I would like to draw attention to the comment in *Prescribers Notes* (May, 1955, volume 1, No. 11) which quotes from the *Practitioner*[1] as follows: "The convenience of oral penicillin must not be an excuse for its widespread use in the treatment of trivial infections, or for vague prophylactic measures. Indiscriminate dosage with penicillin *by any route* [my italics] is potentially dangerous and must be avoided."—I am, etc.,

Birmingham, 6. C. COLEY GRAYSON.

REFERENCE

[1] Fairbrother, R. W., *Practitioner*, 1955, **174**, 28.

SIR,—In view of the recent correspondence on measles, the following case may be of interest.

We were urgently called to see a girl aged 6½ years who had been making an apparently good recovery from measles (sixth day since appearance of rash). The mother said that the child had suddenly complained of headache and tried to vomit, and then found that she was unable to see. Prior to this, she had been lively and very anxious to get up. Examination revealed no abnormality apart from complete blindness. The pupils were central and did not react to light. Half an hour later the child had a fit with clonic movements of the left arm and leg, with deviation of the eyes to the left. After a few minutes the movement ceased, and the child lay in a semi-stuporous state. Further examination now revealed absent patella and ankle jerks on both sides with a positive Babinski response on the left. There was now a definite nystagmus. Some 10 minutes later a further fit took place, and intramuscular phenobarbitone 1 gr. (65 mg.) was now given. Re-examination revealed definite neck rigidity. Some 20 minutes later the child regained consciousness and also her vision, but was unable to move her left arm and leg. Her speech was somewhat slurred, and deviation of the tongue to the left was noted. After a further hour the child was normal in every respect and has had a completely normal convalescence.

The diagnosis would appear to have been one of encephalitis of a somewhat atypical nature. We would welcome the comment of our colleagues on this case.—We are, etc.,

WILFRID F. ADAMS.
Faversham, Kent. J. CANTOR.

SIR,—Congratulations to Dr. Frewen Moor (*Journal*, June 25, p. 1534). He has had the courage to extend to the practice of isolating measles cases the same scepticism that I expressed a few weeks ago (*Journal*, March 19, p. 727) concerning the isolation of chicken-pox cases. I thought of including measles in my remarks, but lacked the courage to face the resultant storm of abuse. Recently I saw over a hundred cases of measles in a local epidemic. All were promptly isolated and kept so until two weeks after the onset of the rash. Nevertheless I cannot think of one case where the younger brothers and sisters of the patient failed to contract the infection unless they had already had it, and I cannot name for certain a single patient attending one of the affected schools who managed to miss it if he or she was susceptible. In other words, it was all a waste of time.

In case Dr. Moor is misunderstood in the same way as I was about chicken-pox, may I point out that neither of us suggests that the affected children should be sent to school while they are still ill enough to be kept home on account of the severity of their symptoms. Furthermore, neither of us approves of the diseases in principle, and no doubt we should both be delighted if somebody could find a way of effectively preventing them.—I am, etc.,

Margate. M. CURWEN.

An Antibiotic-Induced Staphylococcal Enterocolitis

SIR,—I was most interested in Mr. B. J. Fowler's article (*Journal*, May 28, p. 1313) on this subject. A recent case I had fell into a similar category.

A housewife aged 44 was admitted on May 8, 1955, with a tendon sheath infection of the right thumb which had been treated for two days with systemic penicillin. At operation pus was evacuated which looked as though it was of staphylococcal origin. She was given chlortetracycline ("aureomycin") 250 mg. 4-hourly. On May 11 she developed a mild diarrhoea, and so the chlortetracycline was stopped after a total of 4.75 g. At this point the swab from the tendon sheath was returned negative after 48 hours' culture. The following day the diarrhoea had stopped, and she continued well until the evening of May 14, when she had four motions, and she was not quite so well. In the early hours of the next day she suddenly collapsed, became almost pulseless, cyanosed, cold, and sweating, and complained of a mild retro-sternal pain; pulse 120, B.P. not readable. It was felt that she had either a coronary infarction or a pulmonary embolus, and she was given morphine and intravenous fluids into which were added heparin and noradrenaline in sufficient quantity to restore the blood pressure to about 110/60 and keep it at that. However, the E.C.G. and chest *x*-ray were both quite normal and remained so. The serum electrolytes were also within normal limits on May 15. The following day she passed a blood-stained motion, and a swab of this was cultured but grew no *Staphylococcus aureus*. She was given two pints (1.1 l.) of blood and systemic penicillin and remained on intravenous fluids with noradrenaline, but on the morning of May 17 her blood pressure suddenly fell and she died.

At necropsy the right lower lobe was collapsed and showed evidence of a suppurative bronchopneumonia. The pus cultured from this grew *Staphylococcus aureus* which was sensitive to all antibiotics except chlortetracycline. The stomach was injected and there were petechial haemorrhages in the fundus. The small intestine was injected throughout its length, as was the large intestine, and in the descending and pelvic colon there were patches of brown adherent membrane. Unfortunately no swab was taken from the bowel at necropsy. The adrenal glands were normal.

I think that, despite the absence of direct evidence, this must be a case of staphylococcal enterocolitis. The points of interest seem to be: (*a*) It was a non-alimentary condition for which the chlortetracycline was given. Most, though not all, of the cases reported have been given antibiotics for alimentary tract infections or accompanying operative procedures on the alimentary canal. (*b*) The dramatic suddenness of the collapse, which led me to think at first of an intrathoracic catastrophe. Most patients have had diarrhoea or vomiting for a few days beforehand, whereas this patient was in fact constipated until the evening before she collapsed. The mistakes in the management of this case might be: (*a*) The administration of chlortetracycline. I feel that, in view of the length of history and the failure to respond clinically to penicillin, it was justified to give chlortetracycline, though not in the large dosage I did. (*b*) Failure to recognize the condition early enough and to administer erythromycin.

It would also appear from this case, as from some others that have been described, that this syndrome must be taken into the differential diagnosis of those conditions presenting as acute peripheral vasomotor collapse, such as coronary thrombosis, pulmonary embolus, spontaneous pneumothorax, concealed internal haemorrhage, or, indeed, shock from any cause, especially if the patient has been having one of the broad-spectrum antibiotics or a combination of penicillin and streptomycin.—I am, etc.,

Birmingham. P. D. HOOPER.

Diversities of Sex

SIR,—In his article "Diversities of Sex" (*Journal*, May 14, p. 1173) Dr. C. N. Armstrong writes: "There is no doubt that active male homosexuals recognize passive male homosexuals by some means unknown," and goes on to ask if there is some sixth sense which homosexuals possess.

It is interesting in this context to note the description which the French novelist Marcel Proust—himself a homosexual—gives of the meeting of the Baron de Charlus and Jupien in the first volume of *Sodome et Gomorrhe*. The Baron is the active, Jupien the passive, but Jupien is aware of the Baron's attention and interest and reacts, as Proust himself says, like a flower quivering in anticipation of the fertilizing bee. Charlus had, of course, recognized Jupien, and Proust makes the following comment on the charade of their meeting: "One does not arrive spontaneously at that pitch of perfection except when one meets in a foreign country a compatriot with whom an understanding then grows up of itself, both parties speaking the same language, even though they have never seen one another before" (see *Cities of the Plain*, translated by C. K. Scott Moncrieff, 1949, vol. 1, p. 6, Chatto and Windus).

According to Proust, recognition is both instinctive and mutual. A study of similar meetings described in *A la Recherche du Temps Perdu* might perhaps prove to be of some clinical interest.—I am, etc.,

Birmingham. P. M. W. THODY.