

Contact Sensitivity to Toothpaste

SIR,—I wish to report three cases of acute contact sensitivity to a new toothpaste (Close-Up). Each of these patients changed from their regular toothpaste after receiving a free sample of Close-Up through the post.

Case 1.—A 30-year-old woman gave a two-month history of a sore mouth with swelling and cracking of the lips. Two weeks before this developed she changed her toothpaste to Close-Up and used it once or twice a day. She showed fissuring of the lips with desquamation and oedema of the surrounding skin.

Case 2.—A 36-year-old man developed a weeping eruption at the right side of the mouth with sore gums. He had used Close-Up once a day for three months. There was a right-sided angular cheilitis with swollen gums and desquamation of the tip of the tongue.

Case 3.—A 22-year-old woman used Close-Up three times a day for a week. On the sixth day she developed painful ulcers on the inside of her mouth, particularly inside the lower lip.

In each case signs and symptoms settled within one week of stopping the use of the new toothpaste.

Close-Up contains a sorbitol-glycerin mix as humectant, with refined silica as the abrasive. The main flavouring agents are cinnamon and menthol, with two "permitted" dyes as colorants. Patch tests were performed with these substances and in all cases there was a positive reaction to 0.5% cinnamon oil in petrolatum.

Allergic stomatitis caused by the flavouring agents in toothpaste has been reported before, including cases due to menthol¹ and cinnamon.² Cinnamon oil is widely used as a flavouring agent and preservative in foods, and its use by bakers and confectioners has led to numerous reports of acute contact sensitivity.^{3,4} The clinical picture of gingivostomatitis in each case was variable. Case 1 resembled perioral dermatitis and case 2 a unilateral angular cheilitis, while case 3 had marked ulceration of the mucous membranes without external involvement of the lips.

Attention was drawn towards the probable common aetiology in these cases because all three patients were seen within a short time during which this toothpaste was being extensively advertised and given away as free samples in this area.—I am, etc.,

L. G. MILLARD

Hallamshire Hospital,
Sheffield

¹ Papa, C., and Shelley, W. B., *Journal of the American Medical Association*, 1964, 189, 546.

² Laubach, J., Malkinson, F. D., and Ringrose, E. J., *Journal of the American Medical Association*, 1953, 152, 404.

³ Hjorth, N., *Eczematous Allergies to Balsams, Allied Perfumes and Flavouring Agents*. Copenhagen, Munksgaard, 1961.

⁴ Kern, A. B., *Archives of Dermatology*, 1960, 81, 599.

Constraints on Consultants

SIR,—Concerning your leading article "Constraints on Consultants" (3 March, p. 501), I would like to correct two impressions conveyed through your comments on the report of the professional investigation at this hospital. Firstly, neither I nor my team have ever, either in theory or practice, been at all interested in using behaviour conditioning techniques. Secondly, I do not believe that family relationships cause schizophrasia.

I welcome the opportunity of using the *B.M.J.* to say this because I have, in the

past, found that what a newspaper has written has been attributed to one of my own publications.—I am, etc.,

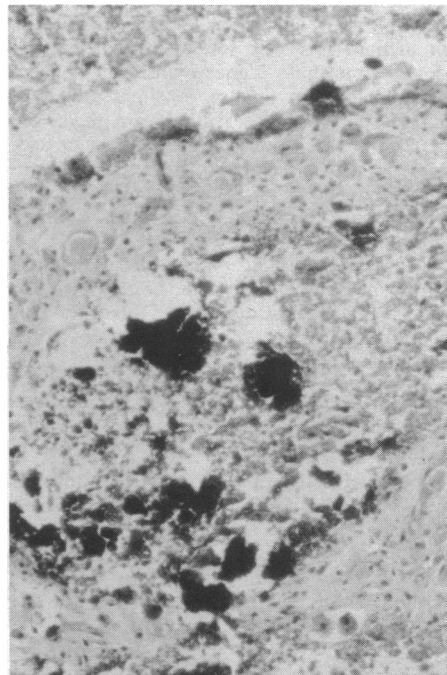
R. D. SCOTT

Napsbury Hospital,
Near St. Albans, Herts

Tumoral Calcinosis in Britain

SIR,—Dr. G. Slavin and others (20 January, p. 147), describing the occurrence of tumoral calcinosis in two immigrants, state that this is a rare condition as yet unreported among the white population of Britain. In view of this it seemed worth while to record three examples of tumoral calcinosis which have been seen at our hospitals during the past few months.

Case 1.—A 48-year-old white man with chronic renal failure was treated by intermittent haemodialysis at Withington Hospital for three years before a renal transplantation was carried out in September 1972. At that time he was observed to have a mass on the medial side of the right ankle. This grew rapidly and when excised two months later formed an encapsulated tumour 5.5 cm in maximum dimension. Histological examination of the specimen showed bands of fibrous tissue separating spaces containing calcified granular material. The fibrous trabeculae contained numerous multinucleated giant cells as well as large polygonal cells each with a single nucleus (see fig.).



Fibrous trabeculae containing giant cells surrounding basophilic granular material. (Haematoxylin and eosin $\times 120$.)

Case 2.—A 29-year-old white man was found to have chronic renal failure in 1967 and since then had been on intermittent haemodialysis at Withington Hospital. A hard mass in the left buttock was first noticed in 1971 and had increased only a little in size when it was excised 12 months later. At operation the tumour was made up of many small nodules which were mainly in the subcutaneous tissue. Histological sections of the nodules showed a structure very similar to the tumour described above.

Case 3.—A 16-year-old white male presented with a solitary tumour in the midline overlying the sacrum in December 1972. Clinical examination did not reveal any other abnormalities but biochemical examination of the blood has not

yet been carried out. When the tumour was excised and examined at Altrincham General Hospital its structure was found to be the same as that of the two other cases.

The histological structure of all three tumours is that of tumoral calcinosis. It would appear that this condition is by no means the white population of Britain. In the patients had biochemical abnormalities associated with chronic renal failure, including raised levels of serum phosphorous and alkaline phosphatase. The occurrence of these tumours in chronic renal failure raises the question as to whether they represent merely a special type of metastatic calcification. With this in mind it should be noted that raised serum phosphorous levels have been reported in a number of other patients with tumoral calcinosis.¹ It is hoped to discuss these points fully in a detailed report later.—We are, etc.,

K. S. VASUDEV
E. TAPP
M. HARRIS

Withington Hospital,
Manchester

R. C. JENNINGS

Altrincham General Hospital,
Cheshire

¹ Lafferty, F. W., Reynolds, E. S., and Pearson, O. H., *American Journal of Medicine*, 1963, 38, 105.

Drop Attacks in Women

SIR,—Dr. D. L. Stevens and Professor W. B. Matthews (24 February, p. 439) have said little about another factor peculiar to women and which may well be related to the greater tendency some of them have to fall. This is in the postural activity of the three joints surrounding the centre of gravity—the lumbosacral and the hip joints.

The female hip tends to lack the degree of extension possible in males. When this deficiency is great, relative lordosis may result. Thus the centre of gravity (within the pelvis) will not be well poised above the centre of the hip joints. To the extent that it is placed anteriorly, so insecurity is favoured. In women, when walking, this may also be aggravated by the increased loading of the hip due to the relatively increased leverage of the wider pelvis. The authors would do well to make a comparative study of these aspects.—I am, etc.,

NORMAN CAPENER

Exeter

SIR,—Dr. D. L. Stevens and Professor W. B. Matthews (24 February, p. 439) describe in detail their examination of people who have had cryptogenic drop attacks. Sometimes careful medical techniques prevent us from looking at information in a more usual context. For example, we are told that these attacks occur in middle-aged women. We know that these women are experiencing body changes so that conception will no longer be possible. Many women talk of "falling for a baby," and we hear about "the fall of Eve." Then again, women talk about "falling in love." It is interesting, too, that some of these women did not complain to their doctor, as if they experienced these drop attacks as an inevitable event like the autumn fall.

To fall is to lose control, and if a woman