Points

Anaphylactoid reactions due to haemodialysis, haemofiltration, or membrane plasma separation

Dr RASHEED AHMAD and others (Sefton General Hospital, Liverpool L15 2HE) write: We have observed these anaphylactoid reactions (4 December, p 1607) in our patients on dialysis. In addition to respiratory symptoms they may also develop abdominal pain immediately after the start of dialysis. We have therefore named this phenomenon "new dialyser syndrome."[1] It can be avoided by treating a new dialyser and blood tubing with formalin before use. Further use of the dialyser does not precipitate this syndrome. We wondered whether this phenomenon could be caused by exudation of the plasticiser diethylphthalate from the polyvinyl tubings. Reuse of the dialyser and blood tubing results in deposition of proteinaceous material within the tubing. This may in turn reduce the exudation of diethylphthalate[2] and hence avoid the "new dialyser syndrome."

[1] Ahmad R, Large B, Raichura N. Recurrent abdominal pain in a patient on haemodialysis. *Br Med J* 1980; **281**:1196.
[2] Gerstoft J, Christiansen E, Nielsen IL, Nielson B. The migration of plasticisers from PVC haemodialysis tubes. *Proc Eur Dial Transplant Assoc* 1979; **16**:739-40.

Diploma in medical practice in developing countries

Dr H M LIPMAN (London W1N 1DH) writes: Surely doctors from developing countries should be trained in methods applicable to the conditions in which they will be practising on returning home, and surely doctors from the developing countries who are intending to practice in the Third World should similarly be trained appropriately? This might best be achieved by a postgraduate diploma in medical practice in developing countries covering the whole range of medicine, surgery, anaesthetics, obstetrics, hygiene, tropical diseases, sociology, and so on. Such a diploma would not in any sense replace existing higher degrees and diplomas, but would complement them. At a later date, as the developing countries developed, centres of excellence might be established in them which would not be a drain on their present limited resources. . . .

Are there two kinds of ward round?

Dr KEITH BALL (Department of Community Medicine, Central Middlesex Hospital, London NW10 7NS) writes: I was glad that George Read appreciated the way the consultant shook his hand on the ward round in Dr T B Brewin's delightful and penetrating story (18 December, p 1765). A handshake is an important part of any consultation whether on the ward, in the outpatient department, or when seeing patients in prison. It provides immediate physical contact, sadly often missing when doctors meet patients today. It can help with the diagnosis of the mental and sometimes the physical state of the patient, and it is a common courtesy which helps to put both parties at ease and on the same level. I once discussed this matter with a kindly physician colleague who stated: "I shake hands with my patients in Harley Street but would feel embarrassed to do so with outpatients." I believe that a handshake is a custom which should be regularly adopted in clinical practice and which would help to overcome the apprehension that patients too often feel in our presence.

Help after a road accident

Mr PETER H SPRIDDELL (Northwood, Middx HA6 2LH) writes: I write this letter hoping to thank one of the medical profession who might read it. On Thursday 23 December at about 9 pm my 18 year old daughter was injured in a car crash on the A40 near the Hoover building on her way into London. In another car behind her was a doctor, who stopped, gave first aid of a very high standard, and telephoned for an ambulance. The police do not have this doctor's name so I am unable to thank him personally. If he reads this letter, however, I should like to express the gratitude of all my family for his prompt and kind actions which helped so much. Thank God there are still good Samaritans about.

Illness of Dorothy Wordsworth

Dr J FINDLATER (Silverdale, Lancs) writes: In her interesting piece on Dorothy Wordsworth Dr Iris Gibson did less than justice to William, which was a great pity. Whereas Dorothy's migraine and barely suppressed conflicts were almost praiseworthy William was made out as a bit of a booby, as all men are to some ladies, and the best she could say of him was that, "There was a divine silliness about him which was endearing." Physically robust, passionate, loving deeply and tenderly, what did it matter if with the intensity of his muse he spoilt an odd night or had a pain in his side? Considering the result, I think few geniuses have been less temperamental and neurotic. An endearing, divine silliness, indeed.

Zoography: the use of animal terms in medicine

Dr L PICTON DAVIES (Alfriston, East Sussex BN26 5XL) writes: Dr E P Wright (1 January, p 27) has omitted from his analogies in ornithology L *pica*, a magpie—the indiscriminate picking up and ingestion of inappropriate material. The magpie was supposed to live on earth or clay.

BCG vaccination scars

Professor N ISLAM (Institute of Postgraduate Medicine and Research, Dacca-2, Bangladesh) writes: I would like to make the following observations on your leading article on BCG vaccination scars (11 December, p 1679). Even though the incidence of hypertrophic or keloid scars resulting from BCG vaccination in Bangladesh is not known, as in many other countries, the fact remains that it occurs in 2-33% of cases. This is sufficient to warrant taking measures against this complication. Admittedly treatment is not simple in developing countries, where even a single injection for BCG vaccination is a formidable task. . . . Most children, however, wear dresses, allowing easy access to sites like the thighs and buttocks. In many others the thighs, abdomen, and chest are exposed. This is in fact usual in most of our rural children, who constitute 80% of the population subjected to BCG vaccination. I would therefore strongly recommend the thighs, abdomen, and chest in order of priority for selection for BCG vaccination in most of the developing countries. . . .

Apical pulse rate and atrial fibrillation

Dr M G JACOBY (Patchogue, New York 11772) writes: A reply to "Any Questions?" (4 December, p 1637) makes no mention of checking the apical rate when patients with atrial fibrillation are stabilised with digitalis. As pulse deficits are not unusual with this arrhythmia the only satisfactory method of clinical control of the heart rate is by checking the apical rate. In my practice patients are taught how to do this and are instructed not to take digitalis if the heart rate is under 70 beats/min. They are also told to take a double dose if the heart rate is above 90 beats/min. To check the only radial pulse rate runs the risk of patients taking too little digitalis.

Do it yourself obituaries

Dr G SANDERSON (Blundellsands, Liverpool L23 6TL) writes: I have long thought that the *BMJ* should have a straightforward deaths column in addition to its obituary notices. This would avoid the delay that otherwise occurs, and friends unwilling to bother with an obituary would send death notices. It would be nice to make it clear that it is not limited to BMA members.

Some years ago when one of my old teachers died he left among his papers a curriculum vitae, which made it extremely easy to write the obituary. I have done the same. This could be made much easier if some kind of form were available for the guidance of tidy minded people.

Corrections

Hours of work of junior hospital doctors

We regret that an error occurred in this letter by W T Berrill (1 January, p 60). The last sentence should have read: "Clearly, we must be practical and allow reasonable rotas and time off, but we should not stray too far from what I suggest is a thoroughly worthy ideal."

Bromocriptine induced psychosis in acromegaly

We regret that an error occurred in this letter by A W Procter and others (1 January, p 50). The last sentence should have read: "This is in contrast to previous reports of bromocriptine induced psychoses, in which the clinical appearance has been that of mania."