Toxoplasmosis

SIR,—In your issue of 23 September (p. 776) it is stated that a positive toxoplasmosis dye test is regarded as possibly significant when the patient's serum remains capable of preventing the uptake of dye by *Toxoplasma gondii* at a dilution of 1 in 256 or more in cases of retinal disease.

It is important to realize that almost all cases of retinitis in early adult life are due to recurrences of congenital infection, and as such may not be accompanied by high dye test titres. Taken in conjunction with the typical fundus appearance of a recurrence of chorioretinitis adjacent to an old scar, a positive dye test in a dilution of 1 in 4 or more is strongly suggestive of toxoplasmosis. Higher titres may of course occur but are not obligatory to sustain the diagnosis.

We have found that immigrants from West Africa and the West Indies with recurrences of congenital infection tend to have higher dye test titres than those usually found in the indigenous population of this country.¹

Lymphadenopathy due to toxoplasmosis is the result of recent infection and higher titres of antibody are therefore to be expected. Such patients very rarely have chorioretinitis.—I am, etc.,

E. S. PERKINS

Institute of Ophthalmology,
London W.C.1

¹ Chesterton, J. R., and Perkins, E. S., *British Journal of Ophthalmology*, 1967, 51, 617.

Growing Pains

SIR,—We are glad that Dr. J. A. Ford and Dr. M. G. Dunnigan (9 September, p. 642) have drawn attention to rickets as a cause of growing pains in children. From our experiences of rickets in Birmingham, and from a survey of 565 school children aged 14 to 16, it is evident that many have complained of aches and pains and been diagnosed as having "growing pains" in the months before a raised alkaline phosphatase has been demonstrated. We have also been impressed with the disappearance of these symptoms with vitamin-D therapy.

In contradistinction to the Glasgow observations our findings show no difference in the incidence of biochemical rickets between the races—Asian, West Indian, and White. We would therefore suggest that rickets should be considered in the differential diagnosis of "growing pains" not only in Asian but also in West Indian and White children.—We are, etc.,

W. T. COOKE

C. H. J. SWAN

P. ASQUITH

V. MELIKIAN

The General Hospital,
Birmingham

Management of Shunt Infection

SIR,—Dr. R. Rao and others (9 September, p. 618) recommend cloxacillin and sodium fusidate in the management of shunts infected by *Staphylococcus aureus* though over 50% of the patients so infected lost their shunts. Our own experience suggests that a more effective combination is clindamycin and sodium fusidate. We have used penicillinase-resistant penicillins both alone and together with sodium fusidate. The

shunt infection usually cleared, but there was a high relapse rate. Wright and Harper¹ reported favourably on the treatment with lincomycin and fusidic acid of staphylococcal infections in patients with cystic fibrosis. Since the introduction of a similar antibiotic combination, clindamycin and sodium fusidate, it has been rare to lose a shunt because of staphylococcal infection.

We do not agree that it is safe to use sodium fusidate alone for a long time, since we have seen the rapid emergence of resistant strains in patients who have received only this antibiotic. In individual patients the phage patterns of these resistant strains were the same as those of previously sensitive strains, a finding described by Lowbury and others,² who warned that sodium fusidate should be used with caution. We prefer to use 2% hexachlorophane cream in the treatment of nasal carriers.³ It is highly effective, though it should be used in conjunction with hexachlorophane soap, and there is no risk of encouraging antibiotic-resistant strains.—We are, etc.,

R. Y. CARTWRIGHT

G. H. HALL

Public Health Laboratory,
Exeter

Whipton Hospital,
Exeter

¹ Wright, E. L. T., and Harper, J., *Lancet*, 1970, 1, 9.

² Lowbury, E. J. L., Cason, J. S., Jackson, D. MacG., and Miller, R. W. S., *Lancet*, 1962, 2, 478.

³ Noone, P., Griffiths, R. J., and Taylor, C. E. D., *Lancet*, 1970, 1, 1202.

Endocrine Exophthalmos

SIR,—It may well be the case that exophthalmos is of pituitary origin, but none of the theories advanced in your leading article (8 July, p. 68) will hold water. In fact they are refuted in standard textbooks of physiology. There is no correlation between presence or absence of long-acting thyroid stimulator and exophthalmos. Thyroid stimulating hormone (T.S.H.) is certainly elevated in secondary hyperthyroidism. However, it is not raised in primary hyperthyroidism, which is something associated with exophthalmos, and T.S.H. is raised in myxoedema of primary thyroid origin. This last condition is not famed for the development of proptosis! Exophthalmos-producing substance is certainly active in fish but has not been shown to be so in man, despite diligent research.

It is well accepted now that exophthalmos can be worsened by radical therapy of thyrotoxicosis with surgery or ¹³¹I to the extent that it has been called and believed to be an iatrogenic disease. Aranow and Day² describe the management of 129 patients aged below 45 years with ophthalmopathy in thyrotoxicosis, none of whom subsequently required surgery for their eye disease. Those patients with nonexophthalmic eye changes were given full dose antithyroid treatment; the other 58 with exophthalmos ("infiltrative ophthalmopathy") were gradually made euthyroid over months. Only ten of the whole group showed an increase in proptosis of 2 mm or more—four actually decreased 3 mm or more and the vast majority were static (± 2 mm). None of the 129 patients nor the control series without prior eye symptoms developed them as a result of therapy.

Prevention is far better than cure, and if gradualism avoids a deterioration in ophthalmopathy it is surely worth a trial. Even if the results of surgery are excellent (and those of steroids are doubtful at present) in reducing proptosis by orbital decompression, it seems a pity to subject patients to what may be an avoidable operation.—I am, etc.,

MALCOLM C. BATESON

Westminster Hospital,
London S.W.1

¹ *Clinical Physiology*, eds. E. J. M. Campbell, C. J. Dickinson, and J. D. H. Slater, 3rd edn. Oxford, Blackwell, 1968.

² Aranow, H., and Day, R. M., *Journal of Clinical Endocrinology*, 1965, 25, 1.

Monitoring Bone Mass

SIR,—Dr. M. C. Bishop and co-workers (16 September, p. 664) reported a loss of bone in patients undergoing haemodialysis. They found a significant reduction in the mean percentage areas of total bone and of mineralized bone in iliac crest biopsies over the first year of dialysis but no significant reductions over one year in another group of patients who were not new to haemodialysis.

As there are many clinicians concerned with "dialysis bone disease" it might usefully be brought to their attention that a method of monitoring bone mass and bone density is available by measurement of the attenuation of a monoenergetic photon beam. While biopsies are sufficiently sensitive to detect a significant demineralization in a group of patients, bone densitometry using a monoenergetic photon source is sensitive to approximately 2% changes in individuals. Measurements may be made at frequent intervals as patients suffer no discomfort and the radiation dose per scan is less than 1/10 mrem.

We reported¹ a serial study of 13 patients initially measured at fortnightly intervals. Long-term monitoring at Leeds General Infirmary by this technique has been continued for nearly four years. Bone densitometry by measurement of photon-beam attenuation cannot indicate changes at the microscopic level, as observed in biopsy, but it is sensitive to small macroscopic changes in bone mass or in bone density.—We are, etc.,

ROBERT R. WEST

University College,
Cardiff

P. J. ATKINSON

Dental School and Hospital,
University of Leeds

¹ Atkinson, P. J., West, R. R., Parsons, F. M., and Reed, G. W., *British Medical Journal*, 1970, 3, 490.

Frequency of Gall Bladder Operations

SIR,—Before leaving Bristol last year I looked at the incidence of gall bladder surgery at Frenchay Hospital from 1953–63 by surveying the case notes of 436 patients who had operations for gallstones. I agree with Mr. C. Holland and Dr. K. W. Heaton (16 September, p. 672) that the 5th decade is the most common age for the disease. The mean age of males falling steadily from 59.5 years in 1953 to 57.2 years in 1963, while the ages of females rose from 48 to 50 in the same period.

I did not, however, find any change in the sex ratio, which remained constant at 1:3, and the number of operations did not rise