CORRESPONDENCE

Correspondents are asked to be brief

Survival in Severe Congenital Heart Disease J. D. Hay, F.R.C.P.	Transatlantic Debate on Addiction P. H. A. Willcox, F.R.C.P.	Abortion or Contraception? P. W. W. Gifford, M.B., and others
Atypical Gonorrhoea J. Vahrman, M.R.C.P.	Research into Psoriasis F. R. Bettley, F.R.C.P.; P. R. J. Burch, PH.D., and N. R. Rowell, F.R.C.P.	Battered-baby Syndrome W. H. Parry, M.D., and Margaret W. Seymour, D.P.H.
Gonorrhoea in the Family J. K. Oates, F.R.C.P.	Mental Deficiency Nursing Sister Celeste and others	Shortage of Technicians J. O'H. Tobin, F.R.C.PATH., and others
Treatment of Paraquat Ingestion T. D. Browne, D.P.H.	Normal Range for Serum Transaminases D. N. Baron, M.D., F.R.C.PATH., and others	Disposing of the Undisposable Katalin E. Schöpflin, L.R.C.P.
Brucellosis and Goat's Cheese? A. M. W. Porter, M.D., and E. L. Smith, M.R.C.P.	Serum Albumin and Survival in Myelomatosis D. P. M. Howells, M.R.C.P.	Israeli Health Service S. Godfrey, M.R.C.P.
The Ward Sister R. C. Mac Keith, F.R.C.P.; I. G. Tait, D.C.H.	Vibration-induced White Finger W. Taylor, M.D., and others	Tetralogy or Tetrad? J. N. Matthews, D.P.H.
Violence in Hospitals P. D. Mellor, R.M.N.; Mary Applebey	Laparoscopic Sterilization through Cusco's Speculum P. H. Addison, M.R.C.S.	R.C.N. Questionnaire J. C. Angell, F.R.C.S.
Treatment of Myocardial Infarction D. McC. Boyle, M.D., and others		

Survival in Severe Congenital Heart Disease

SIR,—Your recent leading article on this subject (26 June, p. 723) indicated the large number of babies born with malformations of the heart (at present they number over 7,000 a year in the U.K.); that 40% of them at present die before they reach school age, most in the first few months of life; and that in a significant proportion successful surgical correction is now possible if it is carried out soon after birth. It was rightly emphasized that this necessitated early referral to special centres at which the babies can be investigated immediately and treated surgically without delay, at any hour of the day or night.

All those with experience of dealing with these babies would agree that this is so. Unfortunately, the full implications of the demands which such investigation and treatment make upon the staff of such special centres were not explained; namely, that before such services can be made available to all babies in Britain in need of them considerable increases in staff—medical, nursing, and ancillary; senior and junior—will be essential, and many more cots will have to be provided in centres for paediatric cardiology throughout the country.

In the meantime, existing staff are struggling to investigate and treat some of these babies while others die untreated. Moreover, the necessity to admit them without delay is resulting in a rapid increase in the number of older children with congenital heart lesions awaiting admission for surgical treatment. The condition of some of these is deteriorating while they wait, so that the risks of operation when it is performed are increased and the benefits which may be expected from it are diminished. This is certainly the case in Liverpool and must also be true of other centres serving large populations in which attempts are being made to provide a comprehensive service for infants and children with congenital heart disease.

The need for a rapid expansion of existing services for paediatric cardiology is, therefore, urgent and must be undertaken without further delay if the general public is not to reach the conclusion that the National Health Service is unable to provide adequate investigation and treatment for children born in this country with a malformation of the heart.—I am, etc.,

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Atypical Gonorrhoea

SIR,—I agree with your leading article on "Atypical Gonorrhoea" (7 August, p. 322) that the condition of benign gonococcaemia is often missed, though relatively common. Between 1964 and 1970 six cases of benign gonococcaemia were diagnosed in hospitals of the Chelsea and Kensington Group, four of them in the infectious diseases unit of the Western Hospital.¹ Only one of the six cases was a male. I report another male case.

The patient, a homosexual aged 36, was

admitted to this hospital on 30 June 1971. Sixteen days before admission he developed pyrexia, malaise, and vomiting. He said that he felt as if he was suffering from 'flu. After a few days he improved, but a week after this he had a similar attack, which was more severe; this lasted for two days only. He then had another remission until four days before admission, when he developed attacks of shivering and painful discoloured skin lesions on his extremities. These con-

tinued to appear at intervals until the day of his admission. This was associated with painful swelling of the right ankle. There was no history of urethritis. His last sexual contact with a male had taken place three months before the onset of his illness.

On admission, his temperature was 38.7°C. He had pustular lesions, surrounded by erythema, on the extensor surfaces of his elbows, over his knees, and on his hands and feet. Some of these lesions were characteristically haemorrhagic. He also had a discrete maculopapular rash on his trunk and a few maculopapules on his face. As he was not very ill and there was no evidence of endocarditis it was decided not to treat him until the diagnosis was confirmed bacteriologically.

He was afebrile on 2 and 3 July and pyrexial again on 4 and 5 July, when the temperature reached 38.5°C. The temperature then became normal spontaneously and remained so until the day of his discharge. On 7 July he developed painful swelling of the right wrist. The skin lesions continued to appear in crops, mainly on the elbows, knees, hands, and feet, until treatment was started. *N. gonorrhoeae* was isolated from a small ulcer in his rectum and from his urethra after prostatic massage. Blood culture was negative on two occasions. Gram-negative intracellular diplococci were seen in a smear taken from a pustule but no organisms were cultured from this lesion. The gonococcal complement fixation test was strongly positive. He was given 500,000 units of penicillin intramuscularly from 7 to 20 July. Two days after starting treatment all the skin lesions had crusted over and the swelling of the right wrist had subsided. Smears and cultures from the affected sites after treatment were negative.

Blood cultures are often negative; smears from skin lesions sometimes show the organisms but it is unusual to culture them.¹ A negative gonococcal complement fixation test is usual and does not exclude the

diagnosis. In this patient it was positive, probably because the disease had remained latent for so long.—I am, etc.,

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¹ Wolff, C. B., Goodman, H. V., and Vahrman, J., *British Medical Journal*, 1970, 2, 271.

Gonorrhoea in the Family

SIR,—With the current high incidence of gonococcal infection I feel the following account might be of interest.

A 6½-year-old girl developed a vaginal discharge and as a result was referred by her general practitioner to the casualty department, where a vaginal swab eventually produced a growth of gonococci. She was given a course of ampicillin 250 mg six-hourly for five days. At the end of this time a repeat swab was negative for the gonococcus and the child was referred to the venereal disease clinic for follow-up.

When she attended there was clinical evidence of vulvovaginitis, though smears were negative for the gonococcus. The mother was incensed when it was suggested that she should be examined, and it was only after the possible routes of infection in her daughter's case were explained to her that she consented. She was four months pregnant and had no symptoms such as vaginal discharge or dysuria. She had recently remarried and denied sexual relations with anyone other than her present husband for the last two years. On examination she had minimal evidence of cervicitis but no gonococci could be found in the smears. She agreed to attend again in two days' time with her husband.

She duly appeared and by this time the cultures were positive for the gonococcus in both cervix and urethra. The daughter was re-examined and smears from the vagina now showed gonococci to be present. The husband, who accompanied his wife, was interviewed, and said that he had no symptoms at all and denied sexual relations with anyone other than his wife for a period of 18 months. On examination he had no urethral discharge and the urine was quite clear after being held for two and a half hours. A scrape from the meatus before passing urine, however, showed many typical negative diplococci, both extracellular and inside pus cells.

The source of the infection remains a mystery as is so often the case with this disease. Nevertheless, the story serves to illustrate the following characteristics of gonorrhoea:

The disease is nearly always a mild one if not wholly latent in women. This latency does not protect women (or children) from the serious complication of salpingitis, which develops in about 10% of all patients.

That true latency can also occur in men is not so well known but it is familiar to every venereologist and may indeed be commoner than is generally supposed.

Gonococcal vulvovaginitis in a child should always lead to an examination of the parents.

Gonococcal vulvovaginitis in a child is frequently difficult to cure, and careful follow-

up is necessary to ensure that it has been achieved.—I am, etc.,

J. K. OATES

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Treatment of Paraquat Ingestion

SIR,—Clark¹ found that Fuller's Earth and bentonite could absorb paraquat in the gastrointestinal tract of animals, inhibiting its systemic absorption and preventing death if given soon enough after its ingestion. Both earths were found to be more effective than stomach wash out alone. Fuller's Earth (calcium montmorillonite, sub-bentonite) was the more efficient of the two and also more easily made into suspension. Kaolin, Decalco, and Amberlite had very little effect.

As a consequence of this work 300-g packets of pure Fuller's Earth (Surrey finest powder, Laporte Industries Ltd.) sterilized at 150°C to kill spores are now stored in the factories where paraquat is manufactured. Recommendations for their use in human ingestion are also available for use by the nursing staff. Should treatment be required, one litre of water is to be added to one packet of Fuller's Earth and shaken for one minute to produce a suspension. After a stomach wash out, the suspension will be passed through the stomach tube, which will need to have a wide bore (for example, 30 F.G., 18 E.G.). In children, where a narrower tube has to be used, some dilution of the suspension will be necessary. As much as can be tolerated will be given. If there is likely to be any delay in arranging gastric lavage the patient is to be made to vomit, and then will be given the suspension to drink. Fuller's Earth has no toxic effect but, as it is not absorbed, bulky frequent motions occur after its use.

If there is doubt that paraquat has been absorbed, simple urine tests should be done during the 48 hours after the suspected absorption. To one of two 25 ml-samples of urine sufficient of a freshly made up 1% solution of sodium dithionite in N/10 sodium hydroxide is added to produce alkalinity (10 ml is usually adequate). The same quantity of N/10 sodium hydroxide is added to the second sample as a control. If paraquat is present an immediate colour change to green-blue is apparent. This test will detect paraquat down to a level of 1 p.p.m. (0.1 mg/100 ml) in urine and, using normal instead of N/10 sodium hydroxide, to about 10 p.p.m. (1 mg/100 ml) in stomach contents. If the urine tests prove negative in the first 48 hours, it is quite definite that paraquat has not been absorbed in sufficient quantity to produce systemic after effects. If one is positive, timed urine samples for quantitative analysis should be collected as the amount of paraquat in urine over the first 48 hours provides a good indication of the ultimate prognosis.

So far Fuller's Earth suspension has only had to be given to a few men who thought that they could have been splashed in the mouth with paraquat liquor. They were given mouth washes of the suspension and some of it to drink. McGeown (personal communication) has used bentonite in two cases, but there was an interval of about two hours in each between the paraquat ingestion and its administration and both patients eventually succumbed.

Mr. R. J. Gow, A.R.I.C., Laboratory Manager, Imperial Chemical Industries Ltd., Widnes, developed the analytical test for paraquat.—I am, etc.,

T. D. BROWNE

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Mond Division,
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¹ Clark, D. G., *British Journal of Industrial Medicine*, 1971, 28, 186.

Brucellosis and Goat's Cheese?

SIR,—Three middle-aged patients in our practice, Mr. and Mrs. A. and their friend, Mr. B., recently undertook a protracted tour of Spain. They drank sparingly of milk, which was always in cartons and presumably pasteurized. Mr. B., however, was fond of goat's cheese, which he ate frequently, a taste shared to a lesser extent by Mr. A. Mrs. A. took a monoamine oxidase inhibitor drug regularly and always abstained from all forms of cheese.

Two days before their return home Mr. A. became unwell and Mr. B. succumbed one week later; each developed a febrile illness. The diagnosis of brucellosis due to *Brucella melitensis* was eventually confirmed by blood culture in each case. Mrs. A. has remained well.

The circumstantial evidence from this controlled study indicting goat's cheese is strong and the moral evident.—We are, etc.,

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E. L. SMITH

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The Ward Sister

SIR,—Miss Pamela Jefferies's "Personal View" (7 August, p. 367) deserves to be read seriously by everyone concerned with nursing of patients in hospitals.

I wish to add a cogent reason to the very proper plea that nurses, like doctors, should be able to continue to advance in salary and position without abandoning the care of patients. The continuing advance in medical knowledge and techniques is reflected in the general acceptance that continuing education is essential. The advances in medical care involve new knowledge, skills, attitudes, and methods of thought in patient nursing. The continuing education of those who do nursing can only be done by people who are themselves practising and have special experience of older and newer skills of nursing.

We need to encourage the ward sisters who enjoy clinical nursing to stay on doing it. Miss Marjorie Mudge (7 August, p. 368) may feel that the nursing officer makes an "invaluable" contribution to in-service training but she must surely agree that it needs to be complemented by the invaluable contributions of someone who is au courant with the work. The only person who can be a satisfactory tutor for a ward sister asking for postgraduate education in modern methods is an experienced ward sister currently practising them. The nursing officer may for a few years after leaving the wards be able (in Miss Marjorie Mudge's phrase) to "act as a consultant in nursing practice." But however wise, within a few years she will of necessity become some-