of various joints, specially the knee joint, without the guineaworm being inside the joint cavity, and in these the larvae play no role. Fairley and Glen Liston (quoted by Manson Bahr 1966⁴) failed to induce any local or general reaction by subcutaneous injection of guineaworm larvae. It is therefore likely that it is a toxin liberated by the adult worm that causes the arthritic lesion irrespective of its actual location.—We are, etc.,

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Penicillin-induced Haemolytic Anaemia

SIR,—We read with interest your leading article and the paper by Dr. J. M. White and others (6 July, pp. 4 and 26) and feel that, in view of the small number of reported cases in Great Britain, it would be of value to report another case of penicillin-induced haemolytic anaemia.

On 12 April 1968 a 32-year-old woman was admitted to hospital for the investigation of abdominal pain accompanied by rigors. Seven years previously she had undergone mitral valvotomy for rheumatic heart disease. Penicillin had been administered on many occasions.

Optimum Size of Books

SIR,—The review entitled "Paediatrics," by Professor D. Hubble (13 July, p. 110) prompts me to write about an attitude which has for long irritated me. Professor Hubble says the book is not only better but also bigger, and then raises the point "to what size should the textbook be allowed to grow and what should be omitted from it to keep it within its allotted span?"

I believe that reviewers (and this seems to be a common attitude; I am not referring specifically to Professor Hubble) adopt the wrong criterion when, as they often do, they praise second editions for not exceeding the size of the previous one while incorporating new material. Should not the criterion for judging a book be its completeness rather than its size? Will the reader who refers to a textbook find in it what he by right expects to find? Why should there be an "allotted span" for textbooks and who

allots it? Does a new discovery in medicine which must be described in a textbook mean that something else known long before is necessarily no longer true or useful and must be thrown out to make way for the new arrival?

Sellar and Yeatman in their humorous classic *1066 and All That*¹ quoted a possibly fictitious review of their book from *Punch* consisting of the three words; "This slim volume." They were being funny; others seem to make a fetish of a limited size in books in all seriousness. Of course one is against prolixity and turgidity, but shall we be bullied, consciously or otherwise, by commercial interests into praising the smaller at the expense of the more complete? Will the day ever come when we will be judging authors or medical consultants by the criteria by which beauty queens are chosen?—I am, etc.,

EMANUEL AGIUS.

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- Sellar, W. C., and Yeatman, R. J., *1066 and All That*, 1930. London.

Aphthous Ulceration

SIR,—Your correspondent Dr. A. J. Moore (25 May, p. 494) stresses trauma as a cause of aphthous ulcers, and asks if his observations have been borne out by experience in other practices.

Recently I had a female patient, aged 48 years, with a crop of aphthous ulcers on the buccal surface of her upper lip. The ulcers were resistant to mouth washes, mouth paints, and the administration of hydrocortisone sodium succinate pellets (2.5 mg.). After reading Dr. Moore's letter I examined her toothbrush, to find that it was practically bald in the centre and the bristles curved gracefully outwards from the middle line. The use of a new toothbrush was quickly followed by the disappearance of the ulcers.—I am, etc.,

Gwelo, Rhodesia.

J. C. COMLINE.

Addiction to Methedrine

SIR,—A patient of mine who has recently ceased to take intravenous methylamphetamine in a dose of ten ampoules or so a day told me how he got it from general practitioners. In the waiting room he used to think himself into the part of a deprived addict, walk in weak and pale, slump into a chair, and throw his head back. Breathing with difficulty, he would announce that he was a Methedrine addict and urgently needed the drug. The doctor would look grave and say, "I'm sorry but I never prescribe to addicts." Thereupon the patient would intensify his symptomatology, making the doctor feel very anxious. Eventually the doctor would, as like as not, say, "Well, very well, then, I'll give you a prescription for five ampoules, but you understand that that's the last you get from me."

It must be pointed out that although there are many points of similarity between narcotic addiction and methylamphetamine addiction there are also very great differences. One of these is that the former produces a physiological dependence, whereas the latter does not. Consequently the Methedrine

On this admission a diagnosis of subacute bacterial endocarditis was made and she was treated with benzyl penicillin in increasing dosage, culminating in the intravenous administration of 20 mega units a day for eight days. At the start of therapy the results of haematological investigations were as follows: haemoglobin 12.9 g./100 ml., white cell count 6,700/cu.mm. Film appearances normal. Subsequent haematological investigations demonstrated a falling haemoglobin with increasing evidence of haemolysis. Sixteen days after the beginning of therapy the haemoglobin had fallen to 7.0 g./100 ml., the reticulocyte count was 26%, the nucleated cell count was 11,500 cu.mm., and spherocytes and normoblasts were seen in the peripheral blood film. At this time the direct antiglobulin test was positive with an optimum A.H.G. dilution of 1-64 using a broad-spectrum antiglobulin

reagent, and also positive using an anti-IgG reagent. Penicillin antibodies were demonstrated in the serum by the standard passive haemagglutination technique of de Weck.¹ The major antibody was shown to be IgG, but we were also able to demonstrate a small IgM component.

Penicillin therapy was discontinued on the sixteenth day, and no other treatment for the anaemia was instituted. During the next seventeen days the haemoglobin rose to 10.2 g./100 ml. with a fall in the reticulocyte count to 4%. When seen two months after

We are grateful to Dr. L. Martin for permission to publish the case history of this patient.

—We are, etc.,

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REFERENCE

- ¹ de Weck, A. L., *Nature (Lond.)*, 1964, 202, 975.