

Correspondence

Letters to the Editor should not exceed 500 words.

Rheumatic Fever and Rheumatoid Arthritis in Children

SIR,—The subject of rheumatic fever and rheumatoid arthritis in children is beset with so many problems, and there is so much that we do not know about them, that it would be wise to avoid dogmatic statements about the correct choice of treatment.

As for the use of corticosteroids in rheumatic fever, many would agree with Professor E. G. L. Bywaters (26 June, p. 1655) that they should be reserved for children with carditis. On the basis of controlled studies in Sheffield we believe that they can prevent the development of carditis, and so we prefer to give them in all cases. We would agree that not many children who come to hospital without signs of carditis subsequently develop carditis during their stay in hospital. But some do, and we have several times seen it develop in children receiving salicylates alone, while we have never seen it develop in children receiving corticosteroids.

I feel in addition that a warning about some of the treatments advocated by Professor Bywaters would be in order. He wrote, "Children do not develop peptic ulcers as adults do" with prednisone. I saw a child who required 20 pints (11.4 litres) of blood for her haematemesis as a result of corticosteroid therapy in another hospital. Her frequent complaints of abdominal pain had been ignored.

The dose of aspirin recommended by him for rheumatic fever (4 g. per day for a child of around 10 years old) is more than I personally would dare to recommend a family doctor to give. For rheumatoid arthritis Professor Bywaters recommends salicylates in a dosage sufficient to give a blood level of 20 to 30 mg./100 ml. It would be very difficult for a family doctor to have single or repeated serum-salicylate levels estimated. In any case the upper limit of the range (30 mg./100 ml.) is very near the toxic and dangerous level, and I would not dare to recommend that to a family doctor. Professor Bywaters recommends the use of phenylbutazone—without emphasizing the danger of this treatment.

As for the diagnosis of rheumatoid arthritis, Professor Bywaters wrote that "only a single . . . joint may be involved, and here it is imperative to do an open biopsy to distinguish the disease from tuberculosis." Surely the first step is to carry out a tuberculin test. If it is negative, the arthritis cannot be due to tuberculosis (unless the child has miliary or meningeal tuberculosis or other potent reason for anergy).—I am, etc.,

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Prevention of Rheumatic Fever

SIR,—I have just received a copy of the *Prevention of Initial Attacks and Recurrences of Rheumatic Fever* [see *B.M.J.*, 26 June, p. 1625], and would like to make some comments on same.

On page 2 it states "It is important to remember that sulphonamides, although useful as a continuous prophylaxis for the prevention of recurrences . . . are not effective for the prevention of initial attacks of rheumatic fever if they are given for the treatment of existing streptococcal infection."

For many years I have been swabbing and re-swabbing throats, and in my experience the haemolytic streptococci of the Lancefield groups are penicillin-sensitive, and in the great majority of cases sulphonamide-resistant, and if they are sulphonamide-sensitive they soon develop resistant strains. This never happens when the patient is given penicillin.

Further on the report contains the following statement, "It should be emphasized that in a majority of sore throat patients it is only by means of the bacteriological examination of a throat swab that it is possible to distinguish streptococcal infection from other causes." I am in full agreement with this. In my opinion sulphonamides should not be used in the treatment of the acute sore throat,

unless a swab shows that the causative organism is sensitive to sulphonamide. This so rarely happens that one is not justified in using them.—I am, etc.,

Sheffield 5.

J. G. COONEY.

REFERENCE

- ¹ Cooney, J. G., *Brit. med. J.*, 1960, 2, 387.

Hookworm Infections Acquired in Britain

SIR,—In an article entitled "Hookworm Disease in Immigrants" which appeared last year in the *B.M.J.*, Drs. S. N. Salem and S. C. Truelove described four cases of hookworm disease in immigrants resident in this country, and in their summary they suggested that in this connexion a public health problem exists on two counts: "First, that there may be many immigrants suffering from hookworm infestation who need to be treated for the sake of their own health. Secondly, the possibility of the spread of hookworm disease in Great Britain must exist while such cases go untreated." Regarding the first count, there is clearly a need for the treatment of infected persons for purely medical reasons; there is now evidence that their treatment is

imperative from the public health aspect as well, for we have recently diagnosed hookworm infection, by faecal examination, in two Pakistani children who were born in this country.

These children, aged 6½ and 7½ years, are resident in the Shires and have never been abroad. Hookworm eggs passed by them were cultured to the infective larval stage and identified as *Ancylostoma*, most probably *A. duodenale*. *Ancylostoma* and *Necator americanus* infections were also diagnosed in some of the adult occupants of the same house, but the parents of the two children were negative.

This is the first record of human hookworm transmission in Great Britain, apart from the well-known account of its occurrence formerly in Cornish tin mines, where climatic conditions underground, temperature, and humidity were favourable for the development of hookworm eggs to the infective larval stage. Hitherto it has been thought that the English climate (above ground) is unfavourable for the soil development of hookworms and other parasitic infections prevalent in tropical and subtropical countries. We must now revise our ideas about this, and we may infer from the present cases that a prolonged spell of warm summer weather, such as was enjoyed in 1964, could provide the conditions necessary for hookworm transmission. The circumstances of the transmission, however, have not been determined in the present instance. The house where the children live has been inspected, and it was found that infection indoors was most unlikely to have occurred; nor did the small backyard provide any clue. It seems most probable that the children became infected by contact with contaminated soil in public playgrounds or picnic sites frequented by parties of immigrants. These possibilities are now being investigated.

It would be of great interest to hear of further cases of hookworm infection in children born of immigrants in this country; such information might give some indication as to the extent to which hookworm transmission is taking place.—We are, etc.,

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REFERENCE

- ¹ Salem, S. N., and Truelove, S. C., *Brit. med. J.*, 1964, 1, 1074.

Bullous Lesions in Acute Barbiturate Intoxication

SIR,—It is interesting to recall, in relation to the correspondence on bullous lesions in acute barbiturate intoxication (Drs. G. W. Beveridge and A. A. H. Lawson, 27 March, p. 835; Dr. G. Warnock, 1 May, p. 1188; Drs. D. I. Freeman and M. Raza, 5 June, p. 1495) that during the war the erythematous areas corresponding to compression sites seen in patients rescued from bombed build-