal ulcer.—I am, etc.,

Barnsley, Yorks.

ANDREW G. BUTTERS.

Amphetamine in Barbiturate Poisoning

SIR,—The widespread use of the barbiturate drugs, with consequent increase in the incidence of acute poisoning resulting from them, whether accidental or intentional, adds importance to a recent article on the problem from the pen of Dr. J. D. N. Nabarro (October 21, p. 924). A desire to have the results of his clinical experience in this matter elucidated prompts my letter. The author cites several cases from which the reader can only conclude that amphetamine sulphate has

commendable therapeutic value in acute barbiturate poisoning. He follows with the suggestion that the drug is directly indicated (to the exclusion of the at present more widely advised picrotoxin) if rapid rousing of the patient is desired, as in the case of the asthmatic (Case 2); and he goes on to say, "Many of the properties of amphetamine referred to make it questionable whether the use of this drug in barbiturate poisoning is ever justified."

Dr. Nabarro renders a clinical service by drawing attention to the untoward properties of a drug which has such widespread applications, and he clearly regards as important the cardiovascular side-effects in question. But how important are they, and how frequently do they occur? The enormous quantities of "dexedrine" and "benzedrine" which are now taken prove conclusively that these drugs are not ordinarily associated with significant side-effects at all. But, even agreeing with Dr. Nabarro that cardiovascular toxicity occurs, surely it is better to risk a possible though rare cardiac arrhythmia while leaving a coma quickly, than to avoid the arrhythmia and invite the delayed bronchopneumonia.

It is unreasonable to discard a drug of proved value in the treatment of barbiturate poisoning because it has side-effects, especially when, as Dr. Nabarro says, "no undesirable results seem to have followed the large amounts of amphetamine administered," and more especially when he goes on to admit that picrotoxin quickly induces dangerous "preconvulsive muscular twitchings." Surely the association of an untoward drug effect with the cerebral rather than with the cardiac component of the human being does not necessarily lessen its significance. In short, far from being a "useful ancillary drug," as Dr. Nabarro says, in the treatment of such cases, amphetamine sulphate is the drug of choice for acute barbiturate poisoning; it is picrotoxin which is ancillary.

Finally, none of my comments contradict or are contradicted by Chakravarti, who wrote: "In relation to its toxicity benzedrine is the most potent substance for arousing narcotized mice, being more potent than cardiazol or picrotoxin; on the other hand, as an antidote to lethal doses of the same narcotic, benzedrine is quite useless."—I am, etc.,

London, N.W.3.

H. CREDITOR.

Dangers of Penicillin Snuff

SIR,—It was with some concern that I read recently in the press of the extensive and frequent usage of penicillin snuff in the treatment and the prevention of the common cold at a Midlands factory. In the course of a personal research during the past six years on the aetiology and treatment of the common cold I have used this method of treatment, and from personal clinical observations I am of the opinion that the following are some of the risks involved:

1. In some patients frequent inhalation of penicillin snuff produces a degree of penicillin sensitization which on subsequent use causes an allergic rhinorrhoea. This in effect defeats its own object.
2. I have observed patients who have been thus sensitized develop anaphylactic shock and/or severe acute urticaria when penicillin therapy has been used for other infections at a future date. In these cases patients have been denied the benefit of penicillin therapy in much more dangerous infections for what is a relatively trivial complaint.
3. By repeated inhalation of penicillin snuff the organisms responsible for the secondary stage (muco-purulent catarrh) of the common cold eventually become resistant, and not only has the treatment no effect but if any other part of the body becomes infected with these organisms penicillin treatment is ineffective.

From clinical experience, my own opinion is that penicillin snuff is only of value in converting the secondary stage of the common cold to the primary stage of simple rhinorrhoea, which in itself can be controlled by instillation of a mixture of a vasoconstrictor and antihistaminic.

The works medical officer will find that he will reduce the incidence of the common cold in susceptible persons if they are given regular dosages of glucose and vitamin C, thereby avoiding the risks I have pointed out.—I am, etc.,

Whitburn, Co. Durham.

FRANK CORT.