

diagnose this most easily resectable of all abdominal neoplasms before life is threatened by the advent of acute obstruction.—I am, etc.,

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REFERENCES

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- ² Savage, P. T., *Brit. J. Surg.*, 1960, 47, 643.
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SIR,—In assessing a patient with gastro-intestinal disturbance the present tendency to hasty reference for barium meal or enema examination is to be deprecated. Such action increases the already significant waiting-list for these procedures which are, moreover, increasingly expensive and time-consuming as techniques elaborate and improve. Furthermore, as Drs. A. N. Exton-Smith and G. Osborne indicate (June 24, p. 1799), the aged or frail patient may find the investigation an ordeal and occasionally, in the case of the barium enema examination, a peril. Nor can one disregard the recommendations of the Adrian Committee on reducing radiation dosage.

I agree with Drs. Exton-Smith and Osborne that tests for faecal occult blood give some guidance in the selection of cases for such examinations. Unfortunately they do not state which method they employ. The modern orthotoluidine tablet tests of the Ames Company (London) Ltd. are simple and inexpensive and their use makes for a rapid, efficient, and relatively inoffensive examination of the patient's faeces. They are therefore of particular value in the investigation of an iron deficiency anaemia which may be caused by gastro-intestinal bleeding.

In general practice such anaemias are often severe, and a search for occult blood loss will coincide with the administration of oral iron. As I previously indicated,¹ this is correct procedure with all preparations except ferrous fumarate tablets, which lead to the development of false-positive results in the faeces. Drs. T. D. S. Halliday and I. M. Cuthill substantiated this belief,² recorded the confusion which such misleading results had caused, and advised that published information on that preparation should carry a warning of this obstacle to its use. I have now appraised a newcomer to the field of iron therapy: a preparation of ferrous carbonate and ascorbic acid ("ferrodic"). This product also causes false-positive results for occult blood, *in vivo* and *in vitro*, with either the obsolescent benzidine test or the orthotoluidine tablet tests. In view of the experiences of Drs. Halliday and Cuthill, I feel that awareness of this fact may help to reduce the number of patients referred for barium examination.—I am, etc.,

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REFERENCES

- ¹ Illingworth, D. G., *Brit. med. J.*, 1959, 2, 1099.
- ² Halliday, T. D. S., and Cuthill, I. M., *ibid.*, 1960, 2, 1310.

Antimony and the Heart

SIR,—Your annotation, "Antimony and the Heart" (June 10, p. 1665), very properly underlines the possibility of cardiovascular damage following treatment of schistosomiasis with trivalent antimonial substances. To this may be added the possibility of liver damage. While few would disagree that tartar emetic or antimony sodium tartrate *given in the classical course* are the most active (and most toxic) schistosomicides at present

available, it must be appreciated that the conditions under which they are used materially affect their efficacy and practical value in treatment.

In areas endemic for schistosomiasis, hospital facilities are usually grossly inadequate and only a small proportion of those requiring treatment can be admitted. The majority must be treated as ambulatory out-patients pursuing their normal occupations. Under these conditions, a thrice-weekly course of intravenous injections of tartar emetic may extend over four weeks. Cardiovascular toxicity apart, the side-effects are frequently severe, the interruption to earning capacity is considerable, and, unless under compulsion, many patients may fail to complete the prescribed course. The over-all efficacy of tartar emetic may be seriously affected by the lengthy course of treatment and the severity of side-effects.

Unlike bacteria, schistosomes do not multiply within the body and, in general, the pathological effects of the disease are related directly to the weight of infection and to its duration. Thus, in an endemic area where reinfection is likely, the virtue of striving after radical cure through the prolonged use of highly toxic drugs is open to doubt. It is in this context that the use of other trivalent antimonials such as sodium antimonyl-gluconate, B.P., may offer the advantages of reduction in length of treatment and reduced severity of side-effects, leading to a lower incidence of absenteeism and, consequently, a lower level of infection in the population under treatment.

The absence of more effective and less toxic schistosomicides is only too apparent, but, meanwhile, the need to treat demands the use of available drugs to best advantage in the prevailing circumstances. Trivalent antimony has been in use for the treatment of schistosomiasis for more than 40 years, but there is still need for controlled quantitative studies with the available preparations to define the least toxic and most effective regimen.—I am, etc.,

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Cataract and Steroids

SIR,—Following a report by Black *et al.*¹ and also your annotation (January 14, p. 116) on the occurrence of posterior subcapsular lens opacities as a possible complication of steroid therapy; we have examined 98 asthmatic patients receiving steroids. Fifty-two of these had received prednisone or an equivalent analogue in a daily dose of 10 mg. or more for one year or more. Of these, 41 received continuous therapy for between one and three years and 11 for between four and nine years. All of these patients were examined under a mydriatic by ophthalmoscopy and slit-lamp microscopy.

One case only showed bilateral, posterior, polar, subcapsular cataracts. This was a female patient aged 60 years who had received more than 10 mg. of prednisone per day for three years. However, elsewhere, she had also been given many courses of gold intramuscularly in the treatment of her asthma. This may be relevant to the development of her cataracts. Moreover, in this case, in addition to subcapsular changes, opacities were present in the posterior cortex of the lens mainly localized to the axial region. Therefore the changes in this one case are of doubtful aetiology, nor quite typical of those described by Black *et al.*