Points

Myocardial infarction on holiday

Dr D F LEVINE (West Cornwall Hospital, Penzance TR18 2PF) writes: Another summer and the wards are again beginning to fill with the middle aged and elderly casualties of exhausting car and coach journeys to the far south west of England. At best the myocardial infarction means a ruined holiday but all too often it becomes that most catastrophic of family events, the death of a relative a long way from home. It becomes painfully familiar each year that patients with angina that is unstable or of recent onset tolerate long journeys poorly. Afterwards usually comes the question, "Why didn't my doctor warn us?" Invariably the same answer, an anodyne excuse to avoid criticism of a distant colleague. A plea therefore to general practitioners, particularly in the north and midlands: advise your patients about the dangers of long journeys if they have symptomatic cardiovascular disease. Many patients will carry on regardless, but they should at least be given the benefit of advice on which they can make an informed choice. If they still insist on travelling then they should carry a letter with some medical details.

Consensus on HIV testing

Dr GORDON STAINER (Cowes, Isle of Wight PO31 7SH) writes: I think that Dr Ian W B Grant (30 July, p 356) may be underestimating the intelligence of the public when he states that owing to the recent ARM resolution on AIDS "it will now be incumbent on doctors to terrify patients with the spectre of AIDS in circumstances where the purpose of the test is usually to exclude, and only rarely to confirm, one unlikely but important item in the differential diagnosis." I maintain that if the facts are explained tactfully to a patient no terror need be entailed. The patient at low risk simply needs to be told that, although the diagnosis is unlikely in his or her case, the test needs to be done for the sake of completeness. Many patients nowadays will be well aware of whether or not they have done anything to cause themselves to be at risk of AIDS. If they do not regard themselves as being at risk the blood test should not terrify them. If, however, they have been putting themselves at risk then the issue of AIDS must be confronted by both doctor and patient anyway, and this can be discussed before doing the test. I do not condone terrifying the patient, but a certain amount of anxiety is necessary for patients to alter behaviour putting them at risk. I therefore think that discussing the issue of AIDS when doing a blood test on those at risk may make them alter their dangerous behaviour. AIDS is a terrifying disease that must be confronted by all members of society, and I cannot see any logic in not confronting it when doing a blood test.

Medical audit

Dr JACKIE SPIBY (King's Fund Centre for Health Services Development, London NW1 7NF) writes: Much as I was heartened to see that Mr John Warden thinks that medical audit will be on the agenda of this parliament (23 July, p 248) I was distressed to see his erroneous definition of it. Medical audit is primarily about improving the quality of care to patients and has been described as "the sharing by a group of peers of information gained from personal experience and/or medical records in order to assess the care provided to their patients, to improve their own learning, and to contribute to medical knowledge." The use of the word audit has unfortunate associations with accounting, but, as the Royal College of Physicians' working party on medical audit agreed recently, it is the most commonly acknowledged term for peer review of the quality of medical care. Of course, efficiency is one element of quality, and in many cases medical audit may define sources of economy, but it is not its primary function.

Changing nature of anal cancer

Mr ANTHONY R DIXON (Leicester Royal Infirmary, Leicester LE1 5WW) writes: I found Mr Robert W Talbot's editorial on anal cancer interesting (23 July, p 239), particularly the aetiology and the evidence supporting the possible venereal transmission of the human papillomavirus. Although agreeing that the risk factors for the sexual transmission of this oncogenic virus are likely to be the same for squamous cell carcinoma of both the cervix and the anus, I would like to point out that it is not just homosexual men who are at risk in the younger age group. Analysis of the patients treated for squamous cell anal carcinoma over the past eight years in the Leicester hospitals group suggests an association with cervical neoplasia and thus the human papillomavirus. The age at presentation was seen to fall into two groups: those under 50 years and those above 60 years (range 30-80 years). There were five patients under 50, four of whom were women with a mean age of 39. Three of the four had received previous treatment for either in situ or invasive cervical neoplasia some five to 13 years earlier. Two of them had had anal intercourse, one later developing Bowen's disease of her inner thigh. As to the human papillomavirus being involved and which DNA subgroup, results of molecular biological studies are awaited.

Ingrowing toenails

Dr P J HARNEY (Dursley GL11 4AE) writes: In their paper on the treatment of ingrowing toenails (30 July, p 335) Messrs P A Sykes and R Kerr did not mention the role of the general practitioner. For the past five years I have regularly performed segmental phenolic ablation in general practice, and I know that many other general practitioners do the same. The procedure is simple and quick. The patient is spared a long wait for an appointment with a surgeon or chiropodist, whose time could be better spent on tasks more appropriate to their technical skill. The financial savings to the National Health Service are self evident.

Vital statistics and race

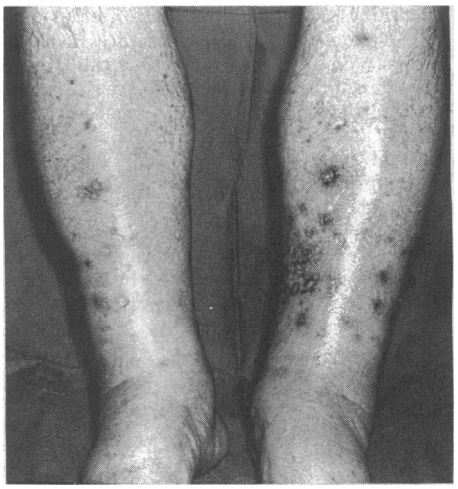
Dr R R GORDON (Halstead, Essex CO9 1SF) writes: Minerva tells us of American vital statistics relating to blacks and whites and says that such figures are not available here (30 July, p 368). Strictly this is true, but we do have Office of Population Censuses and Surveys figures in relation to child mortality that depend on the "country of birth of the mother" (series DH3, birthplace of mother). A convenient example of this relates to postneonatal mortality. In England and Wales this averaged out for the years 1978-85 at 4·2 for every 1000 live births. For mothers born in India (including and not including Bangladesh) the rate was 4·0, for those born in the Caribbean Commonwealth 4·4, and for those born in Pakistan 6·4. Except for mothers born in Pakistan there is considerable "equality." The high rates for Pakistanis do not of course reflect poor social conditions but the high incidence of lethal congenital anomalies (metabolic and structural) resulting from autosomal recessive genes in homozygous form. Without this the Pakistani postneonatal mortality rate would probably also be equal.

Drug Points

Vasculitic leg ulcers associated with diltiazem

Drs ANDREW J CARMICHAEL and C J PAUL (Skin Hospital, Birmingham B15 1BR) write: Further to Dr R A Wakeel's and colleagues' communication (9 April, p 1071) we wish to describe another severe cutaneous reaction after treatment with diltiazem.

In January 1988 a 59 year old man was admitted as an emergency with painful bilateral leg ulcers. He had a history of obesity, epilepsy, transient ischaemic attacks, hypertension, and angina; and he was taking sodium valproate 400 mg, aspirin 300 mg, methyldopa 1500 mg, metoprolol 200 mg, isosorbide dinitrate 40 mg, and nifedipine 60 mg in divided doses daily. His treatment had not been changed for 12 months before July 1987, when he was noted to have dependent oedema and diltiazem 60 mg three times daily was substituted for nifedipine with no improvement of the oedema. Within two months a non-itchy, purpuric rash developed symmetrically on his legs. During the next few weeks this evolved into erosions and multiple painful, punched out ulcers 1-2 cm in diameter (figure), requiring his admission to hospital.



Punched out vasculitic ulceration of the lower legs

The only evidence of systemic disease was microscopic haematuria and 0·21 g of proteinuria in 24 hours. Urinary casts were absent, and serum creatinine concentration and blood pressure were normal. Investigations for possible causes of his vasculitis were negative,[1] apart from a positive radioimmunoassay test for hepatitis B surface antigen and core antibody. There were no other clinical or laboratory findings to suggest polyarteritis.[2]

The diltiazem was stopped, analgesics were started, and the ulcers were dressed. He was discharged from hospital after two weeks. Three months later the ulcers had healed, the pain and microscopic haematuria had resolved, and no new purpura were noted. His hypertension and angina were stable, and his hepatitis serology was unchanged.

The temporal relation between the skin lesions and the diltiazem, with resolution after the treatment was stopped, strongly implicates the drug. The presence of hepatitis B surface antigen is interesting in view of its suggested association with polyarteritis.[3] The resolution of the vasculitis despite the persistence of the hepatitis antigen suggests that the surface antigen had, at most, only a potentiating role.

This case highlights another severe cutaneous reaction, associated with microscopic haematuria, related to treatment with diltiazem. Neither the manufacturer nor the Committee on Safety of Medicines (personal communications) has received previous reports of similar reactions to diltiazem. We recommend caution in the use of diltiazem in patients who are known to be hepatitis B carriers. Such patients should have regular monitoring by urine analysis.

1 Ryan TJ, Wilkinson DS. Cutaneous vasculitis: angiitis. In: Rook A, Wilkinson DS, Ebling FJG, Champion RH, Burton JL, eds. *Textbook of dermatology*. Vol 2, 4th ed. Oxford: Blackwell Scientific, 1986:1121-85.

2 Sack M, Cassidy JT, Bole GG. Prognostic factors in polyarteritis. *J Rheumatol* 1975;2:411-20.

3 Gocke DJ, Hsu K, Morgan C, Bomardieri S, Lockshin M, Christian CL. Association between polyarteritis and Australian antigen. *Lancet* 1970;ii:1149-53.

Corrections

Generalised chorea due to digoxin toxicity

The therapeutic range of digoxin in this drug point by Dr L J M M Mulder and others (30 April, p 1262) was wrongly quoted as 10-26 µg/l. It should read 1·0-2·6 µg/l.

Psychiatric illness among British Afro-Caribbeans

An authors' error occurred in this letter by Drs Gabrielle Milner and Gwilym Hayes (30 July, p 359). In the first sentence of the second paragraph the percentage of Afro-Caribbeans examined was incorrectly published as 10%; the correct figure is 16%.