with but a single fold and this, it is suggested, is acceptable pending the general adoption of A5 size papers. It also incorporates a useful gusset of about 6 mm to allow for expansion and would give a most useful increase in writing area as regards continuation cards. The large scale use by the Services would suggest possibilities of economies in its production for the N.H.S. and in filing systems.—I am, etc.,

L. D. CHURCH

Penn, Bucks

SIR,—Among all the burning enthusiasm for the new general practice record files, I would like to know how it is proposed to finance the capital outlay required for the storage of these. Our practice have in their filing cabinets the records—frequently bulky, especially those of recent newcomers—of 13,500 patients. We have tried open filing and prefer the cabinet system, we shall be most loath to change. I expect there must be other practices in a similar potential predicament.—I am, etc.,

ALAN J. REEVES

Camborne, Cornwall

*Attention is drawn to the footnote to the letter from Dr. J. J. Cormack (9 June, p. 613). The D.H.S.S. has said that when the report of the working party set up to consider this matter has been received consideration will be given to whether any special arrangements will need to be made to meet the costs of conversion of storage equipment and premises—ED., *B.M.J.*

Dangers of Corn Starch Powder

SIR,—Further to your recent leading article on corn starch powder hypersensitivity (2 June, p. 502), we wish to make a preliminary report concerning the breakdown of an abdominal wound apparently as a result of this phenomenon.

An 11-year-old boy with bilateral testicular maldescent was admitted for right orchiopexy in January 1973. Recovery was uneventful, although the scar soon became a little hypertrophic. He was readmitted for left orchiopexy in April. He was discharged on the fourth postoperative day with the wound in a satisfactory condition. However, he had to be readmitted later following the development of a considerable wound discharge. Swabs from the wound were repeatedly sterile. Despite regular wound toilet, healing did not progress and one month after the second operation he was returned to the theatre for wound débridement. There was necrosis of the subcutaneous fat and external oblique aponeurosis. This tissue, with all remaining catgut and nylon suture material, was removed and the wound closed with stainless steel wire. Specimens were sterile on culture but histological examination showed the presence of foreign body granulomata. The wound healed but two weeks later broke down again. The possibility of starch hypersensitivity was then entertained. Granulomatous tissue was taken for biopsy and the slides, together with those from the previous débridement, were examined under polarized light. Crystals with the typical "Maltese cross" pattern were seen at the centres of numerous foreign body granulomata. Finally, two months after the left orchiopexy, the wound was again excised and its depths curetted. The surgical team did not use gloves, a non-touch technique being employed. Subsequent healing has progressed satisfactorily.

The boy himself had no history of any prior hypersensitivity, though there was an atopic tendency on the maternal side of the family. Standard surgical gloves were used in both orchiopexies; in addition, at the left orchiopexy the wound was dusted with an antibacterial powder, Cicatrin, which contains a high proportion of corn starch. The scar from the right orchiopexy has not undergone any visible change since the left-sided operations.

Therefore, in general surgical practice, it seems that corn starch powder, which can reach the patient's tissues not only via the surgeon's gloves but also, as pointed out by Dr. L. Michaels and Mr. N. S. Shah (23 June, p. 714), from antibiotic preparations, may cause a serious local reaction in the parietes as well as in the peritoneal cavity.

—We are, etc.,

MAX PEMBERTON
MARK JOHNSON

Chase Farm Hospital,
Enfield, Middlesex

Penicillamine in Rheumatoid Arthritis

SIR,—Without wishing to dissuade practitioners from prescribing penicillamine (Distamine) for their patients with severe and active rheumatoid disease, I would like to sound a note of caution. From several of the inquiries I have recently received about penicillamine it is clear that some prescribers are unaware of the absolute necessity (1) of starting with a small dose and (2) of doing white blood cell and platelet counts weekly or fortnightly at first and monthly thereafter for as long as a patient is maintained on the drug. To proceed otherwise is to involve patients in a game of Russian roulette, for fatal aplastic anaemia and agranulocytosis have been reported in the past. Some unpredictable depression of white cells and platelets is not at all unusual and responds rapidly to withdrawal of penicillamine. This drug requires as much discretion in its use as does, for example, gold.

There is now a good deal of published work about penicillamine, and if anyone who proposes to use it would care for a review and bibliography I will send him one.—I am, etc.

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Medical Director,
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Cubital Tunnel Syndrome

SIR,—I refer to Dr. C. F. Bolton's letter (19 May, p. 424). Feindel and Stratford¹ described the anatomy of the cubital tunnel in 1958 and I have elsewhere quoted their excellent work.² To keep the history of the cubital tunnel syndrome in perspective one should mention that Osborne³ in 1957 demonstrated lesions of the ulnar nerve due to compression by the arcuate ligament when the capacity of the tunnel was diminished.

Dr. J. R. Williams and I described the cubital tunnel external compression syndrome (17 March, p. 662) with the object of focusing attention on a condition occurring in hospital practice which is ill-recognized, potentially serious, and probably avoidable. At this time a classification of ulnar com-

pression neuropathy at the elbow, such as we have given, should add to the recognition and understanding of a sometimes crippling condition.

Dr. Williams and I have attempted to contribute to the knowledge of the cubital tunnel syndrome, not to duplicate the work of already well-recognized authorities.—I am, etc.,

THOMAS G. WADSWORTH

London W.1

- 1 Feindel, W., and Stratford, J., *Canadian Medical Association Journal*, 1958, **78**, 351.
- 2 Wadsworth, T. G., *Clinical Orthopaedics and Related Research*, 1972, **85**, 127.
- 3 Osborne, G. V., *Journal of Bone and Joint Surgery*, 1957, **39B**, 782.

Subclinical Brucellosis

SIR,—Dr. Eirian Williams (23 June, p. 717) wonders "how many clinicians would agree that in practice subclinical brucellosis is always a perfectly obvious state." I cannot speak for others, but if someone in apparently perfect health with no history of illness in the past shows a high level of antibody in his blood, then I think most clinicians would agree that the antibody is the result of previous subclinical infection. I would not use the term subclinical, as is suggested, where antibody titres remain positive after recovery; nor if during an earlier acute illness the diagnosis was not considered. In either case the term would be inappropriate.

It is not clear to me how the veterinary surgeons in my series who were visited, interviewed, and histories recorded, should not be designated as examples of subclinical infection because they were not examined. In the absence of a history of recent or past illness may one not relate their antibody level to subclinical infection? Dr. Williams also asks why "another label" for the great majority of veterinary surgeons (to whom may be added dairy farmers, slaughterers, and their families) who despite laboratory findings are well. I do not propose the use of another label, merely that of a well-known, widely recognized, and long-established term in clinical medicine.—I am, etc.,

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Lomotil Intoxication in Children

SIR,—Your leading article (23 June, p. 678) is commendable in drawing attention to the possible hazard of Lomotil poisoning in children. However, I would urge that in such a situation the treatment should be as simple as possible.

To suggest that the appropriate dose of nalorphine is "5 to 10 mg/1.73 m²" implies that every practitioner can easily, accurately, and rapidly calculate body surface area. One is faced with coating the unclothed surface of the body either with silver paper or wax-impregnated garments, which are subsequently removed and cut up and weighed. Alternatively one could use the formulae¹ of: (1) Du Bois: $S = W^{0.425} H^{0.725} \times 0.007184$ or (2) Meeh: $S = 0.123 \times \frac{W^2}{H^2}$, where S = surface area (m²), W = nude weight (kg), and H = height (cm).

Even to use a nomogram necessitates