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Intestinal Lipodystrophy

SIR,—Dr. S. F. Cahalane's comment (*Journal*, June 15, p. 1421) on your annotation (*Journal*, April 27, p. 998) on the diagnosis of Whipple's disease is very apt to a case with which I am concerned at the present time. In this patient, a young woman, a muscle-cell tumour had caused blockage of lacteals in the jejunal mesentery, and had produced an appearance in the jejunal mucosa and in lymph nodes which bears a striking resemblance to Whipple's lesions. In this case, biopsy of an abdominal node might have been misleading.—I am, etc.,

Worksop, Notts. G. A. DUNLOP.

Pseudomonas pyocyanea in Cetrimide

SIR,—Not only cetrimide but soap and chloroxylenol solutions and calamine lotion are liable to contamination with *Ps. pyocyanea* in bottles covered with corks. Mr. P. J. Keen (*Journal*, June 8, p. 1363) is undoubtedly right in thinking that the use of alternative forms of cover on bottles will reduce or eliminate the risk. It is well known that bacterial growth-promoting substances are present in cork.[1] Experimental evidence reported by us in 1951[2] suggested that *Ps. pyocyanea*, probably deposited by contaminated fingers, received protection and perhaps nourishment from cork stoppers; after the introduction of screw-cap bottles for storage and dispensing of the fluids mentioned above, *Ps. pyocyanea* was no longer found in any of them on repeated samplings, and *Ps. pyocyanea* infection of wounds became less frequent. Since that time (in 1953) an improved cetrimide which is more active against *Ps. pyocyanea* has been made available by the makers. In view of this, it is interesting that Dr. G. L. Robinson (*Journal*, May 25, p. 1242) should recently have found *Ps. pyocyanea* in cetrimide solutions as we did in solutions of the earlier product.—I am, etc.,

Birmingham, 15. E. J. L. LOWBURY.

REFERENCES

[1] Nelson, J. H., *J. Path. Bact.*, 1942, 54, 449.
[2] Lowbury, E. J. L., *Brit. J. industr. Med.*, 1951, 8, 22.

Rheumatoid Arthritis of Crico-arytenoid Joints

SIR,—The articles on rheumatoid arthritis of the crico-arytenoid joints by Dr. J. E. G. Pearson (*Journal*, May 4, p. 1047) and Dr. W. S. C. Copeman (*Journal*, June 15, p. 1398) and Drs. O. A. Baker and E. G. L. Bywaters (p. 1400) were of great interest to me. A further case is at present under treatment in the Royal Southern Hospital, Liverpool.

The patient, a tram driver aged 61, has suffered from rheumatoid arthritis for 18 years and is now severely crippled. His two brothers also suffer from rheumatoid arthritis, but neither has had any laryngeal involvement. The patient's left knee, left wrist, and right elbow are ankylosed and there is very little movement in the other knee or in the small joints of the hands and feet. The shoulders and the temporo-mandibular joints are affected to a lesser extent, while the hip-joints have largely escaped. There are several rheumatoid nodules over the elbows and sacrum. Successive courses of treatment with sodium aurothiomalate, phenylbutazone, salicylates, oral cortisone, and intra-articular hydrocortisone had all failed to halt the progress of the disease. During the twelve months prior to admission the only forms of treatment used were physiotherapy and calcium aspirin 10 gr. (0.65 g.) six-hourly. E.S.R. records are available for 1954 and 1955 and varied between 18 and 33 mm. (Wintrobe) until December, 1955, when the reading fell to 8 mm. At that time the Rose test was positive 1:128. Since then mild exacerbations of joint pain have recurred up to the present time and suggest that the disease is still active. At the time of writing the E.S.R. is 25 mm. and the Rose test is positive 1:256.

The patient had always been fond of singing and possessed a good voice. Three years ago his voice became croaky and made singing impossible. Three months before admission he experienced increasing difficulty in swallowing fibrous foods, such as grape skins, and towards the end of the period noticed a dry, slightly sore feeling in his throat and all swallowing became uncomfortable. On March 14 this year he developed a dry cough and slight dyspnoea which suddenly increased three days later with the onset of inspiratory crowing. He was admitted to hospital and within a few hours the stridor became severe and he was cyanosed. Examination of the chest and pharynx at this time did not reveal any abnormality. The patient was transferred to the Liverpool Ear, Nose, and Throat Hospital and an emergency tracheotomy was performed under local analgesia. Next day a direct inspection of the larynx under general anaesthesia showed that the vocal cords were apparently normal but were in a paramedian position with very little abduction. Since then there has been persistent bronchitis and a course of penicillin was required to control an acute exacerbation. Purulent discharge from the trachea and wound edges became excessive at one stage, but cleared up with a course of sulphadiazine. The outer tube is changed monthly and the inner tube is cleaned several times daily. There is no suggestion of stridor when the tube is corked, and the patient is able to converse freely although the croak persists. The symptomatology of this case corresponds with the majority of the previously reported cases. A period of minor alteration in the voice is followed successively by dysphagia, dyspnoea, and stridor.

It is notable that three out of the four cases reported in the *Journal* of June 15 had serious involvement of only one crico-arytenoid joint. One might expect that if only one joint is affected the chances of symptoms developing will be much reduced, and it may be that many cases remain undiscovered because of this. I suggest that sufferers from rheumatoid arthritis developing voice changes should have a laryngoscopy. It is possible that if a diagnosis could be made at an early stage and intensive treatment pursued tracheotomy might be avoided.

I am indebted to Dr. R. W. Brookfield for permission to describe this case.—I am, etc.,

Liverpool, 8. D. P. MANNING.

Prevention of Recurrences of Rheumatic Fever

SIR,—The fact mentioned by three of us (*Journal*, May 25, p. 1234) that penicillin V is a costlier oral prophylactic than penicillin G is mildly criticized by Mr. R. Levin (*Journal*, June 22, p. 1474) on the grounds that its higher cost is offset by the smaller doses necessary to achieve a given blood level. This is too ingenuous an argument. The virtue claimed for penicillin V lies in its superior efficiency, dose for dose, in the maintenance of an effective prophylactic level; to reduce the dose is to reduce the advantage. At present for rheumatic fever prophylaxis it is still cheaper to use penicillin G than to use penicillin V in a dose which retains comparative benefit.—We are, etc.,

E. G. L. BYWATERS. G. T. THOMAS.
KATHERINE HALLIDIE-SMITH. E. J. HOLBOROW.
Maidenhead.

Gardening Hazard

SIR,—The gardening gloves mentioned in Dr. E. M. Town-Jones's letter (*Journal*, June 29, p. 1532) had no doubt been impregnated with sodium chlorate used as a weed-killer. Being relatively non-poisonous it is commonly regarded as harmless. It is, however, so inflammatory that a solution splashed on gardening gloves, shoes, or the legs of one's Saturday afternoon trousers can become dangerous, and Dr. Town-Jones's letter is a useful reminder of this fact. Sodium chlorate is much used in the manufacture of fireworks.—I am, etc.,

London, S.E.18. T. C. SCOTT WEBB.

SIR,—The accident reported by Dr. E. M. Town-Jones (*Journal*, June 29, p. 1532) under this heading is probably more purely a gardening hazard than his letter suggests. Had the gloves worn by his patient been used previously when handling sodium chlorate as a weed-killer? This substance is usually used in solution, but when allowed to dry in contact with an organic material (such as leather or cloth) it becomes highly inflammable—even explosive.—I am, etc.,

Ballanard, I.O.M. B. B. HARRISON.