Tuberculosis in Immigrants

SIR,—Your leading article (30 January, p. 247) on "New-style Cold Abscesses" is valuable in drawing attention to two recent papers in the *British Journal of Surgery*^{1 2} which describe a clinical manifestation of tuberculosis relatively much more common in the immigrant section of our population. These subcutaneous cold abscesses, which are quite often multiple, are a form of tuberculous disease well recognized in many developing countries. But one cannot allow the statement with which the leading article begins to go unchallenged. It is simply not true that "most tuberculosis seen in Britain today is in the immigrant population," though it is possible that most of the tuberculosis seen by the surgeons in Bradford and Birmingham, who wrote the two articles in question, is in immigrants.

A survey carried out by the British Tuberculosis Association in 1965 showed that an undue proportion (actually 16.5%) of all tuberculosis occurred in immigrants, mainly those from Commonwealth countries of Asia.³ The survey is being repeated this year. There has been only a modest influx of immigrants since 1965. Experience in Bradford and other cities shows that immigrants continue to experience a relatively high incidence of tuberculous disease for several years after coming to this country.⁴ So there may be rather more cases in immigrants in 1971 than in 1965. At the same time, cases of tuberculosis in the indigenous population have been declining by about 10% per annum,⁵ so there will be considerably fewer cases in this group. Nevertheless, one can confidently predict that in 1971 there will be at least twice as many cases of tuberculosis in the indigenous British population as in the immigrant population.—I am, etc.,

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¹ Shaw, N. M., and Basu, A. K., *British Journal of Surgery*, 1970, 57, 418.

² Ward, A. S., *British Journal of Surgery*, in press.

³ British Tuberculosis Association, *Tubercle*, 1966, 47, 145.

⁴ Aspin, J., *British Medical Journal*, 1962, 1, 1386.

⁵ Department of Health and Social Security, *Annual Report of the Chief Medical Officer for 1969*, London, H.M.S.O., 1970.

Gynaecologists' Views on Amphetamines

SIR,—In his article on dysmenorrhoea (6 February, p. 329) Dr. V. R. Tindall rightly draws attention to the desirability of avoiding the use of amphetamine-containing substances in the treatment of this condition, giving alternative preparations of value.

I am therefore particularly concerned at the recommendation of Professor Philip Rhodes¹ for the use of Drinamyl (dexamphetamine plus amylobarbitone) and Edrisal (acetylsalicylic acid plus phenacetin plus amphetamine) in dysmenorrhoea with the express intention of producing an elevated mood by reason of their amphetamine content. It is now widely agreed that virtually the only condition for which amphetamine might be considered of value is narcolepsy, and its use as a pep pill is universally condemned.

It is disturbing enough that Professor

Rhodes should recommend Edrisal for its mood elevating qualities, but positively alarming that he should advocate the prescription of "purple hearts" for anything.

Might I express the hope that both he and other gynaecologists will search their consciences to see whether they cannot in good faith now join the large band of qualified men who are operating a voluntary ban on these substances?—I am, etc.,

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¹ Rhodes, P., *Update*, 1970, 2, 1501.

Antidiuretic and Hypoglycaemic Activity

SIR,—Vasopressin, chlorpropamide, paracetamol, and aminopyrine have a number of structural features in common, which might explain why these drugs may all have antidiuretic activity.¹ The common features are a phenyl group, usually *para*-substituted, associated with an amide or amide-like group terminated by a relatively hydrophobic group. Vasopressin includes the sequence tyrosine-phenylalanine (Fig. 1).

Folate Deficiency and the Pill

SIR,—Attention has been drawn recently to the development of folate deficient megaloblastic anaemia in women on oral contraceptive therapy.¹ No biochemical or radiological evidence of malabsorption was obtained in these patients, but the results of small intestinal biopsies were not reported. We have recently had the opportunity of studying a patient who developed a severe folate deficient anaemia while on oral contraceptives, in whom initially there were small intestinal changes which reverted towards normality on stopping oral contraceptives and giving folic acid supplements.

A 21-year-old housewife, who had had two previously normal pregnancies, presented two years ago with a severe anaemia. Her diet had been satisfactory and she has never

Antidiuretic activity tends to be preserved if the tyrosyl hydroxyl group is modified.² The calculated lowest energy conformations of vasopressin³ show this sequence exposed and available for interaction with receptor sites. Of the other drugs, the common features are most easily seen in the structure of chlorpropamide (Fig. 2), but they can

also be discerned in the structures of paracetamol and aminopyrine. Metformin has none of these structural features. It is a strongly basic derivative of guanidine, and might interact with a receptor site specific for the arginyl residue of vasopressin, which is essential for the antidiuretic activity of the hormone.²

If this structural analysis is correct, then chlorpropamide and metformin should show synergism with respect to both antidiuretic and hypoglycaemic activity.—I am, etc.,

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¹ *British Medical Journal*, 1971, 1, 302.

² Schröder, E., and Lübke, K., "The Peptides," vol. 2, p. 365. New York, Academic Press, 1966.

³ Gibson, K. D., and Scheraga, H. A., *Proceedings of the National Academy of Sciences of the United States of America*, 1967, 58, 1317.