

Correspondence

Paralytic Ileus after Hexamethonium

SIR.—C. HIRSON and A. R. KELSALL (*Lancet*, 1951, 1, 585) report a death which they ascribe to "paralytic ileus" during treatment with hexamethonium compounds. We have recently encountered a similar case.

A man aged 66 was admitted to hospital. He was hypertensive (blood pressure 205/110) and had recently been the victim of a left-sided cerebrovascular accident. He showed grade II retinopathy, but his renal and cardiac state appeared satisfactory. He had a hyper-acid dyspepsia with pylorospasm. With bed rest, blood pressure fell to 175/110. Hexamethonium therapy was cautiously begun and he was discharged after 18 days on an oral dosage stabilized at 500 mg. thrice daily. He appeared to have improved greatly during his time in hospital. His residual paralysis had almost cleared and his blood pressure had fallen to 148/82 recumbent, 140/70 standing. At the out-patient clinic a week later, he reported that he was rather constipated. His blood pressure was a few points higher than on discharge. One month later his blood pressure had further risen to 188/110 recumbent, 164/106 standing. He was less troubled with constipation, but noticed that his mouth was dry. The dose of hexamethonium was increased from 1.5 to 1.75 g. a day.

A week later he became nauseated. Next day he began to vomit bright green fluid and had some diarrhoea. His practitioner noted that his pulse was feeble and his blood pressure unrecordable. He immediately stopped methonium therapy, but the blood pressure did not rise. After two days of vomiting the patient was readmitted. He was severely dehydrated and his abdomen was distended. Occasional faint bowel sounds were heard. His blood pressure remained unrecordable and he died one day later.

Necropsy was carried out by Dr. Archibald Dick, who reported: "Hypertensive disease of moderate severity as evidenced by changes in heart and kidney. Generalized atheroma. Area of softening in left cerebral hemisphere as result of old thrombosis. The most interesting features were found in the alimentary tract—namely, stomach grossly dilated with bile-stained fluid; mucosa somewhat atrophic with numerous small erosions in middle third and pyloric region; slight degree of pyloric stenosis due to considerable scarring from healed duodenal ulcer. Common bile duct entered duodenum unusually high up. Small intestine, particularly jejunum, was grossly dilated with appearances of a paralytic ileus, there being much congestion and oedema, while a considerable amount of fluid filled the lumen; no mucosal ulceration was found. No distension or other abnormality noted in colon. Histologically the stomach showed slight superficial necrosis but little cellular infiltration, and, as necropsy was performed fifteen hours after death, post-mortem autolysis probably caused this. The jejunum and ileum showed very marked necrosis of the mucosa; submucosa oedematous and blood and lymphatic vessels being dilated. Appearances were consistent with a pressure necrosis due to accumulation of fluid and gas in the intestine. Little inflammatory cellular reaction; no abnormality noted in ganglia in small intestine."

It seems highly probable that this patient's death was immediately attributable to C6 therapy. The mechanism is obscure, but is presumably related to a profound disturbance of the control of blood pressure and exchange of electrolytes.—We are, etc.,

W. ARTHUR MACKEY.
GAVIN B. SHAW.

Glasgow.

First Mention of Rickets

SIR.—Under this heading Mr. F. N. L. Poynter (May 12, p. 1081) quotes Thomas Fuller's reference to rickets (1647), which he suggests has not yet met the eye of the historian of the disease. This is not so. The passage from the 1649 edition is quoted and commented upon in Drummond and Wilbraham's *The Englishman's Food* (1939, pp. 187 and 188). The relevant section in the 1647 edition (number "XX") is entitled "The new disease"; it differs in minor points from the passage given by Mr. Poynter.

There are, of course, earlier mentions of rickets in English. "The new disease" is not, I think, mentioned in the weekly Bills of Mortality (which started in 1592 and were resumed

in 1603) until the year 1634; thereafter the word "Rickets" appears almost continually among the list of "Diseases and Casualties." There is much evidence that the disease suddenly became prevalent in England during the first 20 years of the 17th century: Whistler (1645), Fuller (1647), Glisson (1650), Sir Thomas Browne (about 1650), and others suggest this. But it is obscure why this should have been so; and at the middle of the century certain remedies were quoted as if they had been in use for some time (Browne states that many rooks were killed for their livers to cure the rickets, and Whistler praises the livers of cows and frogs). The divine Fuller's mention of the woman of the West who healed many by cauterizing the vein behind the ear, to which attention is drawn by Mr. Poynter, seems to be a layman's ignorant statement concerning the common treatment by English nurses of blood-letting by cutting the veins at the back of the ear; this practice is described in detail by Whistler, writing two years earlier.—I am, etc.,

Oxford.

H. M. SINCLAIR.

Dr. Ricketts

SIR.—Mr. F. N. L. Poynter (May 12, p. 1081) is mistaken in his suggestion that Fuller's reference to rickets in *Good Thoughts in Worse Times* has not been noted by the historians. In the excellent section "Rickets in England" in *The Englishman's Food*, Drummond and Wilbraham, 1939, the early references, including Fuller's, are dealt with at some length.

There is, however, an earlier English reference than Fuller's which I have not seen noted elsewhere. On p. 980 of the monumental *Theatrum Botanicum*, 1640, when discussing the virtues of "The French supposed white Thistle," Parkinson writes: "Galen saith that the roote and leaves hereof are of an heating qualitie, and good for such persons that have their bodies drawn together by some Spasme or Convulsion, or by some other infirmitie, which disease is truly to be called the Rickets, which happening sometimes to children doth so binde them in their Nerves, Ligaments and whole structure of their body, that it suffereth them not to grow or prosper eyther in height strength or alacritie." This is not a very detailed description, but it is an obvious reference to the condition which by then had come to be recognized as a distinct disease, and may be the first in an English medical book.

With regard to the first record of the English word "rickets," the earliest appearance found by Drummond and Wilbraham was in a Bill of Mortality for the City of London dated 1634, which recorded 14 deaths from that cause.

The same authors point out that the early references to rickets all indicate that it first attracted attention about 1620. This is further supported by an interesting note by that garrulous antiquary John Aubrey, which was first brought to light by Oliver Lawson Dick in his edition of the *Brief Lives*, 1949, and which certainly bears repetition in a medical journal: "I will whilst 'tis in my mind insert this Remarque, viz.—about 1620 one Ricketts of Newberye, a Practitioner in Physick, was excellent at the Curing Children with swoln heads, and small legges: and the Disease being new, and without a name, He being so famous for the cure of it, they called the Disease the Ricketts: as the King's Evil from the King's curing of it with his Touch; and now 'tis good sport to see how they vex their Lexicons, and fetch it from the Greek Πάχυς, the back bone."

I think this derivation is as likely as any, and it would be interesting to know more about "Dr. Ricketts, of Newberye."—I am, etc.,

Fiern Barnet, N.11.

G. O. MITCHELL.

Herpes Zoster and Chloramphenicol

SIR.—We wish to report the following case.

A woman aged 45 years was seized with some discomfort in the left eye on November 10, 1950. The pain increased in severity, radiating up to the forehead, and was accompanied by some photophobia and epiphora. Two days later she sent for her doctor (R. G. K. H.), who found the eye in an inflamed condition and asked an ophthalmologist (J. A. R.) for a second opinion.

Examination disclosed only a mild generalized conjunctival suffusion with a localized patch of definite conjunctival injection at the limbus at 4 o'clock. It was thought likely that a keratitis or possibly an iritis would develop. Suitable local treatment for a conjunctivitis was instituted without benefit, and every effort to allay the pain by analgesics, including morphine, was tried without much avail.

On the morning of November 14 a small erythematous patch appeared on the forehead on the course of the supraorbital nerve and the eyelids had become swollen. There was increased conjunctival injection. A diagnosis of herpes zoster of the supra-orbital branch of the left trigeminal nerve was made by R. G. K. H. Later in the day she was seen by all three of us, when she was becoming worn out with intense pain in the eye and the lack of sleep. The diagnosis of herpes zoster was now quite definite, as the patch on the forehead had a number of small vesicles on it and there was one spot at the paranasal site in the distribution of the nasociliary nerve. The eyelids were swollen and there was some conjunctival injection, but the cornea was clear. The patient was started on 0.5 g. chloramphenicol six-hourly the following day, with 1% atropine drops daily to the eye. In two days she was free from pain, while the herpetiform eruption and congestion of the eye were subsiding. The drug was continued in smaller doses for a further three days and the atropine discontinued.

When she was last seen five weeks from the onset the neuralgic pains were considerably less and she was getting about the house quite well. There was some residual swelling in the upper eyelid with a little conjunctival injection and one minute corneal infiltrate paracentrally at 9 o'clock.

In view of the annotation "Herpes Zoster and the New Antibiotics" (*British Medical Journal*, 1950, 2, 1485) there are several points about this case which are worth considering. Chloramphenicol was given early, and produced rapid relief from pain and rapid recession of vesiculation and oedema. There was definite evidence of corneal involvement, but this did not progress. This is all completely contrary to the normal experience in a case of this type.

Further, the husband, a friend, and the cook all developed chicken-pox about a fortnight after the onset of the patient's herpes zoster. This would seem to establish the fact that the virus concerned was of the same strain as that in chicken-pox, and presumably explains the efficacy of chloramphenicol in this particular case.

One of us has long held the view that there is more than one type of infection responsible in herpes zoster to account for the undoubted association of one group of cases with outbreaks of chicken-pox and the absence of this association in the remainder. This would also explain the varied results accompanying the use of chloramphenicol in cases of herpes zoster.—We are, etc.,

Winchester.

R. G. K. HODGSON.
J. A. ROBERTSON.
C. B. S. FULLER.

SIR,—Dr. A. Barham Carter's excellent paper (May 5, p. 987) has inspired us to write of our own experiences in six cases in general practice—a much smaller number than his experiences cover—but we think possibly seen even earlier in the course of the disease than his.

Our experiences have been almost identical with his, the early crusting of the lesions being particularly noticeable. They were similar regarding the duration of the after-pain, which did not seem to be at all diminished by the use of the antibiotic drugs. All our cases were in old people.

At the moment, it seems to us that the large expenditure on antibiotics is unwarranted in cases of zoster while the prices remain at a high level, and we have discontinued the use of them for this reason, although the case against is by no means proved.—We are, etc.,

Norwich.

F. R. WILSON.
P. H. A. JONASON.

Tests for Sugar During Antibiotic Treatment

SIR,—Because streptomycin and dihydrostreptomycin are reducing agents and contain sugar in their molecular structures, routine reduction tests performed on the urine from patients receiving intramuscular injections of these antibiotics

may be positive. Also it has been recorded recently that similar results are encountered when massive intravenous penicillin is given—e.g., 86 million units average daily dose (Whipple and Bloom, *J. Lab. clin. Med.*, 1950, 36, 635).

Recently in this laboratory repeated examinations on cerebrospinal fluids obtained from a patient with *Staphylococcus aureus* meningitis were made. Apart from other findings, the sugar estimations during a course of chloramphenicol showed a sugar decline from 80 mg.% to 33 mg.% over nine days. On the twelfth day the C.S.F. sugar was again 33 mg.%. It was decided to change the treatment, and 100 mg. dihydrostreptomycin sulphate in 10 ml. distilled water was given by intrathecal injection. Twenty-four hours later a sugar content of 55 mg.% in the C.S.F. was recorded.

In both tubercular and pyogenic meningitis considerable attention is given to the C.S.F. sugar content by most authorities, and the raising of the total amount of reducing substances in the C.S.F. by intrathecal injection of antibiotics may give temporary false sugar values, with no accurate index for correction available, so that estimations carried out during and for an indeterminate time after this form of treatment are invalidated.—I am, etc.,

Board of Health Laboratory,
Guernsey.

HENRY WILSON,
Technician in charge.

Warts

SIR,—I have read with considerable interest the paper by Drs. A. Lyell and J. A. R. Miles, together with the annotations on the fascinating subject of warts (April 28, pp. 933–4). A study of this common affection makes one realize some of the limitations of medical knowledge and teaches, above all, humility. One of the most simple and banal of conditions, the wart would seem to obey no laws other than its own. Apparently a virus infection, it comes and goes as it pleases. Recurrences are common after surgical removal and yet quite frequently lesions disappear as a result of wart charming. The exact significance of inclusion bodies, demonstrable in only a small percentage of warts, has for long been a vexed question, although they are generally accepted as evidence of a virus aetiology. The fact that Lyell and Miles were able to show that these bodies occurred predominantly in plantar, palmar, and peri-ungual warts is of considerable interest and merits further investigation, but unfortunately the series of cases is small, and where one is dealing with so ubiquitous a subject one must have a very large number of cases to justify drawing clinical conclusions. This particularly applies to the suggested resuscitation of the word myrmecia. From the point of view of wart charming, it may be of use, but from a scientific point of view it can but add confusion to a subject already confused enough. Indeed, I think the same argument applies to the word verruca, so beloved of the chiropodist, and would suggest that it should give way entirely to that simple but expressive word "wart."

While agreeing with your annotator that as regards immediate results surgical removal is the most reliable method of treatment, I feel that the high relapse rate is not emphasized enough. When this is taken into account the long-term result varies but little from that of the more simple and practicable methods, the majority of which act on all probability by "charming." It would seem reasonable to suggest that the individual practitioner should take advantage of this susceptibility in the wart, and, if his scientific conscience will not allow of the more bizarre and dramatic forms of wart charming, that he should at least try the effect of suggestion in the form of simple drying pastes and lotions. By so doing he will find that he will reduce, frequently to an unexpected degree, the number of lesions requiring surgical removal. In particular the usefulness of 3% formalin in treatment of plantar warts is not always appreciated, for its routine use will usually serve to clear 50–70% of these lesions.—I am, etc.,

Huddersfield.

A. J. E. BARLOW.