Employment of Epileptics

During the war physically handicapped people previously considered to be unemployable were encouraged to train for essential work. Thousands of these took their places as wage-earners, and by April, 1950, the names of 15,078 epileptics appeared on the *Register of Disabled Persons*; of these, 13,563 were actually in work. This is particularly encouraging, as occupation and interest are direct anticonvulsants.

The task of finding work for an epileptic now officially falls to the disablement resettlement officer, who is guided by the report he receives from the patient's own doctor at the time of registration. However, continued supervision and encouragement by a social worker is often a determining factor in keeping an epileptic at work. Also knowledge of the patient in his home surroundings, visits to prospective employers, and consultation with the patient's doctor do much to ensure that the individual epileptic is placed in work for which he is most suited.

British Epilepsy Association

The British Epilepsy Association, formed in 1950 as a memorial to the work of Dr. J. Tylor Fox, aims at educating the public in the nature and social effects of epilepsy, and so help epileptics to take their proper place in the community. Parents of epileptics, or the patients themselves, often welcome the knowledge that their difficulties are understood and shared by other families. The association forms a unit of which they can become members. An attempt is made to find a solution to individual social problems. In addition, simple explanatory pamphlets have been published, designed to help parents and employers, and these can be obtained from the British Epilepsy Association, 7, Victoria Street, London, S.W.1.

Correspondence

Because of the present high cost of producing the Journal, and the great pressure on our space, correspondents are asked to keep their letters short.

Pethidine Hypersensitivity and Histamine

SIR,—In the last year there have been communications to the *Journal* describing severe hypersensitive reactions to pethidine.[1 2] The possibility that pethidine might produce the symptoms of the hypersensitive reaction by releasing histamine is suggested by the observation that it causes a triple response on injection into human skin.[2 3] This possibility is further supported by experiments demonstrating that the pharmacologically related opium alkaloids do actually release histamine.[3 4] Also, the urticarial rash and oedema of the lips and eyelids following pethidine administration in the patient of Dr. E. B. Butler are strikingly similar to the signs occurring when histamine is released from the tissues of unanaesthetized dogs following administration of histamine-releasing drugs. I would therefore like to mention here results shortly to be published in detail which demonstrate that pethidine, under certain conditions, is an effective releaser of histamine.

It was shown that the intra-arterial injection of relatively small amounts of pethidine into an isolated, perfused preparation of cat's skin released large amounts of histamine. In the intact cat, intravenous injection of large doses of pethidine produced increased plasma histamine levels.

The clinical picture of circulatory collapse, urticarial rash, and facial oedema occasionally seen following pethidine may therefore well be due to the release of histamine in patients who, for an as yet obscure reason, release histamine much more readily than others after administration of this drug. Since mepyramine considerably mitigates the signs accompanying histamine release in response to a histamine-releasing drug (although the histamine release persists),[5] the antihistamine compounds may be effective agents in combating the rare but alarming hypersensitive reactions to this drug.—I am, etc.,

National Institute for Medical Research, Mill Hill, N.W.7. M. SCHACHTER.

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Allergy and Rheumatoid Arthritis

SIR,—The letter of Dr. R. W. Barter (January 12, p. 109) referring to the use of antihistaminics and a postulated condition of hypersensitivity in rheumatoid arthritis recalls the case history of a patient which may be of interest.

The patient, a girl aged 14 in 1932, commenced with a disturbance affecting most of the joints of the body, including the elbows, knees, wrists, and small joints of the hands. This consisted in sudden painful swellings of the joints, subsiding after a week and recurring at about monthly intervals. These attacks were repeated for about six months, and then a condition typical of rheumatoid arthritis followed.

The joint disturbance at the onset was not associated with any rise in temperature, splenic enlargement, or any systemic sign or symptom of note. The sudden onset of the swelling appeared to me at the time typical of that associated with angioneurotic oedema.

In addition to the usual antirheumatic therapy of that period, anti-allergic treatment consisting in calcium injections and injections of milk was given, with no benefit. It is possible that treatment with the modern antihistaminics would have been of use here. The patient at present presents all the features of an advanced crippled state of rheumatoid arthritis. Arthroplastic operations on both elbow-joints and knee-joints have recently been performed.

The mode of onset of the disease in this case, and the subsequent history, would indicate that a condition of hypersensitivity is associated with rheumatoid arthritis.—I am, etc.,

Manchester. JACK CARR.

Acute Infectious Lymphocytosis

SIR,—In Dr. H. G. Dunn's very interesting article on acute infectious lymphocytosis (January 12, p. 78) he describes infestation with *Giardia lamblia* occurring at the same time and suggests this association is worthy of future investigation. I should like to add another case in which the two diseases appear to have coincided.

In August, 1951, a boy of 3 admitted to hospital for investigation of a congenital cardiovascular defect was found to have slight coryza and mild diarrhoea. Investigation of stools revealed many cysts of *Giardia lamblia*, and he had at that time a total leucocyte count of 49,000 per c.mm., of which 72% were normal small lymphocytes and 24% eosinophils. He was treated for five days with "atebrin," and after three weeks the leucocytes fell to 5,900 per c.mm. with 45% lymphocytes and 25% eosinophils, and no cysts or ova could be found. After another month the eosinophilia also had disappeared. There was nothing clinically to suggest glandular fever, leukaemia, or whooping-cough, and the child's subsequent history has been uneventful.

This case would thus appear very similar to those of Dr. Dunn.—I am, etc.,

Ashford, Middlesex. JEAN M. WEBSTER.

SIR,—The article by Dr. H. G. Dunn (January 12, p. 78) prompts me to report two further similar cases recently seen.

These were brothers, aged 3 and 1½ years, admitted in November with a history of loose stools and vomiting for one day. No abnormality, apart from slight nasal discharge, was found on physical examination, but stool specimens from both children showed cysts and flagellate forms of *Giardia lamblia*.

White blood counts (W.B.C.) were: elder brother, total 83,600 (80% lymphocytes, 5% eosinophils); younger brother, total 85,600 (89% lymphocytes, 4% eosinophils, 1% monocytes). They were each given a short course of mepacrine, the diarrhoea settled, and the stools revealed no *Giardia* on several occasions. The lympho-