Giant Hogweed

SIR,—It seems appropriate at this time of the year to report a case of dermatitis due to the giant hogweed (*Heracleum mantegazzianum*).

A boy aged 7 years was seen on 5 June, two hours after playing with stems of the giant hogweed. He had raised erythematous patches on both forearms, the front of the neck, and both legs. There were several blisters of $\frac{1}{2}$ in. (1 cm.) diameter and two blisters of 1 in. (2.5 cm.) diameter on the neck. He was treated with a hydrocortisone spray. When he was seen a week later the blisters had dried up, but the livid discoloration of the skin remained. Two weeks after exposure to the plant, disfiguring purplish-brown pigmentation in all the affected areas was very marked.

It has been suggested that this is a phytophoto dermatitis due to sensitization of the skin to ultraviolet light a furocoumarin compound contained in the sap of the plant. There seem to be few references in the medical literature to giant hogweed dermatitis—although the plant, which grows to a height of 10–12 feet (3–4 m.), is not uncommon in waste spaces. The giant hogweed presents the danger of long-lasting and unsightly skin pigmentation in children or gardeners who come into contact with the sap in sunny weather.—I am, etc.,

Liverpool 17.

JANET H. SMELLIE.

REFERENCES

- ¹ Jones, J. G., and Russell, D. G., *Practitioner*, 1968, 200, 704.
- ² Birmingham, D. J., Key, M. M., Tubich, G. E., and Perone, V. B., *Arch. Derm.*, 1961, 83, 73.

Common Courtesy

SIR,—I am goaded into writing to you by my experiences over the last few months while applying, as a hospital junior doctor, for a post in general practice. I feel that I must comment on the extreme rudeness of some members of our profession. On four occasions I have submitted applications for positions advertised in the *B.M.J.*, but in three cases the principals of these practices, doubtless feeling safely anonymous behind the shield of their box numbers, have not even deigned to reply.

Is the flood of doctors into general practice, contrary to popular opinion, so great that these men would develop acute bouts of writer's cramp if they replied to all their applicants? Surely not in many cases, and even in these few instances these brilliant medical men must be capable of finding some ingenious way around the problem. When applying for positions recently I had a duplicated sheet produced detailing my qualifications and experience. Is a similar duplicated reply card even too much effort, or even a small advertisement saying the position has been filled? We do not ask for self-sacrificing behaviour from these doctors, only common courtesy.

Is it any wonder that young doctors are disillusioned when working in Great Britain? We have been brought up to believe that our profession places great store by ethics and courtesy, but in this short series of cases 75% of the doctors concerned were evidently willing to abandon even the most basic human etiquette when sheltered by anonymity.—I am, etc.,

Scarsdale Hospital
Chesterfield, Derbyshire.

K. T. SCHOLES.

Improvised Stretcher

SIR,—When dealing with road accidents it is essential to lift the injured persons from a vehicle with the utmost gentleness, and, if at all possible, in the position in which they are found. Within the confines of a saloon car this may be extremely difficult, using the normal points of access and relying upon gripping clothing without dragging or twisting the body, to say nothing of the contortions required on the part of the rescuer. Matters can be simplified by using one blanket in the following manner:

The aim is to put a cradle under the patient with the minimal disturbance, and to produce handholds at a distance.

One end of the blanket is rolled up twice, and the remainder infolded upon itself like a Venetian blind until a narrow strip is produced which can be slipped carefully under the patient's knees. With the roll behind the knees, the folded portion is brought backwards under the buttocks (which need to be lifted slightly) and then unfolded upwards between the seat and the patient. The patient is now cradled, he has not been disturbed, and he can be lifted out sideways supported and controlled by handholds at a distance. After extrication the patient may be lowered to the ground with the blanket protecting him below and above. By infolding the sides of the blanket it can now be used as a stretcher.—I am, etc.,

Catterick, Yorks.

KENNETH C. EASTON.

Pain in the Face

SIR,—Professor Henry Miller's McCurich Oration (8 June, p. 577) laid great emphasis on careful history-taking in the diagnosis of pain in the face. He also stressed the importance to the clinician of being familiar with certain symptom complexes to avoid unnecessary suffering through their over-investigation or a failure to recognize them. Migrainous neuralgia, he states, requires greater publicity,

for it is still subject to both these hazards.

The Merseyside and North Wales Faculty of the (then) College of General Practitioners published a survey of migrainous neuralgia in 1966.¹ This I believe to be the only extensive survey of the condition coming from general practice. Twenty-six cases were discovered in the practices of 233 general practitioners who covered a population of about 544,000.

I have reason to believe that this incidence is considerably higher. Contributing to the above survey sharpened my awareness of the condition, which often lies undiagnosed and untreated. Since taking over a small rural practice in Devon four years ago three clear-cut cases, all in males, have revealed themselves. To make a diagnosis of migrainous neuralgia, Professor Miller states, is not just academic in importance, for the condition is so eminently treatable. I have found in these cases, and others seen on Merseyside, that ergotamine tartrate by metered aerosol, which delivers just less than 0.5 mg. per dose, easier to administer and as effective as injection. It is important to ensure that the drug is administered prophylactically and according to the periodic pattern in the particular sufferer. This is in contrast to the use of ergotamine tartrate in migraine, which is administered at the onset of an attack. This distinction in treatment procedure emphasizes the need for separating the two conditions diagnostically, for occasionally they co-exist. I am, etc.,

C. H. STEWART-HESS.

Crediton, Devon.

REFERENCE

- ¹ Hardman, R. A., and Hopkins, E. J., *J. Coll. gen. Practit.*, 1966, 11, 195.

Chondrocalcinosis

SIR,—With reference to your leading article on chondrocalcinosis (2 March, p. 533), and especially to the diagnosis and heredity of the disease, several authors¹ in 1966 estimated the number of published cases at "more than 150"—263. But many of the case reports are incomplete from a diagnostic point of view. The incidence of the disease is probably higher than that suggested by the figures given above, since some cases are asymptomatic and many are certainly misinterpreted as rheumatoid arthritis. Others produce a sepsis-like clinical picture.

D. J. McCarty² gives the following diagnostic criteria for chondrocalcinosis: a case is considered "definite" if calcium pyrophosphate dihydrate (C.P.P.D.) crystals have been demonstrated in tissues or synovial fluid by definitive means (e.g., by the x-ray diffraction powder pattern with calculation of the interplanar spacings between the atomic sheets) or if crystals compatible with C.P.P.D. are demonstrated by compensated polarized light and typical calcifications are seen on roentgenograms. If only one of the latter criteria are found, a "probable" diagnosis is made. According to Curry *et al.*³ examination with polarized light microscopy is less satisfactory for differentiating between various types of arthritis. Free crystals of different types (including C.P.P.D.) can occur in the synovial fluid in various sorts of arthritis, and only if C.P.P.D. occurs in abundance is it a definite sign of chondrocalcinosis. From a diagnostic point of view,

the most reliable and best technique is to determine the presence of C.P.P.D. by x-ray diffraction. This method can be used even when only microscopic specimens of the material are available.

Calcification of the meniscus in the knee is very common in chondrocalcinosis. In the roentgenological examination of such cases various projections should be tried in order to visualize also calcifications of the joint cartilage, which are of greater significance in the diagnosis of chondrocalcinosis. The synovial fluid (joint effusion) has been described as milky and was of such appearance in one of our cases at Ljungby.

In their series of 33 cases D. Žitnan and Š. Sitaj¹ found five pedigrees with 24 cases, and they regard chondrocalcinosis as hereditary, as it affects a greater number of members of one family, passing from generation to generation. It is true that of 80 cases McCarty found only two crystallographically proved examples of familial disease, but three other "definite" cases had asymptomatic siblings with typical calcifications on roentgenograms and many others gave histories suggestive of the disease in close relatives. Several other authors have found a familial occurrence of the disease. Perhaps about 60 familial cases are described in the literature. At the department of internal medicine, Lasarettet, Ljungby, we found the disease (with x-ray diffraction) in 4 of 12 siblings. Familial investigations are of particular interest in chondrocalcinosis, but are difficult because the disease does not seem to become manifest before the age of 20 years, and because in long-standing cases arthritic alterations predominate and are accompanied by a gradual loss of calcified cartilage, which makes a roentgenological diagnosis difficult. In the investigation of the mode of inheritance it is also important to find out how many members of a family or of a sibship are not affected or not carriers of the gene for the disease.—I am, etc.,

CURT W. EKELUND.

Department of Medicine,
Lasarettet, Ljungby, Sweden.

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- McCarty, D. J., in *Arthritis and Allied Conditions*, 7th ed., p. 113, ed. J. L. Hollander, 1966, Philadelphia.
- Currey, H. L. F., Kay, J. J., Mason, R. M., and Swettenham, K. V., *Ann. rheum. Dis.*, 1966, 25, 296.

Epidemic of Glandular Fever

SIR,—We wish to report an epidemic of glandular fever in a rural practice of 3,000 patients covering some 24 villages over an area of 34 square miles (86 sq. km.).

Of the 75 patients with this clinical diagnosis, 54 have had positive Paul-Bunnell tests as well as the characteristic abnormal monocytes, while 21 have so far been Paul-Bunnell negative. More cases are still coming to light. 13 families have had two or more cases and six have had three or four members involved. We think that these patients who are Paul-Bunnell negative have, in fact, got glandular fever and not toxoplasmosis or one of the other conditions with which it may be confused. This is because other members of the family with the same clinical picture and blood film appearances have been Paul-Bunnell positive at some stage in their illness.

One of the presentations, which we have not seen described elsewhere, is as an acute psychiatric disorder: five of our series presented thus, and were only subsequently diagnosed as glandular fever. Of these, two had acute schizophrenia and three acute depression with suicidal tendencies. We would suggest that if more haematological studies were done on patients with glandular fever-like clinical states then the incidence of the disease might be seen to be well above the figure of 38 per 100,000 population found by Penman.¹

We are grateful to the pathology department of King's Lynn General Hospital for performing all the tests on our patients.

—We are, etc.,

King's Lynn,
Norfolk.

MICHAEL KLABER.
JEAN LACEY.

REFERENCE

- Penman, H. G., *J. Hyg. (Lond.)*, 1966, 64, 457.

Magnesium and Mania

SIR,—Chronic mania is uncommon, and in modern psychiatric practice laboratory investigation is unlikely to include a magnesium serum analysis. Persistently disturbed and violent patients can now be treated effectively with phenothiazines, of which chlorpromazine is the most reliable.

The hypothesis that there may be a link between chronic mania and hypomagnesaemia has yet to be tested, but, since Dr. J. R. Govan and others (4 May, p. 278) have re-emphasized the twofold action of magnesium as a central depressant and as a block to the transmission of neuromuscular impulses, it may be useful to record some unpublished work (Horsley, 1937) on the use of intravenous magnesium sulphate in chronic mania.

A woman of 45 had suffered for many years from chronic mania complicated by periodic bouts of homicidal violence. The powerful sedatives in common use in 1937 were quite ineffective, and so an attempt was made to reduce the furore by the slow intravenous injection of a 10% solution of magnesium sulphate. During the injection the patient relaxed and, with slurred speech, she described subjective sensations of tingling, generalized flushing, and lethargy. The next day the patient was still subdued but fit to resume her usual occupation as the ward's best scrubber. Some months later, in another outburst of violence, similar treatment was again effective.—I am, etc.,

Kings Langley,
Herts.

J. STEPHEN HORSLEY.

Overcrowding in Psychiatric Hospitals

SIR,—Dr. C. Entwistle's conclusion (8 June, p. 626) that national adoption of "techniques . . . employed at Rubery Hill Hospital would save the National Health Service hundreds of millions of pounds" is speculative. He suggests we have chosen inappropriate techniques to treat our patients, but our scheme¹ was merely a preliminary assessment of long-stay patients on our firm. This had not been previously attempted, but as a result of it we are convinced we have very few chronic patients left who could be discharged unless unexpected increases occur in local authority or community aftercare

services in this area. Although therapeutic community benefits are widely acknowledged, it has still to be proved that group methods are superior to intensive individual psychotherapy, chemotherapy, physical, or other methods of treatment for chronic psychiatric patients, particularly in the elderly category. Most of the patients we interviewed were severely institutionalized and had been in hospital for periods exceeding 30 years.

"Revolving doors" are largely contingent upon the recurrent illnesses we are obliged to treat, although they are certainly preferable to closed ones. Precipitate discharge of chronic patients from one mental hospital can readily lead to overcrowding in neighbouring hospitals, particularly in densely populated urban areas and if adequate aftercare is not developed. The findings from our recent review suggest that our hospital will remain the permanent home for many of our chronic and elderly patients. We are privileged to make their stay here as comfortable and enjoyable as possible, which means, among many other things, doing away completely with all locked wards. But we are still overcrowded, despite transfer of more than 60 patients to surrounding hospitals following recent difficulties. Criteria for admission to the psychiatric hospital need to be far more selective. Patients who are not mentally ill should never have to be admitted to mental hospitals merely because there are no beds for them elsewhere. The late Dr. H. B. Kidd, of the Towers Hospital, Leicester, emphasized that many wrongly placed patients tend to vegetate and deteriorate rapidly. Furthermore, unless there is far greater reciprocity between all the psychiatric services overcrowding will increase and new chronics will emerge, thereby perpetuating the vicious circle. For instance, as a first step I would welcome smoother and swifter exchange of patients from the psychiatric hospital to local authority welfare accommodation.—I am, etc.,

Shelton Hospital,
Shrewsbury, Shropshire.

J. C. BARKER.

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Deputizing Services and Practitioners' Liability

SIR,—With reference to the letter from the Secretaries of the Medical Defence Union and Medical Protection Societies (22 June, p. 765) regarding the indemnification of sub-scribers to a deputizing service against errors and omissions of administrative staff, may I clarify the situation so that all deputizing services are not tarred with the same brush?

Many services, this one included, indemnify the user of the service against action brought against him arising from the negligence or default of any of the Service employees, including lay and administrative employees. The sums vary from £100,000 to £250,000 for any one specific incident.

Users of a deputizing service should make inquiry to ensure that they are indemnified and would be advised not to use a service which does not provide such indemnification.—I am, etc.,

B. JOHN MAXWELL,
Medical Director,
Liverpool Locums Ltd.

Liverpool 6.