Zoster in Families

SIR,—I was interested in Dr. R. E. Hope-Simpson's report of zoster in three siblings (7 September, p. 626), and would like to report two cases of zoster which may be of some interest. These occurred not in siblings, but in husband and wife. They had recently returned from holiday abroad and were in perfectly good health when within a day of each other they both developed herpes zoster, affecting the ophthalmic division of the trigeminal nerve in the wife and a thoracic segment in her husband.

In view of the current theories of the aetiology of this condition I thought these two cases were of some interest.—I am, etc.,

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Spontaneous Primary Hypothyroidism with Unilateral Exophthalmos

SIR,—The relationship between thyroid status and ophthalmopathy in Graves's disease is still incompletely understood. In most cases the eye signs develop either together with or following the treatment of hyperthyroidism, but it has been known for a long time that ophthalmopathy may precede clinical hyperthyroidism,¹ while some patients with ophthalmopathy apparently never become hyperthyroid. More rarely, eye signs develop in a patient with primary hypothyroidism who has never shown symptoms of thyrotoxicosis.² We recently saw a patient without a history of hyperthyroidism in whom the development of unilateral exophthalmos preceded the onset of clinical hypothyroidism by over three years.

A 49-year-old man was referred to this hospital in May 1974 because of symptoms of fatigue, cold intolerance, and listlessness of one month's duration. In March and April 1971 he had been seen elsewhere by an internist, an ophthalmologist, and a neurologist because of protrusion of the right eye. He appeared clinically euthyroid, his serum hormonal iodine was 5.2 µg/100 ml (normal 3.0-6.0 µg/100 ml), and no neurological disturbances were found. In February 1972 he was admitted to the department of ophthalmology of the University of Amsterdam (Wilhelmina Gasthuis) for an extensive examination, including stereoscopic radiography, planigraphy, phlebography, arteriography, ultrasonography, electromyography, and brain scintigraphy. There was a right-sided proptosis of 3 mm and the patient complained of diplopia, but the motility of the eye was hardly impaired. Apart from a stricture of the superior ophthalmic vein no other abnormalities were found. The patient appeared clinically euthyroid; the serum thyroxine (T₄) level was marginally elevated (14.0 µg/100 ml; normal 5.0-13.5 µg/100 ml), the T₄ binding index was normal (0.95; normal 0.85-1.20). Endocrine ophthalmopathy was considered probable. The radioiodine uptake, determined in May 1972, was normal (19, 29, and 42% at 2, 6, and 24 hours respectively; normal limits at 24 hours 20-50%); however, these values were virtually unchanged during triiodothyronine suppression, which confirmed the endocrine nature of the eye signs.

When the patient was seen in our outpatient department the eye signs were not appreciably changed, but signs and symptoms of hypothyroidism were obvious. In addition to the symptoms mentioned above, his movements had become slow and his voice lower, and he had gained 10 kg in weight over a period of eight weeks. The thyroid gland was hardly palpable. Primary hypothyroidism was confirmed by laboratory tests: serum T₄ 1.6 µg/100 ml; serum thyroid-stimulating hormone 45 µU/ml; 24-hour radioiodine uptake 15%.

Endocrine ophthalmopathy may develop while the patient is clinically either hyperthyroid, euthyroid, or hypothyroid. Some of

the euthyroid patients eventually become hyperthyroid. To our knowledge, hypothyroidism developing spontaneously in a previously euthyroid patient with endocrine ophthalmopathy has been reported only once before.³—I am, etc.,

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- 1 Werner, S. C., *American Journal of Medicine*, 1955, 18, 608.
- 2 Fox, R. A., and Schwartz, T. B., *Annals of Internal Medicine*, 1967, 67, 377.
- 3 Haydar, N. A., *Journal of Clinical Endocrinology*, 1963, 23, 215.

Management of Lithium Treatment

SIR,—The paper by Dr. J. L. Crammer and others (14 September, p. 650) regarding plasma lithium levels is timely. In many quarters an exaggerated respect is shown to the value of a serum or plasma lithium estimation with little regard to when the blood specimen was taken. Amdisen¹ has cogently pointed out how essential it is to take blood for serum lithium 12 hours after ingestion of the last lithium tablet, and this point is correctly emphasized in the paper. There are, nevertheless, a number of points that we would like to qualify, some of which are at variance with our own work.

Though a number of sustained-release tablets do not release their active drug except in an alkaline medium, this is not the case with Priadel and Lithium Phasal, the two sustained-release preparations used by Dr. Crammer and his colleagues. Both these preparations are designed to disintegrate slowly irrespective of the pH of the medium in which they are present. We have found no difference in the rate of release of lithium in vitro from Lithium Phasal in artificial gastric and intestinal fluids under similar conditions, while the rate of release of lithium from Priadel is slower in intestinal juice than in the acid medium.² It is also stated by Dr. Crammer and his colleagues that "fasting may be expected to produce delay [in pyloric opening] like propantheline," thus leading to delayed absorption of any drug administered in the fasting state. The converse is in fact the case; simultaneous ingestion of food with a drug delays absorption of the drug by decreasing gastric emptying.³ More variable results are therefore likely to be obtained if lithium (or any other drug) is given after breakfast because of the different amount of food taken by each patient. The authors also suggest that the lithium dose be taken in the evening or when going to bed. We have shown an increased nocturnal excretion of lithium and so, in order to achieve the same plasma level, this practice would require a larger dose of lithium to be given at night than during the day.²

We are surprised at the claim that the faecal excretion of lithium in all preparations was less than 0.1 mEq/24 hours. The previous results on faecal excretion of lithium from this unit, to which the authors refer⁴ (though the reference is not actually listed), were obtained after administration of aqueous lithium citrate. Recent work with sustained-release preparations of lithium by us has shown faecal excretions as high as 7 mEq/24 hours.²

Finally, Dr. Crammer and his colleagues suggest that a lithium tolerance test be per-

formed on patients before beginning lithium treatment in order to determine the most appropriate dosage. Geisler *et al.*⁵ have already described a method of determining renal lithium clearance from the results of which one is able to determine the dose of lithium that the patient should receive at the start of treatment. A new test seems unnecessary.—We are, etc.,

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- 1 Amdisen, A., *British Medical Journal*, 1973, 2, 240.
- 2 Birch, N. J., *et al.*, *British Journal of Clinical Pharmacology*, in press.
- 3 Goodman, L. S., and Gilman, A., *The Pharmacological Basis of Therapeutics*, 4th edn., p. 6. New York, Macmillan, 1970.
- 4 Hullin, R. P., *et al.*, *British Journal of Psychiatry*, 1968, 114, 1561.
- 5 Geisler, A., Schou, M., and Thomsen, K., *Pharmakopsychiatrie NeuroPsychopharmologie*, 1971, 4, 149.

Prazosin in Hypertension

SIR,—We have read with interest the report by Drs. G. S. Stokes and M. A. Weber (11 May, p. 298) on the effectiveness of prazosin in the management of hypertension. As most of their patients suffered from uncomplicated essential hypertension we would like to communicate our initial experience in a group of 25 patients of whom 16 had secondary hypertension and 16 had renal impairment.

Poorly controlled hypertension was the reason for initiating therapy with prazosin, and in all instances the agent was added to pre-existing hypotensive agents. Five patients had exudative retinopathy, another four had diastolic blood pressure readings equal to or greater than 130 mm Hg, and another nine had evidence of left ventricular hypertrophy. The group received an average of five months' therapy and nine patients required a total daily dose of 10 mg or more of prazosin. The diastolic blood pressure was lowered to 100 mm Hg or less in 17 patients, and five of these achieved a diastolic pressure of 80 mm Hg or less. Two patients died from the vascular complications of their hypertension and one patient defaulted. Though side effects were attributed to prazosin in nine cases, in none did this necessitate withdrawal of the drug.

We conclude that prazosin is valuable in achieving control of hypertension in refractory hypertension states when used in combination with other medications and may be used in the presence of renal insufficiency.—We are, etc.,

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La Condition Humaine

SIR,—What a depressing Personal View has been written by Dr. S. Bradshaw (14 September, p. 682). It cannot go unchallenged.

If science has destroyed the spirit of Christianity, has scientific analysis of the pigments also destroyed the beauty of the great paintings? Scientific archaeology, far