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.

W. H. LYLE
Medical Director,
Dista Products, Ltd.

Fleming Road
Speke, Liverpool

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.,

R. J. HENDERSON

Public Health Laboratory,
Royal Infirmary,
Worcester

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

knowledge of the height and nude weight of the child and ready access to the nomogram itself. These surface area formulae are themselves subject to considerable error and discrepancy. To relate the dose of nalorphine to 1.73 m² surface area entails further complicated mathematics, since not even the most precocious child is likely to have a surface area approaching that figure.

Let us leave mathematics to the mathematicians and allow clinicians faced with respiratory depression due to Lomotil to ventilate with oxygen and to give the antidote based on the less complicated measurement of body weight.—I am, etc.,

C. E. BLOGG

London E.3

¹ Starling, E. H., and Evans, C. A. L., *Principles of Human Physiology*, 14th edn., ed. H. Dawson and M. G. Eggleton, p. 543. London, Churchill, 1968.

Prevention of Hyaline Membrane Disease

SIR,—Further to your leading article (14 April, p. 65) delayed clamping of the cord after delivery may also be important in the prevention of the respiratory distress syndrome. It is estimated that (particularly if ergometrine is given to the mother and the cord is not clamped) a baby can receive a volume of blood from the placenta equivalent to as much as half its entire blood volume after delivery.¹ Hypovolaemia seems a logical cause for failure of pulmonary expansion which this simple precaution helps to prevent. The baby (especially if premature or dysmature) should be held at or beneath the level of the vulva, and if the cord is pulsating well it is important not to cut it off from this significant, warm, oxygenated blood transfusion.

Though rarely practised, this is not a new idea, and Erasmus Darwin wrote in 1803 that "another thing very injurious to the child is the tying and the cutting of the navel string too soon. . . ."—I am, etc.,

LOUIS D. COURTNEY

Department of Obstetrics and Gynaecology,
Lisarn Hospital,
County Cavan, Eire

¹ Dawes, G. S., *Foetal and Neonatal Physiology*, Chicago, Year Book Medical Publishers, 1968.

Intrathecal Streptomycin and Deafness

SIR,—The article by Dr. J. Stevenson (19 May, p. 411) on bacterial and tuberculous meningitis has deservedly drawn much attention (23 June, p. 716).

As a person who became totally deafened at the age of 50 years I cannot allow to pass unchallenged the statement by Dr. Stevenson that "many experienced clinicians still favour the use of intrathecal streptomycin in the earliest stages" of tuberculous meningitis. Mention is also made of drug resistance and hypersensitivity necessitating a change to one of the newer drugs.

There would seem no essential difference between the management of childhood tuberculous meningitis and that in the adult—in both the prognosis is more favourable when early diagnosis is made and adequate chemotherapy given (with the tubercle bacillus in mind) while awaiting the results of culture in order to establish the diagnosis.

The ototoxicity of the neomycin group of drugs, including streptomycin, is well documented in the literature—for example, by Berg.¹ The sequel of deafness, particularly when acquired early in life before auditory memories are established, is a tragedy of the first degree. I doubt whether this risk is worth taking. I am persuaded from my comparatively wide reading in the field of sensory neural deafness that streptomycin should not be used intrathecally. This I understand, is the opinion of most of the experts since newer drugs have become available for the treatment of this critical illness. The fact that deafness as a result of intrathecal streptomycin may occur in only a minority of cases is no justification for its use even as a life-saving measure when these newer drugs may be tried.—I am, etc.,

MABEL L. HAIGH

Wetherby, Yorks

¹ Berg, K., *Annals of Otolaryngology and Rhinology*, 1949, 58, 448. Berg K. *Am. Otol.* 1949, 58, 448-455.

Behçet's Syndrome and Venous Thrombosis

SIR,—Since reading the two case reports by Drs. T. Chajek and M. Fainaru (31 March, p. 782) we have treated a 21-year-old man who presented with a deep vein thrombosis and features suggesting Behçet's syndrome—recurrent mouth ulcers, acne, pyoderma, and intermittent epididymitis but without genital ulceration. The plasma fibrinogen titre was 1/128 and plasma fibrin-fibrinogen related antigen was 12 µg/ml.

Ten days before admission the patient had jolted his left hip slightly while playing with a child. Two days later the whole limb began to swell. On admission ascending venography revealed an extensive femoral vein thrombosis. Intravenous streptokinase was given, 600,000 U in the first 30 minutes followed by 100,000 U hourly for 96 hours. Treatment was accompanied by an unusually severe febrile response (temperature up to 41°C). Intravenous infusion sites had to be changed frequently because local phlebitis developed rapidly. Warfarin was given after 60 hours' streptokinase infusion. Owren's one-stage prothrombin time was 14% of normal at 96 hours. Clinically there was a dramatic reduction in size of the leg associated with the development of dilated superficial veins over the thigh. However, a second venogram showed extension of the femoral thrombosis and presence of thrombus in several tibial veins that had been clear previously.

The improvement in Drs. Chajek and Fainaru's cases of superior vena caval occlusion treated with fibrinolytic agents was assessed solely by clinical examination. While appreciating that failure of recanalization of an occluded superior vena cava is less likely to be accompanied by a marked clinical improvement, we would emphasize that physical signs of improvement may not indicate disappearance of thrombus. Our patient's leg probably improved because of dilatation of collateral veins at a time when thrombus was actually extending. In Behçet's syndrome thrombophlebitis frequently develops at venepuncture sites¹ and this too was a feature in our patient. Caution is needed, therefore, in the absence of convincing evidence of thrombolysis, before advocating the use of intravenous fibrinolytic agents. The treatment of venous thrombosis in this rare syndrome may require a different approach from that considered appropriate in other circumstances. Our understanding of the

problem would be improved by further case reports, especially since enough cases are unlikely to be available for the purposes of a clinical trial.—We are, etc.,

D. A. TIBBUTT
D. T. DURACK
J. T. MACFARLANE
P. J. TEDDY

Radcliffe Infirmary,
Oxford

¹ Pitney, W. R., *Clinical Aspects of Thromboembolism*, p. 26. Edinburgh and London, Churchill Livingstone, 1973.

Smallpox

SIR,—I must congratulate Dr. A. B. Christie on his recent article on smallpox (23 June, p. 539).

As rightly brought out in the article, it is the variola sine eruptione which proves a challenge in diagnosis, but equally important are the very mild modified cases of smallpox which if not detected early keep the torch of a smallpox epidemic burning. While instituting the "expanding ring technique"¹ for the control of an epidemic of smallpox, it is most important to keep a vigilant watch on the most immediate contacts who,

Langer's lines, after Dixon.² Reproduced by courtesy of Messrs. Churchill Ltd.