Sulphonamides in Measles

SIR,—I was very interested in the observations recorded (April 21, p. 567) by Dr. J. Frankland West. He writes that he would be interested to know whether similar results have been experienced.

I have just experienced a similar successful result by treatment with sulphadiazine. This was given to a boy aged 5 years when I found him to have a temperature of 100.5° F., with no physical signs, and it was given in the hope that, should some serious condition develop that would later need such treatment, a good start would have already been made. I did not then have reason to suspect developing measles, which did come on after three days. The attack was surprisingly mild, with very slight cough and no inflammation or any soreness of the eyes; there was a very sparse rash, and the whole condition cleared up within 48 hours.

This child's sister, a year older, developed measles. She was first seen by me when the rash and other symptoms made the diagnosis obvious. At that time it did not occur to me that the chance giving of sulphadiazine to her brother had any beneficial effect on the attack of measles, and she was not given this drug; she had a most severe attack, with a higher temperature, very sore discharging eyes, a very profuse rash, and a marked lengthening of the attack.

More extensive statistics on the effect of this drug on measles would, I consider, be most useful.—I am, etc.,

London, N.W.1. M. D. RIPKA.

SIR,—I should like to testify to the highly beneficial effects of sulphathiazole in measles. In the recent epidemic, in which I saw some 106 cases, I gave it at first to the more severe cases, and its effect was so striking that I began giving it to nearly all cases, with equally almost astonishing results. The epidemic though heavy was only mild, in that spring measles is generally milder than the winter type.

I am convinced that, pneumonitis or no pneumonitis, sulphathiazole is also a "specific" for measles. The usual complications, particularly otitis media and pneumonia, thanks to sulphathiazole, worked out at less than 6% with no deaths, while the duration of the illness was curtailed by half. I wish to emphasize that, while the majority of cases were mild, there were many severe cases too.—I am, etc.,

Kennington. H. J. POWELL.

SIR,—I treated nearly all my cases during the recent epidemic with sulphanilamide and got excellent results. I gave sulphadiazine to one patient, whom I suspected was developing measles, merely because a friend who was with me (we were stopped on the road on Easter Monday while on our way to see a patient of my friend) had some sulphadiazine in his car. The child did develop measles, and I switched over to sulphanilamide with the usual good results. This may interest Dr. J. Frankland West, whose letter has prompted this.—I am, etc.,

London, W.11. RALPH JONES.

SIR,—Dr. Frankland West's experience with sulphadiazine in measles prompts me to send in mine. A couple of years back I had fourteen cases in a girls' residential school. It was a severe epidemic of measles, to judge only from the temperature, which ranged between 103.5° F. and 105° F. at the peak of the illness, and there were no complications, due undoubtedly to the same sulphadiazine. The ages of the patients were from 5 to 15; all of them were given 1 g. of the drug as an initial dose, followed by 0.5 g. four-hourly till the temperature was normal. In no case was treatment begun before the diagnosis of measles was established before the appearance of the rash. In every case except the 5-year-old patient the rash had faded and the temperature dropped to normal in 48 hours. In the only resistant case this took 96 hours. The patients, moreover, suffered little "illness" once under the influence of the drug, and returned to a normal diet more quickly; in fact their worst phase was while waiting for the rash to appear.

This does raise the question of the period of isolation in such cases, and also of the immunity they developed. There was no question of their well-being. A factor strongly brought out was the good effect on their skins. Those who had previously suffered from acne seemed to have procured a new skin!

A child of 6 months, seen last month with a temperature of 102° F., a persistent cough, and a rash, and also diagnosed as suffering from measles by another medical man, lost rash, temperature, and cough on 0.15 g. sulphaguanidine twice a day for a period of 3 days. This latter drug I have found extraordinarily effective in this dose 2-hourly for the influenza which seems to correspond clinically with the "genuine" disease and which responded poorly to both sulphathiazole and sulphamezathine.—I am, etc.,

Hereford. T. PIRES.

Sulphonamide Therapy in Otitis Media

SIR,—I have read with great interest as a country practitioner your correspondence on sulphonamide therapy in otitis media following the letter of Mr. A. R. Dingley (March 24, p. 422). Does he yet realize that the vast majority of cases we general practitioners see are at an early stage, which he, as a consultant, will rarely be called to see? I find that the pain is almost invariably relieved after the second dose of the drug, but the drum must be inspected frequently and carefully if the occasional case which proceeds to suppuration and requires timely paracentesis is to be detected. If this routine is carried out competently with an adequate auriscope, and some means of testing hearing, I regard the treatment as absolutely safe.

Parents are beginning to realize now that we can do more than give anodynes if called to treat their children in the early stages. Furthermore I find that if an attack can be aborted early there is no longer that increased liability to subsequent attacks in the presence of nasopharyngeal infection, which invariably follows a first attack when suppuration and discharge have taken place.—I am, etc.,

Bakewell. SINCLAIR M. EVANS.

"Predisposition" to War Neuroses

SIR,—Dr. Frederick Dillon in his letter (April 21, p. 570) says that in my article (March 31, p. 444) it is suggested that "predisposition to breakdown under war conditions can be correctly estimated from the occurrence of nervous and mental illness in the family and personal history of the patient and from a poor work record." I would not dare to suggest that it is possible to estimate *correctly* when a patient is likely to break down even under stress of war. Many patients fulfil these factors as to predisposition and are able to withstand the shocks and stresses of war. On the other hand, if these factors are to be ignored why do the great majority (I cannot give the exact figure) of the admissions to this neurosis centre satisfy these conditions?

Surely the control group can be supplied by those patients who are admitted to the surgical side and who show no evidence of neurosis and no predisposition in the form mentioned. Even some of those with *no* predisposition break down if the stresses are severe enough.

I agree with Dr. Dillon that a number of neurotics have made excellent soldiers, but these are the exception rather than the rule. I also agree that mildly obsessional persons often have excellent work records, but when they develop obsessional neuroses the work does suffer as a result. Abnormal personality traits alone of whatever type do not constitute predisposition, but when added to the other factors mentioned, surely the risks of a neurosis developing in such an individual are considerably increased when exposed to the stresses of war.—I am, etc.,

Sutton Emergency Hospital. LOUIS MINSKI.

Malaria in West Africa

SIR,—I was most interested in the article by Squad. Ldr. D. G. Ferriman on the diagnosis of malaria in West Africa (March 10, p. 328), and especially the section on subclinical malaria. This condition and that of clinical malaria—i.e., cases in which positive blood films are not found—are forming the majority of the cases seen out there to-day.

Although no reference is made to the period during which the data were obtained, it appears that it would be before 1944, because during that year the suppressive dosage of mepacrine was increased from 0.2 g. twice weekly to 0.1 g. daily. With this change of dosage there has been a very definite change in

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the relative incidence of the three types—M.T. malaria, clinical malaria, and subclinical malaria—as reported in the article, and it is this fact that has led me to write this letter, which is not intended as a criticism of a very excellent article.

In the early period of 1944 I was fortunate enough to conduct an experiment with the increased suppression dose. The station was divided into two equal groups, each barrack block being divided equally, both numerically and, so far as possible, by trades, as night workers (e.g., wireless operators) were found to have a greater incidence than other trades. One half were then given the old dose of 0.2 g. mepacrine twice weekly, and the others were given 0.1 g. for six days a week. Unfortunately the experiment was terminated some two months later, before really reliable statistics could be obtained, by the introduction of a suppressive dose of 0.1 g. daily to all personnel, but there were definite indications that the increased dosage reduced both the primary and secondary attacks of malaria considerably. More marked, however, was the reduction in the number of positive slides obtained. These indications were more than confirmed with the introduction of the daily suppressive dose of 0.1 g. mepacrine. Positive blood films became much less frequent, and in fact furnished some indication of the state of antimalaria discipline on the station. If more than 50% of cases were found to have positive slides, it could be assumed that discipline was lax. I also found the examination of blood films of value in assessing whether or not a patient had been taking his suppressive mepacrine. In most positive slides parasites were relatively scanty, and the rings usually poor, woe-begotten affairs. If a textbook appearance was found it was almost certain that suppressive mepacrine was not being taken regularly, and in most cases a direct challenge to the patient would substantiate this fact. To obtain 90 positive slides out of 136 consecutive low-fever cases, as reported in the article, would be most exceptional to-day.

Regarding clinical features, temperatures of more than 102° F. are rarely seen in my experience. Splenomegaly was not found to be anything like as high as the 25% quoted in the article; it occurred in less than 10% of the cases I saw, but tenderness over the spleen and under the left costal margin was very frequent. The description of the anomalous behaviour of malaria resembling other diseases, and also that of subclinical malaria, was greatly appreciated, as these are the types of malaria most commonly presenting themselves to a Service medical officer. In this connexion I found that a careful history of the two days before reporting sick was of great value, especially in those cases where the temperature was between 99 and 100° F. In nearly all cases of clinical and subclinical malaria the following history could be obtained, in most cases without the use of leading questions.

There would be the development of lassitude, and a feeling of over-tiredness during the afternoon, and by evening there would be a definite anorexia associated with varying degrees of headache. Usually the headache was occipital and slight. This would be followed by a poor night's rest, but on rising the following morning the headache would have disappeared and the appetite returned; there would still be a disinclination for work. Work would be begun, however, and during the forenoon the headache would recur and increase in intensity throughout the afternoon. The anorexia would return, and if the man did not report sick at this time he would usually retire early without his evening meal. He would have a good night's sleep—often described as "a very heavy sleep"—but when he awoke the headache and anorexia would be marked, and he then usually reported to the medical officer. The remission of headache and anorexia on the first morning with a return of the symptoms later in the day was not found in cases of upper respiratory tract infections, between which and clinical malaria a differential diagnosis has most frequently to be made.

A good case history was found to be of increasing importance in the diagnosis of malaria as found in the Service to-day, as the classical signs and symptoms of high temperature, rigor, enlarged spleen, and positive blood films are rarely seen. It is more than likely that these will be even less often found with the introduction of this new scheme whereby all personnel shall have had 1.75 g. of mepacrine before landing in Africa, or shall be given additional doses of 5 gr. quinine daily until they have had this amount of mepacrine. I personally had had only 0.4 g. prior to landing and this appeared to be about the average amount of mepacrine taken before landing in 1943 and early 1944. As a result the malaria incidence was relatively high in personnel during the first two months on the coast, because there was not a sufficient concentration of mepacrine in the tissues to afford protection, and it was in these cases that I found the highest percentage of positive slides.—I am, etc.,

J. C. HUTCHINSON,
Flight Lieut., R.A.F.V.R.

Treatment of Cerebral Malaria

SIR,—In the *Journal* of April 21 (p. 560) the leading article on pathogenesis of cerebral malaria, and on page 567 the letter on adrenaline in the treatment of malaria by Lieut.-Col. D. C. Macdonald, claim attention. In spite of statements to the contrary, cerebral malaria is nearly always due to *Plasmodium falciparum* infections, neglected, unrecognized, masked, ineffectively treated, or misdiagnosed. Special strains of *Plasmodium falciparum* are particularly liable to produce this complication—e.g., the variety current in the region of Kermanshah. The absence of demonstrable malaria parasites in the peripheral blood not infrequently makes diagnosis a bit harder. Blood films of venous blood, or liver, spleen, or sternal puncture, are of value occasionally, but often are disappointing. The erythrocyte sedimentation rate can be helpful. Intravenous saline, which can be used as a vehicle for quinine bihydrochloride or for adrenaline, is usually a necessity: these drugs may be injected with a hypodermic needle into the rubber tubing of the saline infusion set. It is necessary to warn against the injection of quinine bihydrochloride solutions into the rubber tubing of a set giving citrated blood, since troublesome clotting will ensue. Even after intravenous quinine it is advisable to test for quinine any sample of urine that can be obtained.

Patients who remain obstinately unconscious after repeated intravenous injections of quinine are encountered from time to time among the cases brought in too late for effective therapy (as reported by Col. A. W. D. Leishman and Capt. A. R. Kelsall, *Lancet*, Aug. 19, 1944, p. 231) and confusion with the prolonged coma of hyperthermia is a possibility which nearly always has to be considered. The modern Army system of prophylaxis (one tablet of mepacrine a day) will prevent blackwater and cerebral malaria, not completely perhaps, but very nearly. Idiosyncrasy to this drug may be rare, but does occur. Prophylactic quinine may not be absorbed, and urine tests for quinine—or the mixture of methylene blue with the preparation used—are advisable. Inspection of the urine of a patient taking mepacrine or "blued" quinine is often enough, but is a wise precaution. In the "shock-like" condition of malarial coma, intravenous adrenaline may release adrenocortical hormones (Voge), perhaps an explanation of the undoubted benefit which follows.

Spleen contraction for convalescents taking anti-relapse courses may be encouraged by two-mile walks, cold baths, sunbathing, swimming, hill-climbing, aeroplane trips, and breathing carbon dioxide from a mask as well as by injections of adrenaline, effective as this procedure may be. The spleen is not the whole story: capillaries in other abdominal viscera, the lungs, muscles, glands, and skin all may harbour the parasites of relapse in closed sections opened by exercise, etc.—I am, etc.,

FRANK MARSH,
Pathologist, A.I.O.C.

Intestinal Obstruction by Gall-stones

SIR,—I have read the article by Mr. Maurice Lee on intestinal obstruction by gall-stones (April 21, p. 555) with interest, because in December, 1944, within a few days of each other I encountered and operated upon two cases which occurred in my own general practice. Both cases were in elderly females. Case 1 was a typical case of acute intestinal obstruction. The gall-stone was lodged near the end of the ileum. Case 2 was unusual. The patient was fat and florid and suffered from myocardial degeneration, and as a result of clinical and radiological investigation I diagnosed a probable "ring" stricture in the pelvic colon. With the intention of performing a colostomy I opened the abdomen through a left grid-iron incision, and was agreeably surprised to find a large gall-stone (rather less than the size of a golf-ball) lodged at the pelvi-rectal junction and easily "milked" upwards into the pelvic colon and

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