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.,

F. C. HARRIS

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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.,

C. K. DAVIES

British Military Hospital,
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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.,

A. R. ROBINSON

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Yorks

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

is now well recognized. Often the patients are referred to hospital as cases of tetanus.¹⁻³ Similar side effects from metoclopramide, commonly given as an antiemetic, are not so well known.

A 25-year-old man was referred to hospital as a case of tetanus, with one day's history of increasingly frequent muscle spasms affecting the face and limbs. His immunization history was uncertain. Though there was no recent history of trauma he had had a paronychia for 10 days, and this was thought to be a likely source of infection.

On examination on admission no abnormality was found, but soon after he started bizarre dystonic movements affecting the tongue, jaw, and both lower limbs. Inquiry disclosed that he had been taking metoclopramide for over 36 hours for nausea. He had had 100 mg (10×10 mg) in all, the last 10-mg dose having been taken an hour or so before the onset of the distress. The only other drug he had been having was sulphamethoxazole-trimethoprim for his paronychia, which had healed. Acute dystonia induced by metoclopramide was considered as the most likely diagnosis, and the patient responded swiftly to a 2-mg intravenous dose of benztropine.

Realization of this rare reaction to this very useful drug is essential and benztropine should be at hand to give intravenously whenever an atypical tetanus arrives at the casualty department of a hospital.

We wish to thank Dr. B. K. Mandal for his help and for allowing us to publish details of his patient.—We are, etc.,

P. S. VENKATESWARAN
A. G. OTTO

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- 1 Ramsden, P. D., and Froggatt, D. L., *British Medical Journal*, 1972, 1, 246.
- 2 Mandal, B. K., and Sengupta, P., *British Medical Journal*, 1972, 1, 441.
- 3 Snowden, J., *British Medical Journal*, 1972, 1, 572.

Skin Exfoliation after Renal Failure

SIR,—Exfoliation of the skin associated with acute renal failure has been reported.¹ No further reports have been published, so we report the following cases.

A 26-year-old man had acute renal failure after cholecystectomy. He was successfully treated with mannitol and frusemide. On the seventh day flakey exfoliation of the skin of the scarlet-fever type developed on both hands and feet and also on the back. The skin became hard and dry. Bacterial study did not help in diagnosing the cause. Fungal cultures were negative, and the white blood cell count was normal. The exfoliation persisted for about six days.

A 36-year-old woman had acute renal failure after an instrumental abortion 10 days previously, when some detergent had also been injected into the uterus. After curettage and three peritoneal dialyses she recovered completely. Exfoliation of the skin of the scarlet-fever type with large flakes being shed from both hands and feet, developed in the recovery stage. The skin was hard and dry. Fungi were not found and white blood cell counts were normal.

A 4-year-old child was admitted to the dialysis unit because of acute renal failure after gastroenteritis of unknown cause. He received a peritoneal dialysis and four days later entered the polyuric phase. When he was completely recovered desquamation of the scarlet-fever type appeared on both hands, at the root of the nose, and on the dorsal part of the left foot. Again the skin was shed in large flakes, and again bacterial and fungal cultures and white blood cell counts did not contribute to the diagnosis.

In each case the lesion was present on both hands and feet and desquamation also occurred at the free edge of the finger nails. The fact that all three cases recovered indicates that the skin exfoliation is not a poor prognostic sign in acute renal failure.—We are, etc.,

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- 1 Monasterio, G., *Le Nefropatie Mediche*, p. 152. Firenze, U.S.E.S., 1970.

Abdominal Distention

SIR,—In adopting the veterinary procedure used for "blown" cattle and using percutaneous decompression on human patients Mr. G. A. D. Lavy (23 September, p. 767) has used a method already advocated by Johann Peter Frank in the late 18th century.

Johann Peter Frank gave an academic address at the University of Pavia on 1 May 1790 under the title: *De Morbis Pecudum A Medentibus Nequaquam Praetervidendis*. In his lecture Frank stressed the great importance of comparative pathology and medicine and pointed out that human medicine had a great deal to learn from the observation of the diseases of animals and of veterinary practice.

The address was published in the 9th volume of the *Delectus Opusculorum Medicorum*, etc. . . . (pp. 235-48), Pavia 1790, and in a footnote on page 247 the author states: "Meanwhile the puncture of a tympanitic abdomen in a human being has been undertaken twice, by CL. DUSSEAU, vid. Journal de Medec. année 1779, p. 308. Samml. auserlesener Abhandl. für practische Aerzte V.P. II. St. p. 241."

This, I hope, will, at least in part, answer Mr. Lavy's query.—I am, etc.,

R. HELLER

Hillingdon, Middlesex

Was it a Drug?

SIR,—Dr. A. A. Lewis's concern (2 September, p. 588) at the vacuum left by the demise of *Proplis*, for all its shortcomings and illogical distinctions, must be shared by many general practitioners. We really have not time to prepare and submit scientific and legalistic justifications to local medical committees or the Department of Health for treatment that we prescribe under the Health Service. We are repeatedly assured that we may prescribe under the N.H.S. any drugs we consider appropriate in the treatment of our patients provided we are prepared to justify our actions when our prescriptions are for preparations vaguely referred to as "borderline substances." The borderline is usually one between foods and drugs and toiletries.

Let us be delivered from the awful doubt about the propriety or non-propriety of prescribing under the N.H.S. items in this limbo by the issue of a list of all proprietary (and non-proprietary) preparations advertised exclusively to doctors that could, in the most liberal possible interpretation of the

epithet, be called "borderline substances." Let it be made a requirement that the manufacturers of preparations declared "non-prescribable" state this fact on their "product data sheets" supplied to doctors. But please let the list be drawn up by a committee that thinks logically. Surely starch-reduced foods for diabetics and salt-free butter for patients on low sodium diets are still foods not drugs. But surely individual or multiple nutritional factors such as vitamins, protein, amino-acids, or minerals (such as iron, calcium, or potassium) are drugs when prescribed for specific single or multiple nutritional deficiencies.—I am, etc.,

K. MEIKLEHAM

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New Consultant Contract

SIR,—The letter from Dr. D. Lynch (14 October, p. 118) implies that I indicated I was prepared to accept as policy ("A") motion 167 at the A.R.M. in order to prevent a debate on contrary motion 168 from South Middlesex. The facts are that at the time I was invited by the Agenda Committee to comment on the motions submitted for the A.R.M. the National Hospital Medical Staffs Conference had not yet been held. I was not prepared to accept certain motions on the contract proposals other than as references to Council ("AR") until the matter had been debated at the Hospital Conference. In the event, the Conference gave its overwhelming endorsement to the proposals and I was able to accept motion 167 as policy ("A") at the A.R.M.

It is for the Representative Body to decide whether it wishes to debate motions which a chairman of committee is prepared to accept as policy. Later during the A.R.M. the Chairman of the R.B. announced that he had received a letter from representatives of three constituencies requesting a suspension of standing orders in order to permit a debate to take place on motions 165-168. However, the Meeting resolved by the requisite majority to pass to the next business.

It is certainly not my intention to prevent debate on the new proposals. Indeed, I welcome as much debate as possible. Earlier this year 15,000 copies of the proposals were circulated to regional committees for hospital medical services and to other bodies, and there has been widespread discussion in medical staff committees.

Last week, at the first meeting of the Central Committee for Hospital Medical Services in the new session, I indicated that when negotiations had been completed on the new proposals, the results would be submitted to regional committees for their views and comment. I urge all consultants to take that opportunity to join in discussing the final version of the proposals and to ensure that their representatives on regional committees are aware of their views.—I am, etc.,

CLIFFORD E. ASTLEY

Chairman,
Central Committee for Hospital Medical Services
Middlesbrough, Teesside

SIR,—Messrs. D. E. Bolt and P. F. Jones (12 August, p. 414) stated that the work