

Treatment of Toxoplasmosis

Q.—What is the most effective chemotherapy or antibiotic in the treatment of toxoplasmosis? Are the chances of complete cure good?

A.—Toxoplasma often infects, but rarely causes diseases. So rarely that it would be impossible to conduct a properly controlled therapeutic trial in man. Experiments in artificially infected mice, however, have shown that the best treatment in these animals is by a combination of pyrimethamine and sulphonamides. These drugs act synergistically by blocking the metabolic pathway involving *p*-aminobenzoic acid, folic acid, and folinic acid.¹

Success has been reported with the use of this treatment in patients presumed to have toxoplasmic uveitis² and has been observed in 4 patients proved to have active toxoplasmosis by the isolation of toxoplasma (3 were laboratory infections).^{3,4,5} It would appear to be suppressive rather than curative since toxoplasma was isolated from lymph nodes in one of the patients 30 days after the start of treatment and again 66 days after the completion.³ Daily dosage suggested is 25 mg. of pyrimethamine (after a loading dose of 100 mg.) and 2 to 4 g. of sulphadiazine, or triple sulphonamide (in divided doses), given for 20 to 40 days.

It must be stressed that pyrimethamine is a toxic drug likely to produce leucopenia and thrombocytopenia. A careful watch should therefore be kept on the blood picture, and if these abnormalities develop they should be corrected by the daily administration of leucovorin, calcium, and yeast. Since allergy enters largely into the aetiology of toxoplasmic uveitis it is advisable in this condition to give prednisone either systemically or locally in addition to the specific anti-toxoplasmic treatment.

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Regional Ileitis in Australia

Q.—Is it known why regional ileitis and sarcoidosis are rare in Australia?

A.—Clinical impressions that regional ileitis is relatively uncommon in Australia are supported by hospital admission figures. At the Queen Elizabeth Hospital, Adelaide, over the past five years the incidence of regional ileitis has been 0.16/1,000 admissions compared with 0.49/1,000 during the same period at St. Albans City Hospital, England. In the present state of ignorance of the cause of regional ileitis it is difficult to discuss why this should be so. Ulcerative colitis was only slightly less common in Adelaide—1.40/1,000 admissions compared with 1.64/1,000 in St. Albans.

Sarcoidosis is probably not rare in Australia. In South Australia 25 cases of

sarcoidosis were discovered among 150,000 persons over the age of 15 x-rayed during 1963. The incidence of sarcoidosis reported in any area depends much on the interest of the local physicians in the disease.

The question implies that regional ileitis and sarcoidosis are related diseases. It is true that some cases of regional ileitis show histological resemblance to sarcoidosis. And the incidence of tuberculin sensitivity is low in both diseases, probably a non-specific effect of reticulo-endothelial damage. However, the anatomical distribution of the lesions of

regional ileitis is quite unlike that of sarcoidosis, and tubercle bacilli are very rarely found in regional ileitis but commonly at some stage of sarcoidosis.

Correction.—In the article by Dr. Dorothy E. Speed and her colleagues entitled "Melfalan in the Treatment of Myelomatosis" (27 June, p. 1664) the third and fourth lines should have read: "...The racemic form, melfalan (sarcocysin), was also synthesized in Moscow..."

NEW APPLIANCES

The Chester Portable Lithotomy Table

Mr. S. BENDER, consultant obstetrician, Chester City Hospital, writes: The value of a portable lithotomy stand or table for use by the general practitioner-obstetrician has been well attested by Handfield-Jones (1956) and Goodman (1960), both of whom have described their own designs. Such a table is also valuable in hospital practice; first, for use when a patient needs to be delivered outside the labour ward—for example, in the "eclampsia" room; and, secondly, as part of the equipment of the obstetric flying squad. With lightness in weight and ease of assembly as guiding factors, Mr. Neville J. Warren, instrument technician at the Chester City Hospital, made a prototype, and the table depicted below was finally devised and produced by the Apprentice School of Hawker-Siddeley Aviation, Chester. It is easily port-

able as it weighs only 8½ lb. (4 kg.) (Fig. 1).

The base of the table consists of a wooden spruce frame filled with honeycomb plastic, covered by Formica, and edged with a plastic moulding. The carrying-handle is attached to the trailing edge. The lithotomy poles can be quickly raised and lowered by pressing a release button which operates a knuckle-joint, and these are maintained in the erect position by locking sleeves (Fig. 2). The stirrups, which are of canvas padded with foam rubber, are detachable (Fig. 3).

The design and dimensions are shown in Fig. 2.

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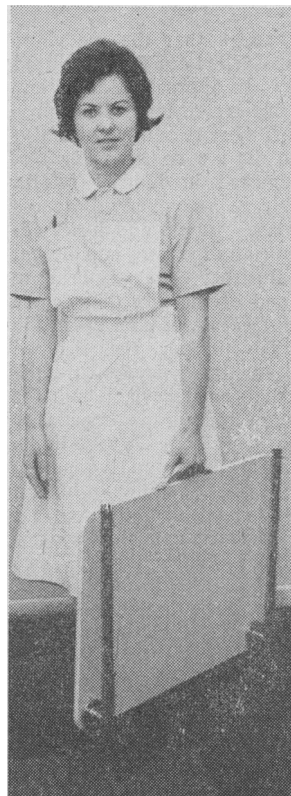


FIG. 1

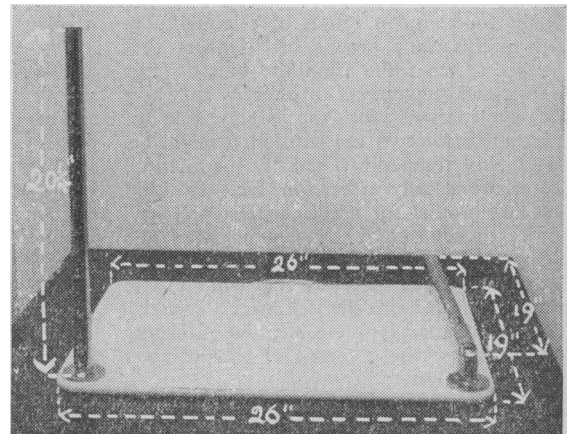


FIG. 2

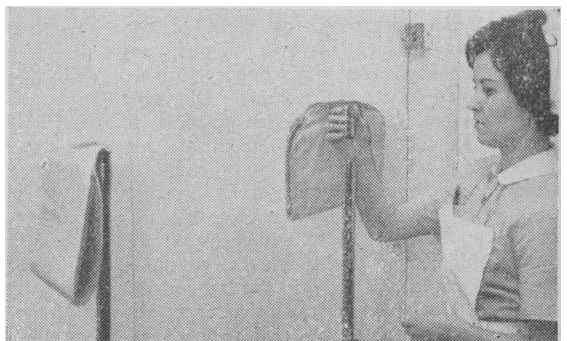


FIG. 3