Fortuitous Therapy for Psoriasis

SIR,—I have had a similar experience to Dr. H. M. Tuddenham (5 February, p. 358), except that my patient's psoriasis responded dramatically to methyldopa.

A female patient aged 68 years has for over 12 years had very severe psoriasis involving the arms and legs mainly, but also areas of the trunk. This has warranted admission to hospital on three occasions, but responded in varying degrees only to tar baths and steroid applications both with and without occlusive polythene dressings.

I began treating her accompanying severe hypertension with methyldopa 10 months ago with doses of up to 500 mg. t.d.s., and the psoriasis immediately showed a dramatic improvement, which has continued since, most areas being now virtually clear.

Unfortunately, I suppose, one cannot be certain in either case that the drug was the cause of the improvement, as psoriasis is well known for its variable clinical course. Even so, such improvements in prolonged chronic cases are remarkable.—I am, etc.,

SELWYN H. GOODACRE.

Swadlincote,
Near Burton-on-Trent, Staffs.

Awareness in Anaesthesia

SIR,—I should like to describe a potential source of awareness during general anaesthesia.

It was thought some patients were less well anaesthetized under the nitrous oxide/oxygen muscle relaxant technique than the flowmeter readings of a particular machine would lead one to expect. Calibration of the flowmeters showed no substantial error. However, further investigation revealed a leak of 1.5 l. per minute from the emergency oxygen supply.

The effect of this can be seen by the following example. If the machine were used with a carbon dioxide absorber and an indicated flow of 2.5 litres of nitrous oxide and one litre of oxygen per minute, the mixture would be expected to contain rather more than 70% of nitrous oxide. In fact the oxygen leak would reduce the nitrous oxide concentration to 50%.—I am, etc.,

RALPH J. WHITING.

Llangollen,
Denbighshire.

Anabolic Steroids and Thyroxine

SIR,—Astwood[1] has shown that prolonged administration of thyroid to patients with diffuse and nodular non-toxic goitres brings about a regression of the goitre in as many as two-thirds of the cases. Our early experience suggested that some of our patients could not tolerate the dose of L-thyroxine sodium (0.3 mg. daily) required for the purpose. They developed tachycardia, palpitation, weakness, and weight loss within a few weeks of commencing the therapy, and were reluctant to continue the drug any longer. All these patients were euthyroid (as judged clinically and by basal metabolic rate and radioiodine tracer studies) and none of them had the above symptoms before starting the treatment.

Methandienone (Dianabol) was administered to these patients in addition to thyroxine in the hope of countering the catabolic effects of thyroxine. Most of them regained their sense of well-being within a week and started regaining the lost weight. Tachycardia continued, but palpitation no longer bothered them. They were now willing to continue the same dose of thyroxine.

A controlled clinical trial using methandienone and a placebo is now in progress. It would be interesting to find out if anabolic steroids would help such intolerant patients to take larger doses of thyroxine, as it has been suggested[1] that thyroid medication might be more effective in non-toxic goitres if used in larger doses.—We are, etc.,

S. D. BHANDARKAR.
R. S. SATOSKAR.

Seth G.S. Medical College,
Bombay.

REFERENCE

1 Astwood, E. B., and Cassidy, C. E., *Clinical Endocrinology*, 1960, **1**. New York.

Treatment of Localized Myxoedema

SIR,—I was interested to read that Dr. R. Hall and his colleagues (4 December, p. 1368) found that ultra-violet irradiation caused improvement of lesions in this condition. I was also interested to read Dr. I. Sarkany's report (25 December, p. 1549) of a patient who improved almost completely during her sunbathing in France.

In the skin department of the Medical College, Baroda, India, we have regularly prescribed ultra-violet irradiation for localized myxoedema without much benefit. However, local infiltrations with triamcinolone have given relatively better results. In Baroda, with its hot tropical climate, the population is continuously exposed to excessive "sunbathing," and yet pretibial myxoedema occurs and does not appear to respond to ultra-violet rays.

Last year I treated three cases of pretibial myxoedema with local infiltration of triamcinolone with good results. The following report describes one of them:

A male, 26 years old, had pretibial myxoedema of both legs for the last three years. During the first two years repeated ultra-violet irradiation producing second-degree erythema was given. He did not show any improvement from this treatment. From November 1965 he was given nightly occlusive polythene dressings with 1% hydrocortisone ointment for five weeks, but the results were not encouraging. On 6 January he was given local infiltration of triamcinolone (1 ml. in an area 1 in. (2.5 cm.) in diameter). The lesions showed marked flattening by 15 January. Since then the lesions have remained stationary.—I am, etc.,

B. S. VERMA.

Department of Skin & V.D.,
Medical College,
Baroda.

Penile Pain in Rabies

SIR,—With reference to penile pain in rabies (Dr. J. E. Bramley and others, 9 October, p. 880) a case was reported by Dr. Sharma in which painful erection of the penis was the presenting symptom of rabies in a patient bitten by a dog.[1] This patient had received 14 injections of antirabic vaccine about seven days after the bite. It is noteworthy that the classical symptom of hydrophobia set in about 24–36 hours after the onset of priapism. Since rabies is not infrequently encountered in India it is useful to bear in mind that the disease may occasionally present itself in this unusual manner.

Another aspect of rabies which deserves comment is the possibility of this disease following the bite of presumably healthy dogs. I know of at least one case of rabies in which the patient was bitten by a presumably healthy dog known to be alive and well several weeks after the incident occurred. The observations of Yurkovsky also seem to indicate that healthy dogs may occasionally act as carriers and transmitters of the disease.[2] It would therefore appear that the risk of infection is not limited to contact with a clinically rabid animal or one which develops rabies within 14 days of biting.—I am, etc.,

S. J. PATEL.

St. Martha's Hospital,
Bangalore 2,
India.

REFERENCES

1 Sharma, N. K., *Antiseptic*, 1965, **63**, 594.
2 Yurkovsky, A. M., cited in *Trop. Dis. Bull.*, 1962, **59**, 776.

Prolonged Latent Period with Plasmodium falciparum Infections

SIR,—The incidence of *Plasmodium falciparum* infections with a prolonged latent period is of interest from immunologic and diagnostic points of view. The present communication reports a case which remained quiescent for at least 17 months.

Mrs. A. B., aged 27 years, mother of two children, came to the United Kingdom in November 1963 from Eastern Nigeria. She was first seen at the Medical Unit, Hospital for Tropical Diseases, London, in August 1964, and was then found to be infected with *Entamoeba histolytica* and *Acanthocheilonema perstans*, both of which were treated. Neither then nor on subsequent follow-up did she admit to having pyrexia. In October 1964 she became pregnant again, and thereafter also attended the University College Hospital antenatal clinic. She was admitted to their obstetric unit on 8 March 1965 complaining of fever of two days' duration, was found to have malarial parasites in her blood, and was transferred to our care on 12 March 1965. She was then 22 weeks pregnant.

On admission she complained of having had attacks of fever, each lasting two to four hours, daily for the previous six days. These were accompanied by shivering and sweating. On examination she was afebrile but anaemic, and had a soft tender liver palpable 1 cm. below the costal margin and a firm tender spleen palpable 5 cm. below the costal margin. The uterus could be felt to 1 cm. below the umbilicus. A blood film showed scanty *P. falciparum* parasites. She had a haemoglobin level of 9.3 g./100 ml. She was treated with a standard course of chloroquine, made an uneventful recovery, and has since been well, though there has not been any diminution in the size of the liver or the spleen.

This case is of considerable diagnostic importance in underlining the fact that *P. falciparum* may give rise to fever a considerable period of time after a person has been removed from a malarious zone. It emphasizes the need to consider malaria as a possible cause of fever in a patient coming to Britain from an endemic area, even though he or she may have been in the country for several months when the illness commences. It also raised some immunological questions. Walters[1] reported a patient in whom *P.*

falciparum parasites were found in the blood after 19 months' stay away from a malarious zone. It is interesting to note that the patient in Walters's report was also five months pregnant. McGregor and Smith[2] found that primigravidae seemed to lose immunity against *P. falciparum*, and Bruce-Chwatt[3] observed an increased parasite density during parturition. These two cases tend to support the suggestion that pregnancy might predispose to clinical recrudescence of *P. falciparum* malaria. In view of the complications associated with this infection great vigilance in detecting and treating it during the antenatal period is necessary.

I wish to thank Professor A. W. Woodruff for permission to publish this report.

—I am, etc.,

A. MAHMOOD.

Hospital for Tropical Diseases,
London N.W.1.

REFERENCES

1 Walters, J., *Brit. med. J.*, 1960, **1**, 1206.
2 McGregor, I. A., and Smith, D. A., *Trans. Roy. Soc. trop. Med. Hyg.*, 1952, **46**, 403.
3 Bruce-Chwatt, L. J., *Ann. trop. Med. Parasit.*, 1952, **46**, 173.

Trusses for Femoral Hernia

SIR,—On two occasions in the last few years I have written to the Ministry of Health protesting at the inclusion of trusses for femoral hernia in the list of approved appliances. On the last occasion I received a reply saying that these appliances were retained at the express wish of a B.M.A. Sub-committee. A letter from the B.M.A. merely confirmed this.

Comment on this stupidity should be superfluous, but this useless and dangerous appliance has again been listed in the latest Ministry of Health standard list of appliances 1966.

Femoral hernia is still the worst diagnosed, and therefore the worst treated, of ailments whose nature has been known to medicine for over 150 years. When diagnosed, the treatment is operative in all but a few percentage of patients whose general condition is too poor. There is no place for treatment by a truss, which cannot keep the hernia reduced. To order such a truss is to indulge in a dangerous pretence, which amounts in my view to malpractice.

I hope the B.M.A. will at once and for ever dissociate itself from this appliance.—I am, etc.,

Birmingham 15. F. WELSH.

Jet Injection in Dermatology

SIR,—The Porton needleless injector described by Drs. E. J. Moynahan and A. Bowyer (25 December, p. 1541) appears to be a great improvement on "hand-cocked" instruments such as the Dermojet.

Dermojets have been in routine use in this department since November 1964. Needleless injections have been of particular value for local anaesthesia and for intralesional treatment with triamcinolone of the conditions listed by Moynahan and Bowyer. I have found the Dermojet of especial value in the treatment of acne cysts, which can be drained and injected with triamcinolone in one painless operation.

The main defect of the Dermojet has been mechanical unreliability of the "cocking" mechanism. Drs. Moynahan and Bowyer are to be congratulated on introducing a superior instrument and one which should be of great value in dermatology.—I am, etc.,

E. M. DONALDSON.

North Staffordshire Hospital Centre,
Stoke-on-Trent.

Consultant Appointments and Medical Representation

SIR,—Dr. A. L. Wingfield (5 February, p. 354) refers to the composition of advisory appointments committees in relation to the appointment of consultants in more than one group of hospitals. While it is true that the group with the larger share normally sends the medical representative, it is possible for two groups to be represented medically. Two of the professional representatives on the committee are nominated by the regional board, and it is in their hands to choose any one they feel suitable to make up a balanced selection committee. It has been the practice in this board for some time for one of our board's representatives to be nominated after consultation with the hospital group which is not sending the official medical representative. By this means both groups are legitimately given voting rights in the selection of consultants.—I am, etc.,

G. C. TAYLOR,
Senior Administrative
Medical Officer.
South-west Metropolitan Regional
Hospital Board,
London W.2.

SIR,—The remedy for Dr. A. L. Wingfield's difficulties regarding consultant staffing is simple (5 February, p. 354). It is for the Joint Consultants Committee to pursue with greater effort than they have hitherto shown the implementation of that part of the Platt report on hospital medical staffing which stresses the need for more consultants. The natural corollary to this is that a consultant should be appointed to only one hospital, and that a firm limit be placed on travelling between hospitals. It is still far too common to find one consultant serving two or more hospitals with anything up to 30 miles between them, and as a result spending more time on the road than in the hospitals concerned.

Too much lip service is being paid to these matters, and much of the effort in solving them is just as half-hearted. As a consequence, it would almost seem that tacit encouragement is being given to those many young and not so young medical graduates who are ready and willing to serve one hospital, if given the chance to do so, to leave the country taking their problems and disappointments with them.

To say that the resultant increase in the cost of consultant staffing is not primarily a medical concern is to risk being accused of irresponsibility. Nevertheless, the sooner our official and unofficial representatives remember that it is the State which pays and employs us; that it is equally well able to bear the consequences of its apparent generosity (namely, the recent prescription charges); and that the National Health Service in one form or another is here to stay—unlike some of our negotiators—the sooner will consultants adopt a more realistic and aggressive attitude to what is happening around them than hitherto.

As far as hospitals are concerned, the nineteenth century has come and gone. *Plus ça change, plus ce n'est pas la même chose.*

Facing up to facts is often unpleasant, it is never unrewarding.—I am, etc.,

Romford, Essex. I. M. LIBRACH.

Postgraduate Training Posts for Overseas Doctors

SIR,—Much is said and written to-day about the part that hospitals in England have to play in postgraduate medical education, with particular reference to overseas graduates.

For some time I have had the feeling that our facilities were being used not only for postgraduate education but for the overseas graduates' own personal benefits, rather than the benefit which might accrue to medical practice as a whole in their countries.

I recently advertised for a registrar in radiology, and my worst fears on the subject were confirmed when I received an application from the head of a department of radiology in India, whose purpose in seeking a training post was expressed in the following words: "A post in England would help me surmount the rigid foreign exchange restrictions imposed by the Reserve Bank of India."

Training posts are intended to provide postgraduate education, and should not be used by established foreign doctors as a source of income while in this country, whatever the difficulties may be in the exchange control of their home country. I feel that we should be guilty of a misdemeanour if we give such people training posts, and I also feel that perhaps the time has come to examine a little more closely our whole attitude towards postgraduate education of some of our overseas graduates if this is their aim and object.—I am, etc.,

General Hospital, W. M. C. ALLEN.
Altrincham.

Young Doctors' Careers

SIR,—Dr. Stephen Whittaker (11 December, p. 1435) states that the average age at appointment for a consultant in the Birmingham Region is 35.6 years, and that increments of salary are awarded to those who have spent two years on National Service.

He hopes that this will give encouragement to young doctors on the consultant ladder, but we feel it is hardly likely to do so in the Western Region of Scotland.

Our ages ranged from 39 to 42 years on appointment as consultant, and we had spent over two years on National Service. We have not succeeded in obtaining any increments from the Western Regional Hospital