

cells per high-power field) and there was a heavy cloud of albumin with many hyaline and granular casts. The specific gravity was 1035. When admitted to hospital four months before, the urine had shown a faint trace of albumin and 40 red cells per field. At that time these findings were attributed to the large amount of streptomycin and P.A.S. he had received previously, as a thorough renal tract investigation revealed no other cause. The bleeding time (3 minutes 25 seconds), clotting time (6 minutes), platelets (400,000 per c.mm.), prothrombin time (17 seconds, control 16.2 seconds), leucocytes 12,000 (polymorphs 66%, lymphocytes 28%, eosinophils 1%, mononuclears 5%), and blood urea (33 mg.%) were all within expected limits. The stools remained negative for occult blood.

Isoniazid was now discontinued, with improvement in the skin and joint lesions. On being given isoniazid, 50 mg., on three successive days, after an interval of 10 days during which he remained on streptomycin and P.A.S., he had a recrudescence of the previous symptoms and signs.

All chemotherapy was then omitted. The joints returned to normal, but the rash varied in intensity from day to day before eventually clearing except for a small area along the left forearm. Three weeks later the isoniazid was again exhibited. Two 50-mg. tablets were given at a 12-hourly interval. This was followed at once by an acute flare-up of the symptoms, which subsided when the drug was stopped except for the rash, which has continued to wax and wane. There was no appreciable change in the number of platelets during the second and third episodes.

Two courses of streptomycin and an 18-months course of P.A.S. had been given in the past without any untoward effect. It would therefore appear that this case of symptomatic purpura was directly due to a toxic effect of isoniazid not previously reported in this country.

I wish to thank Mr. Vernon C. Thompson for permission to publish this case.—I am, etc.,

London Chest Hospital, Arlesey, Beds.

D. M. COLLINS.

Isolation and Quarantine

SIR,—Dr. G. W. Ronaldson's letter (July 26, p. 227) requires an answer. I am content to receive all that Dr. Ronaldson has said about streptococcal and meningococcal infections, but I think we may be speaking of different conditions—he about discharge from hospital, I about letting discharged patients mix freely with all and sundry. "Absence of return cases" is, I admit, a good criterion of effectiveness of isolation, but those exposed at home are few, especially to-day. However, I am generally in agreement that I was over-cautious in Table III; this was really meant to be so, but I stated there were no hard-and-fast rules.

His comments on chicken-pox and scabbing include reference to F. H. Thomson (*Lancet*, 1916, 1, 341), and after reading this carefully I think Dr. Ronaldson has drawn unjustifiable conclusions. Thomson never said, "Each spot is infectious for three days only." What he did say is, "Although it is safe to treat chicken-pox at certain stages of the disease in this special ward with all its precautions against direct and indirect contact infection, it does not follow that it would be safe to treat it in a similar, or even scabbing stage, in an ordinary ward where no such precautions are taken." The stage he referred to was the third day of the poxes, and some patients at this stage infected those exposed, although they were kept in bed and often had in each bed on both sides a child protected by a previous attack. We still do not know how long a child is infectious with chicken-pox, and I still think that with good treatment in healthy individuals the scabs can be cured in 12-16 days

from the onset. If Dr. Ronaldson would suggest the time should be cut to six days whether scabs are present or not and that the small risk of spread be taken, I would agree, because I feel the sooner this trivial disease is over the better.

Lastly, let me say that Table II was condensed from another table, and that during this process some headings were most unfortunately altered. The full table is given at the foot of this page.

This shows that no quarantine was imposed, but all the 203 were under surveillance, and I hope Dr. Ronaldson will agree that this shows a good record for surveillance.—I am, etc.,

R. E. SMITH.

Rugby.

Death from Penicillin

SIR,—In the *Journal* of July 12 (p. 70) there is a report by Dr. W. O. Thomson of a case of sudden death following an injection of crystalline penicillin G. I have had a similar experience with a child aged 3½ years who died some three and a half hours after an intramuscular injection of procaine penicillin. He had had a similar injection the day before. Approximately one hour following the second injection he lost consciousness and became dyspnoeic; he died some two and a half hours later. Post-mortem examination showed a very few petechial haemorrhages on the surface of the lungs and brain and gross pulmonary emphysema. There was no history of previous asthma or other allergy, nor had there been any symptoms or signs of any pulmonary trouble previously.

I also had a patient who during the giving of an intramuscular injection of procaine penicillin became unconscious and had a convulsion; he soon recovered. The nurse who was giving the injection was quite certain that the needle was not in a vein, as she had made sure of this by attempting withdrawal of the piston of the syringe. In the *Journal* of February 10, 1951 (p. 299), Dr. T. V. Humphreys describes a case in which a few minutes after an injection of procaine penicillin the patient became apprehensive and dyspnoeic and had a swollen tongue, urticaria, and convulsions; this patient responded to "anthisan" and adrenaline administration. Dr. Thomson gave his patient adrenaline and nikethamide without effect. A. Yuval (*Lancet*, 1952, 1, 163) reports the case of a patient who within a few minutes of an intramuscular injection of procaine penicillin developed unconsciousness and stertorous breathing; the patient recovered. R. C. L. Batchelor and others (*Lancet*, 1951, 2, 195) mention a feeling of impending death in a patient following an injection of procaine penicillin. I also have had such a case.

In the *Journal* of June 2, 1951 (p. 1269) there is a report on a child who died some days after the application of penicillin ointment to burns. In this case there were oedema and collapse of the lungs and a pericardial effusion causing cardiac embarrassment. Some other fatalities from penicillin treatment have been reported in Swiss, French, and American publications.

We should be aware that these allergic or anaphylactic fatal reactions can follow treatment with procaine penicillin, or crystalline penicillin without procaine, and it would seem worth bearing in mind that giving anthisan and adrenaline, preferably intravenously, may in these very rare cases avert a fatality.—I am, etc.,

Warwick.

J. A. HARPMAN.

Results of Surveillance of 203 Boys Exposed to Infection (1933-47)

Disease to which Boy was Exposed	Measles	Mumps	Rubella	Pertussis	Chicken-pox	Scarlet Fever	Total
Total No. of boys exposed	42	52	28	22	32	27	203
Previous attack*	32	14	11	15	23	14	109
No previous attack	10	38	17	7	9	13	94
Quarantine usually advised (days) ..	16	30	21	21	21	10	4,224
Days lost if all quarantined	672	1,560	588	462	672	270	
Days lost if only those with no previous clinical attack* quarantined ..	160	1,140	357	147	189	130	2,123
No. of boys attacked	0	2	0	1	0	0	3

* Or Dick-negative.