Uganda Asians

SIR,—Miss Ann Ford (30 September, p. 825) writes: "In addition to the complete initial screening which the Asians will have on landing. . . ." I understand that not all immigrants have a chest radiograph but only those whom the medical officer at the airport decides need further investigation. Arrivals at Stradishall, certainly up to last week, were all having chest x-ray examinations at the camp but not at the airports, but I understand that neither at the airport nor at Stradishall camp are the stools of all immigrants examined for bacteriological pathogens and parasites.

Having the majority of these immigrants in a holding camp rather than being immediately dispersed through the country offers an ideal chance to discover who are infected and to eradicate the infection. At the same time blood films for malaria diagnosis should be taken and treatment instituted if needed. These investigations must surely be considered as part of a complete medical examination in people coming from an area where intestinal infections and malaria are endemic.—I am, etc.,

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Problems with Ketamine Anaesthesia

SIR,—Austin and Bevan¹ recently described a child who began to bleed from an unsuspected tongue laceration while having a lacerated lip sutured under ketamine anaesthesia. The patient had to be intubated. They stressed that the drug should not be used freely just because it was easy to administer, and that facilities for intubation should always be available. A recent case in this department reinforces those views.

A 3-year-old boy had a necrotic ulcer of the leg which had been desloughed on three occasions in the operating theatre using ketamine anaesthesia with atropine premedication. Each anaesthetic had been uneventful. Attempts to x-ray the leg while conscious had failed owing to lack of co-operation, so when a change of dressing and radiography was required it was decided to induce anaesthesia in his bed, take him to the x-ray department and back, and then change his dressings, all of which it was thought could be carried out under a single intramuscular dose of ketamine. No premedication was given. Ketamine was administered intramuscularly in a dosage of 10 mg/kg and he lost consciousness in about three minutes. He then began to salivate profusely and it was decided to give intravenous atropine, but no vein could be found. Salivation became even more profuse and total respiratory obstruction occurred. Most unwisely, no provision had been made at the bedside for suction or intubation, so he was picked up and carried to a nearby side-room where these facilities were available. By this time cyanosis was intense, respiration had ceased, and an assistant was unable to hear a heart beat. Endotracheal intubation was easily carried out (relaxation being profound) and intermittent positive pressure ventilation with pure oxygen was started. Repeated tracheal suction was required. The colour soon returned to normal, spontaneous respiration began, and the heart beat and pulse were again detectable. Intramuscular atropine was given, and after some 20 minutes the tube was removed. The planned procedures were carried out, and the patient recovered consciousness apparently none the worse for the incident.

It is now policy in this department to

have full resuscitative facilities immediately available during ketamine anaesthesia just as for any other anaesthetic technique and to premedicate all patients with atropine before this agent is used. Ketamine anaesthesia has many advantages, but it certainly does not absolve the anaesthetist from his primary duty of caring for the patient's airway.—I am, etc.,

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¹ Austin, T. R., and Bevan, D. R., *British Medical Journal*, 1971, 2, 709.

Leucocytosis after Tetracosactrin

SIR,—Recently I needed to know the degree of leucocytosis which may follow the administration of tetracosactrin depot for rheumatoid arthritis. The information was not readily available, and the following case may be of interest.

A man aged 27 had moderately severe sero-positive rheumatoid arthritis affecting the joints of the lower limb, of monarticular onset and four months' duration, with continued disease activity. Pretreatment white cell counts ranged from 9,200 to 11,300/mm³ with the percentage of polymorphs ranging from 63 to 83%. Treatment was begun on 5 August 1972 with a dosage schedule of 1 mg intramuscularly daily for three days and thereafter twice weekly. On 10 August, when a total of only 4 mg had been given, the white cell count was 13,100/mm³ with 90% polymorphs, and on 16 August after a further 2 mg of tetracosactrin the white count had risen to 23,400/mm³ with 63% polymorphs. A careful search excluded an infection. Tetracosactrin was stopped, and six days later the white cell count had fallen to 10,900/mm³ with 68% polymorphs. Tetracosactrin was then restarted and next day the white cell count had risen to 17,300/mm³ with 86% polymorphs. This has subsequently settled at approximately this level, the latest count being 16,600/mm³ with 58% polymorphs.

The possibility of infection was taken seriously in this case, particularly since the onset of the disease had been monarticular and infection had had to be carefully searched for originally. It seems that an appreciable leucocytosis can be expected during such therapy, and I would be pleased to hear of other experiences in this field.—I am, etc.,

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Reversal of Adult Mental Subnormality

SIR,—Multiple adenomatosis presenting with mental manifestations has been reported twice. Fullerton and others¹ described a patient with depression, and Carney and others² a patient presenting with subnormality from birth and episodic confusion with behaviour disturbance. This latter patient had a family history of episodic behaviour disturbance in the father (islet-cell tumour and renal calcification found at necropsy), in the paternal great-grandfather, and in a cousin on the paternal side. The diagnosis rested on finding a serum insulin of 200 μ U/ml in the presence of a blood sugar of 20 mg/100 ml together with a serum calcium of 12.8 mg/100 ml and serum phosphorus of 2.8 mg/100 ml. At laparotomy a number of islet-cell tumours in the head and tail of the pancreas were excised and

the diagnosis confirmed histologically. It was impossible to remove all the adenomata. Because of the reversal of subnormality we report the outcome in this case.

After operation the patient (aged 27) was symptom-free for about six months, when psychometric tests showed a verbal I.Q. of 75 and performance and full-scale I.Q.'s of 71, an organic pattern of response, and no evidence of improvement since the operation. Thereafter, symptoms of sweating, shaking, and behaviour disturbance recurred. Serial fasting blood sugars were 30 to 40 mg/100 ml and fasting serum insulin values 95 to 115 μ U/ml. He was placed on a daily dose of 200 mg diazoxide—a non-diuretic benzothiadiazine with hyperglycaemic effects which probably directly inhibits islet cells.^{3,4} Within nine days his symptoms ceased and his fasting blood sugar rose to 80 mg/100 ml. He has remained symptom-free and returned to work. His mother reports improved behaviour, comprehension, and alertness and speed in performing tasks. Psychometric tests in March 1972 showed a performance I.Q. of 91, a full-scale I.Q. of 81, and improved psychomotor functioning—results indicating much improvement since the previous assessment and confirming that he could no longer be classified as subnormal but within the low-average intelligence range. Probably because adult verbal ability is relatively stable his verbal I.Q. remains low at 75. He is maintained on diazoxide 150 mg daily.

At the first testing there was no suggestion of a potentially higher I.Q., so improvement was neither predicted nor predictable. Undoubtedly he had been backward from birth. This was recognized by his family, village, and school. At an examination by a neurosurgeon in 1956 in connexion with an accident (not aetiologically important) he was diagnosed as backward with slowness, clumsiness, tremor, dyscalculia, and poor memory retention. Since treatment several clinical examiners, his family, and the recent psychometric tests agree on the absence of hypoglycaemic symptoms and improvement in behaviour, responsiveness, celerity, and intelligence, despite the fact that he remains hyperparathyroid.

Examples of reversal of life-long subnormality in adult life are rare, and the improvement in mental functioning under treatment with diazoxide in this case is remarkable. Nevertheless, the coincidence of improvement in symptomatology and objective tests of intelligence with the institution of specific therapy and rise in blood sugar support the conclusion that restoration of the blood sugar to normal with diazoxide is responsible for the improvement.—We are, etc.,

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¹ Fullerton, D. T., Lohrenz, F. N., and Holtey, W. J., *Wisconsin Medical Journal*, 1967, 66, 203.

² Carney, M. W. P., Weinbren, I., Jackson, F., and Purnell, G. V., *Postgraduate Medical Journal*, 1971, 47, 242.

³ Marks, V., Rose, F. C., and Samols, E., *Proceedings of the Royal Society of Medicine*, 1965, 58, 577.

⁴ Dollery, C. T., Pentecost, B. L., and Samaan, N. A., *Lancet*, 1962, 1, 735.

Acute Dystonia due to Metoclopramide

SIR,—Acute dystonic reaction after ingestion of one of the phenothiazine group of drugs