be expected in patients with folic acid deficiency (clinical or subclinical). The findings of Kaimis, Summerly, and Giles (personal communication to Marks and Shuster, 12 September, p. 618) and the demonstration of malabsorption in the proximal small bowel⁴ which is the site of absorption of folic acid, would seem to indicate that, in addition to an increased demand, there may be malabsorption of folic acid in these patients which would further exacerbate folate deficiency.

As correctable malabsorption of vitamin B₁₂ has been described in patients with folic acid deficiency,^{9,10} it would seem likely that the malabsorption of vitamin B₁₂ in patients with various skin diseases is also due to folic acid deficiency. I wonder whether the authors have repeated the study after a course of folic acid. It would also be interesting to see whether the small bowel dysfunction in dermatogenic enteropathy reverts to normal on folic acid therapy alone without local treatment of the rash. If it does (as I suspect) in addition to the local treatment of dermatosis early folic acid therapy would seem to be indicated in patients with enteropathy, even when there are no obvious haematological changes.

Similar explanation probably holds true in enteropathy associated with various chronic debilitating illnesses and also in conditions where increased cellular proliferation is a predominant feature.—I am, etc.,

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Myocardial Infarction and the G.P.

SIR,—The hospital doctor (14 November, p. 433) who can include without explanation a delay of two days in seeing a patient with a coronary thrombosis in a discussion of factors influencing early death clearly needs to spend some time as a general practitioner's receptionist.

He would learn some of the facts in which coronary thrombosis can be presented when first brought to the notice of the medical services. He might then be in a better position to inform general practitioners what information is useful to them so as to avoid once again finding that only five out of 41 of their letters contain any useful information. Those of us who work in hospital can make everyone's work easier by explanation rather than by damning comment.—I am, etc.,

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Safety-pin Swallower

SIR,—We would like to draw the attention of surgeons to the habits of a man who has recently been admitted to Gulson and Walsgrave Hospitals in Coventry, and to St. Bartholomew's Hospital.

His initials vary between H.H. and E.H. and he gives his place of origin as Whiston, Manchester, where he has also been hospitalized on many occasions. On each of these numerous admissions he has claimed to have inadvertently swallowed a safety pin in the course of cleaning his teeth while travelling in a lorry. X-rays have shown the presence of two open safety pins in the stomach or small bowel. His abdomen has been opened a number of times, by his account for ulcer operations, but according to his previous hospital notes for the removal of open safety pins. On several recent occasions the pins have been successfully passed without any operative intervention.

We write to point out to any other surgeons under whose care he may come that despite the rather worrying appearance of the pins on x-ray, he seems to have the capacity to pass them through the gastro-intestinal track without coming to any harm.—We are, etc.,

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Nephrotic Syndrome in the Tropics

SIR,—Dr. J. S. Cameron's excellent review of the nephrotic syndrome (7 November, p. 350) summarizes experience of this disorder in non-tropical areas of the world.

The *British Medical Journal* is very widely read in tropical countries, and readers in these areas may be seriously misled about the causes of the nephrotic syndrome and its management by the account recently published. It has now been established beyond any reasonable doubt that there is a very high incidence of the nephrotic syndrome in West and East Africa, and that in the vast majority of patients an aetiological relationship with quartan malaria can be demonstrated. These patients, however, do not show a response to antimalarial therapy, and the majority also do not respond to steroid administration. Recent experience with immunosuppressive agents like cyclophosphamide and azathioprine has also been disappointing.¹⁻⁵

If one takes a "world" view of medicine, then quartan malaria must rank as one of the major causes of the nephrotic syndrome in childhood. The wide international circulation of the *B.M.J.* makes it imperative that future reviews of the nephrotic syndrome, or for that matter any well-recognized clinical entity, should indicate whether the author has taken a "local" or "global" approach to the subject.—We are, etc.,

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Allergy to Iprindole (Prondol) with Hepatotoxicity

SIR,—I must protest about the assumption that the hepatic damage attributable to iprindole administration is due to a hypersensitivity mechanism. The four letters published to date (7 February, p. 367; 25 April, p. 238; 7 November, p. 368; 21 November, p. 494) do not contain any evidence to suggest that the reported tissue damage is any more than a direct toxic effect of the drug. The finding which prompted Dr. P. J. W. Young's "feeling" (7 February, p. 367) is insufficient to incriminate an immunological mechanism. Thus to continue using the term allergy is both misleading and unjustified.

Consider for a moment what the word allergy implies. In the first instance the individual must come into contact with an antigen, which in the case of drugs is usually a macromolecular complex of drug and protein. Then, as Von Pirquet proposed,¹ a state of altered reactivity exists within the individual with respect to the antigen. This "allergic state" is not manifest as a clinical entity. Upon further contact with the antigen a hypersensitivity reaction might be produced which results in some degree of tissue damage detectable at a clinical level.

With iprindole, therefore, it is imperative to demonstrate that the liver damage is due to either the interaction of a normal antibody with antigen or between specifically allergized cells and antigen. This has not yet been reported and until it has the term "allergy to iprindole" should be discontinued.—I am, etc.,

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SIR,—The suggestion by Drs. D. F. Harrison and I. M. Stanley that the drug iprindole be withdrawn on the evidence presented of hepatotoxicity (7 November, p. 368) is very properly rejected by Drs. L. J. Clein and M. D. Cashman (21 November, p. 494). The drug has been in regular use in this hospital for seven years with no evidence of any serious side effects. In fact, continued clinical use has fully confirmed the findings of our clinical trial¹ that the drug has a particularly low incidence of side effects.

It is not disputed that the occasional hepatotoxic reaction can occur, but it should be borne in mind that this possibility exists for other tricyclic antidepressants as well, and has been recorded.² Nevertheless, the tricyclic antidepressants are regarded as a particularly safe group of drugs. Greater danger exists in the potentiality of some to