Cirrhosis and Dupuytren's Contracture

SIR,—I have read with interest Dr. A. E. Read's article on cirrhosis of the liver (17 February, p. 427) and note that in his brief survey of physical signs he makes no mention of the associated finding of Dupuytren's contracture.

This association, though very real, has to a large extent been neglected in British literature. I am in fact at the moment preparing an annotation on the subject. In the United States more attention seems to have been paid to it, and according to Wolfe *et al.*¹ was present in 66% of male alcoholic patients with cirrhosis. In Nazari's series² a similar association was found in 55% of patients with alcoholic (Laennec's) cirrhosis.

If these findings are truly representative then I feel that the association between palmar contracture and hepatic cirrhosis deserves much wider recognition than it is at present granted.—I am, etc.,

London W.1.

HARALD M. LIPMAN.

REFERENCES

- ¹ Wolfe, S. J., Summerskill, W. H. J., and Davidson, C. S., *New Engl. J. Med.*, 1956, 255, 559.
- ² Nazari, B., *J. Mt Sinai Hosp.*, 1966, 33, 69.

General-practitioner Obstetrics

SIR,—I was interested in Dr. A. P. Millar's letter about general-practitioner obstetrics (17 February, p. 446). I agree there are many advantages in general-practitioner maternity units, not the least of which (as Dr. Millar points out) is continuity of care. However, there are disadvantages when the "normal" becomes abnormal.

Salford has not had a general-practitioner maternity unit for many years. We have recently built a maternity hospital of 104 beds, and in order to try to obtain the best of both worlds we built a four-bedded general-practitioner delivery unit attached to the hospital. In this unit mothers are under the sole care of their general practitioners and domiciliary midwives, and return home within hours of delivery accompanied by the midwife. I note that in Dr. Millar's maternity unit, which is divorced (geographically) from the specialist hospital, there were two stillbirths from prolapse of the cord—a condition with a high foetal mortality. Recently we had a prolapse of the cord in our general-practitioner unit. The patient was immediately transferred to the theatre in the main maternity hospital (a distance of 30 yd. (27 m.)), and a live baby was delivered by caesarean section 35 minutes after the diagnosis was made. The general practitioner assisted at the operation. We have repeatedly found that this unit not only increases the safety of the mother and baby but also helps to bridge the gap between the three divisions of the maternity service.

During 1967 297 mothers were admitted to this unit in labour. Fifteen were transferred to the main unit before delivery because of complications (delay in labour, foetal distress, prolapsed cord). Five patients were transferred to the maternity hospital after delivery because of postpartum haemorrhage: 80% of the mothers delivered within six hours of admission and 96% were discharged within 12 hours of delivery. There were no stillbirths or neonatal deaths.

A follow-up survey of patients delivered in the unit is being carried out and the report will be available at a later date. However, first results show great satisfaction from all the users of the unit—the general practitioners, the domiciliary midwives, and last but not least the mothers and their relatives.—I am, etc.,

Hope Hospital,
Salford.

E. E. RAWLINGS.

Addiction to Isoprenaline?

SIR,—I was most interested to read the observations on the recent increase in the mortality from asthma by Dr. F. E. Speizer and others (10 February, p. 335). In our practice of about 8,000 patients we have over the last few years had one death and several frights from patients who use isoprenaline aerosols. Since we received the warning from the Dunlop Committee we have all been especially careful about prescribing these preparations, and all the doctors in the practice have gone to considerable pains to warn patients about the hazards of excessive dosage. In certain individuals this appears to make no difference, and after a week or a fortnight the patients come back for a refill of 400 doses. These people are so extremely distressed if their request is refused that I get the impression that they are addicts who panic if they feel the drug on which they depend is about to be withdrawn. It seems hardly likely that the inert gas causes addiction, so presumably it must be the isoprenaline. I would like to know what are the experiences and feeling of other doctors towards this problem.—I am, etc.,

Ibstock,
Leicester.

C. A. H. WATTS.

Geriatric Problems

SIR,—I agree with Dr. W. Fine (24 February, p. 507) on the need to ensure that the right patient should be in the right bed at the right time. Often, however, the problem is one of urgently securing a bed for an acutely ill elderly patient when there is no vacant bed in the geriatric department and when the general medical units are reluctant to admit so-called "geriatric" cases.—I am, etc.,

Bolton District General Hospital,
Farnworth, Nr. Bolton.

R. TEPPER.

vacancy can be found. One can understand that there is a great shortage of beds in both the welfare and hospital services, but it will be a long time before we can achieve the ideal in this field. Therefore a rationalization of the use of available resources must be achieved.

The people who eventually enter a welfare home, either from hospital or from the community outside, need an extension of the geriatric expertise from the hospital to keep this frail ambulant group of people from becoming bedfast and hospital cases. Similarly, people in the community who are waiting for a welfare home need continuous supervision as well as intermittent admission to welfare accommodation to prevent them from breaking down and needing hospital accommodation. Clearly it is essential that beds for residential accommodation be used to the maximum potential. Because of the nature of the frail ambulant person (people whose condition varies from week to week) there needs to be a close and direct link between geriatric units and welfare homes. The need is to depart from the "custodial care" practice to providing care more quickly as and when required. Needless to say, some geriatric units practise day hospital care and intermittent admission for suitable cases.

The following gives another example of the lack of co-ordination that exists owing to an unfortunate division of authority, and shows the difference in approach. During the "red alert" and clearly a time of almost "national crisis," and when the hospital service stands up and takes on practically all comers, clearly the sense of urgency should extend to the welfare services, who could then as a matter of priority clear hospital beds of welfare cases to enable the service to pay more attention to the ill and the sick.

Not unless this comes about can the Minister of Health's recent plea for cutting down on the length of hospitalization of patients be effective in any way.—We are, etc.,

M. S. KATARIA.
D. B. RAO.

King's College Hospital
Geriatric Unit,
St. Frances's Hospital,
London S.E.22.

Chlorpromazine in Dystonic Reactions

SIR,—In view of recent correspondence (10 February, p. 381) on the therapy of dystonic reactions, I would like to record my own observations on the use of chlorpromazine in this situation. In Today's Drugs (17 February, p. 431) the suggestion is made that metoclopramide (Maxolon) should not be used with phenothiazines. Case 3, below, records a severe dystonic reaction to this drug alone.

Conventional therapy for dystonic reactions is parenteral benzotropine methanesulphonate (Cogentin).¹ This is rational in those cases showing Parkinsonian features, and it is notable that these reactions are usually dose-dependent and most often due to diethylamino phenothiazines. The dystonic reactions usually occur in young people after only one or two doses of the causal agent. In the case of phenothiazines this is invariably a propylpiperazine. The rationale for using an anti-Parkinsonian agent is less clear.

Case 1.—A girl aged 20 developed facial twitching and sustained oculogyric crises after perphenazine 5 mg. In view of the known value of chlorpromazine in post-encephalitic oculogyric crises this drug was given empirically. Within minutes of receiving an intramuscular injection of chlorpromazine 25 mg. the oculogyric crisis and the muscle twitching ceased.

Case 2.—A woman aged 38 developed her second dystonic reaction to trifluoperazine, approximately 5 mg. in dosage. The first reaction five years previously was diagnosed as hysteria. She showed facial twitching, trismus, and torticollis. The reaction steadily worsened over eight hours, but within 10 minutes of intramuscular injection of chlorpromazine 25 mg. ceased entirely and did not recur.

Case 3.—A girl aged 21 developed jerking of the limbs, twitching of the facial muscles, and retrocolic movements of the head. This followed 90 mg. of metoclopramide (Maxolon). Benztropine methanesulphonate 10 mg. was given intramuscularly with no effect over a two-hour period of observation. Chlorpromazine 25 mg. was given by intramuscular injection, and within minutes the reaction virtually ceased. In this case the movements recurred every three hours and over the next 48 hours this quick and predictable response to chlorpromazine was repeatedly confirmed, until the reaction finally ceased.

The apparent paradox of using a phenothiazine to suppress a phenothiazine reaction requires further discussion. The most attractive hypothesis is that of competitive inhibition between the different groups of phenothiazines. The structural similarity of the side chains, particularly those of diclopramide and chlorpromazine, is notable. This suggests the locus of the propensity to produce dystonia may lie in the side chain itself, as the tricyclic nucleus of phenothiazines is quite unlike the single ring of metoclopramide. Whatever the mode of action, this does appear to be a very rapid and reliable way of treating dystonic reactions of non-Parkinsonian type and I hope it may prove of value to others faced with these very distressing reactions.—I am, etc.,

London S.W.4.

J. P. PATTEN.

REFERENCE

- ¹ Ayd, F. J., *J. Amer. med. Ass.*, 1961, **175**, 1054.

Elastic Band Injuries

SIR,—The interest in this subject has been rewarding.

Dr. F. W. Webb's case (27 January, p. 250) of the elastic band round the child's neck must surely involve some problem of family interrelationship. One wonders if reassessment is needed to prevent any further accidents, particularly in view of the comment that it seemed odd that the mother hadn't noticed.

The picture accompanying Dr. G. Glew's letter (25 November, p. 488) shows an elastic band injury in its early stages. His division of the cases into "deliberate artifacts and accidental production" might hide those cases where the psychology of errors is operative. This would prevent the doctor making the patient aware of the true nature of the disorder, which is important for fundamental cure to take place. Perhaps the spectrum is from the malingerer who can be made to own up, the artifact case who denies knowledge, the patient under tension who forgets with subconscious motivation, and, finally,

someone who just loses a rubber band, if this is possible.—I am, etc.,

Beaumont Hospital,
Lancaster.

R. H. SEVILLE.

Unusual Case of Anaemia

SIR,—Dr. Sheila T. Callender's recent article on occult bleeding from the gastrointestinal tract (13 January, p. 101) prompts me to report an unusual case of iron-deficiency anaemia seen at Guy's Hospital last year.

The patient, a white English girl aged 23, attended the family planning centre prior to getting married and was observed to be anaemic, her haemoglobin being 5.6 g./100 ml. She was referred to Dr. W. N. Mann, who arranged for her admission under his care. On admission she was symptom-free, the only abnormal physical signs were pallor and gross koilonychia. Her diet had been normal and her menstrual loss not excessive. Relevant investigations were as follows: Haemoglobin 4.6 g./100 ml., haematocrit 19%, M.C.H.C. 24%, W.B.C. 4,500, with a normal differential. The film showed marked microcytosis and hypochromia. Plasma iron 15 µg./100 ml. Plasma iron-binding capacity 480 µg./100 ml. Serum vitamin B₁₂ 370 µg./100 ml. Haemoglobin electrophoresis normal. The barium meal was normal. Gastric acidity normal. Examination of the stools for occult blood,

ova, and cysts was negative. Bone marrow examination showed normoblastic erythroid hyperplasia and absent marrow iron stores.

The cause of her gross iron deficiency was most obscure. However, after five days in the ward the patient confessed to a strange habit. For five years she had been eating (not sucking) the contents of the ice box of a refrigerator, about 18 ice cubes, during and after each meal, and if she could obtain ice between meals she would eat it at any time it was available. What effect this habit could have upon her iron absorption or gastrointestinal blood loss we were unable to investigate, as the patient left hospital nine days after admission in order to get married. She stopped eating ice, and was given iron supplements, and two months after admission her haemoglobin had risen to 11.8 g./100 ml.

Subsequent questioning of students revealed that occasional ice eating was not at all uncommon, although none of them did it to the same extent as the patient. It seemed that the habit was not unusual and perhaps might be worth inquiring about in cases of obscure iron deficiency.

I am grateful to Dr. W. N. Mann for allowing me to report this case.

—I am, etc.,

I. G. MCGILL.

Guy's Hospital,
London S.E.1.

Unusual Complication of Oesophageal Reflux

SIR,—Hiatus hernia and oesophageal reflux in the early months of life are frequently treated conservatively and by nursing in an upright position. For some years the joiners' shops in children's hospitals have provided effective though bulky

with a full "Saturday night palsy" with wrist drop and paralysis of the triceps. The photograph shows how the child lay with his flail partially paralysed arm and indicates how easily in a child of this size continuous pressure can be maintained on the radial

"chalasia" boxes, but during the past few years many people have chosen to use a commercially available plastic carrying chair which is much lighter to handle and more attractive.

A recent experience with a child who had been nursed in one of these chairs has drawn attention to a particular risk as the child gets older and larger. This child was found

nerve, either in the musculo-spiral groove, or even higher up in the axilla as in a crutch injury.

Spontaneous recovery occurred within three days after the lesion had been appreciated and the pressure avoided.—I am, etc.,

JAMES LISTER.

Children's Hospital,
Sheffield, Yorks.