CORRESPONDENCE

Correspondents are asked to be brief

Continued Oral Therapy in Diabetes H. S. Brodribb, D.M.108	Payment by Colour R. Hoffenberg, M.D.111	Recurrent Urinary Infections H. G. Jones, M.R.C.S., D.M.R.113
Chloroquine-resistant Malaria? L. J. Bruce-Chwatt, M.D., and J. M. D. Roberts, D.P.H.108	Contaminated Drip Fluid P. G. T. Ford, M.B.111	Simple Method of Measuring Disuse Atrophy A. Beck, F.R.C.S.113
Endocrine and Metabolic Manifestations of Cancer J. G. Azzopardi, M.D.; W. M. Keynes, F.R.C.S.109	Interstitial Cystitis P. H. L. Worth, F.R.C.S., and R. T. Turner-Warwick, F.R.C.S.; D. M. Essenhig, F.R.C.S.111	Foreign Body in the Appendix T. G. Geddes, M.B., and others.114
Diagnosis of Potassium Chloride Stricture R. J. Heald, F.R.C.S.109	Papillary Necrosis in a Transplanted Kidney C. Leroux-Robert, M.D., and others.112	Squelching Caecum in Acute Appendicitis S. N. Joffe, M.B., and J. H. Louw, F.R.C.S.114
Treatment of Asthma with Beclomethasone Aerosol I. Grégg, B.M.; I. W. B. Grant, F.R.C.P.E.D., and others.110	Suction Retractor M. Burke, F.R.C.S.112	Large Doses of Fluphenazine Enanthate F. N. I. Fawzy, M.B., and others.114
The Doctor in Conflict P. Horgan, M.B.; F. Difford, M.B.111	Islets of Munchausen P. D. Robertson, M.R.C.P.E.D.112	Stereophonic Auscultation B. L. P. Dalton, M.B.115
"Sorcerers' Apprentices" D. Gullick, M.B.111	Bone Disease after Gastrectomy W. M. Jordan, B.M.113	Depressive Illness and Aggression in Belfast D. Walsh, D.P.M.115
	Removal of Extruded I.U.D. Ursula E. Mountrose, M.R.C.O.G., and W. L. Whitehouse, F.R.C.S.E.D.113	Registration and the G.M.C. M. A. Simpson, M.B.115

Continued Oral Therapy in Diabetes

SIR,—I was very interested in Drs. A. M. Tomkins and Arnold Bloom's (11 March, p. 649) remarks on their findings. For many years it has been customary in the Hastings Diabetic Clinic to give many patients for whom oral treatment was necessary the right to vary their dose within narrow limits according to their urine record.

The vast majority were on chlorpropamide (464 in 1971) and it was found that even in those who initially required large doses a considerable reduction could be made automatically, an important point in avoiding hypoglycaemia in the elderly. They were instructed to reduce their dose by 100 mg tentatively, if all the urine tests were free of sugar for three or four consecutive days. Should glycosuria return, the dose was restored, or even temporarily increased in times of stress or illness. This seems logical, when one considers how successfully patients vary their insulin according to tests—a much more potent treatment.

Special permission is given to start the first break with the final 100 mg. In quite a high proportion of cases, including those

who started on high doses, patients will come back saying that they have been controlled on diet alone for long periods of the interval between visits to the clinic, and they have needed only the occasional dose of 100 mg, taken on the morning following a finding of glycosuria. These doses are recorded on the urine chart and counted at each visit. Such patients are always left with a supply of the drug, and it is felt that it has been a successful safeguard against a more prolonged relapse.

The termination, or very marked reduction, of such treatment is especially obvious in those patients whose excessive weight has been satisfactorily reduced. It is rare in those who have ever needed chlorpropamide and phenformin. Of course observation of the blood sugar is advisable in view of the prevalence of a high renal threshold in this type of patient. It is gratifying to find the results of this scientific study tend to support such a policy.—I am, etc.,

H. S. BRODRIBB

Royal East Sussex Hospital,
Hastings, Sussex

Chloroquine-resistant Malaria?

SIR,—A report has been published in *Arzneimittel Forschung* (Drug Research) 1970, No. 9, pp. 1206-1210 under the authorship of T. Yoshinaga, Y. Tsutsumi, K. Tsunoda, and Y. Yamamura under the title "Studies on the Antimalarial Property of 4-methoxy-6 Sulfanil Amidopyrimidine Monohydrate (Sulfamonomethoxine: DJ 1550) and on its Effect on the Chloroquine-resistant Malaria." This paper describes a study carried out on 279 African patients from four areas in Kenya, but most (193) of

them were from the Embu area in central Kenya, north of Kitui. The authors state that "the majority of these patients were suffering from tropical malaria (*P. falciparum*) and 15% of them were suffering from a mixed infection of *P. falciparum* and *P. vivax*." "These patients were treated in two groups, one of them by intravenous route, the other orally; 40 mg/kg of sulfamonomethoxine was injected twice a day for two days and 20 mg/kg of this drug was administered orally on the first day, and

10 mg/kg on the second to fourth days."

The authors present nine graphs showing parasitaemia of 20 patients, of whom 17 were treated by various dosages of the tested compound and three were treated by intramuscular injections or oral administration of chloroquine at 20-40 mg/kg for four to six days. The amount of chloroquine in terms of base was not stated.

The graphs indicate that the three adult patients treated with chloroquine had a parasitaemia of the order of 10^3 parasites per 10^6 erythrocytes; in other words that about 10% of their red blood cells were parasitized. Such parasitaemia indicates an extremely severe infection calling for emergency treatment. There is no evidence that such treatment was given. The authors report that "the numbers of malaria parasites did not decrease during this treatment" by chloroquine, but that the effect of sulfamonomethoxine on parasitaemia was rapid in almost all observed cases.

The authors then add that "although the studies . . . are not completed our studies . . . show the definite existence of chloroquine resistant malaria" and that "sulfamonomethoxine is effective not only on chloroquine-sensitive malaria, but also on chloroquine-resistant malaria in Kenya."

This blunt statement is of such importance that one is justified in looking carefully at the methods employed in this drug trial. Unfortunately it appears that the main method of blood examination used by the authors was unconventional, to say the least. It consisted first of taking 1 ml of the patient's blood, haemolysing it in 0.3% saponine solution; then "10,000 ghost erythrocytes in the sediment of this material obtained after centrifugation were examined with phase microscope and the number of ghost erythrocytes which contained malaria parasites was shown as a percentage."