criticism it would be a shame to miss seeing the unique niche this drug has in the treatment of urinary infections by organisms previously only susceptible to intramuscular therapy. We were fortunate in having some of the earliest clinical trial material of carfecillin and were therefore able to witness a number of occasions when its use cured urinary infections which would previously have been treated with a parenteral antibiotic. In particular, the life of a middle-aged paraplegic was transformed by carfecillin. Previously he had been subject to repeated febrile episodes with malaise and sweating accompanied by the isolation of a *Pseudomonas aeruginosa* from the urine and treated by admission to hospital and intramuscular therapy. Though no antibiotic (including carfecillin) ever cleared his urinary tract of infection permanently, a course of carfecillin started at the onset of a febrile episode controlled it quickly, enabling him to remain at home. Eventually confidence in the therapy enabled him to take a holiday, his first since the onset of his illness two years previously.—I am, etc.,

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Bristol

Skin Reactions to Beta-blockers

SIR,—I was interested to read the comments of Dr. J. B. Cumberbatch (30 November, p. 528) on an apparent reaction to oxprenolol.

For the sake of accuracy, however, I should make it clear that in my letter of 26 October (p. 229) I did not intend to imply that the reactions to practolol I noted were in fact "exacerbations of psoriasis," though they appeared at first sight to be so. As I pointed out in the earlier part of my letter, by virtue of its psoriasiform appearance a practolol rash may be missed when superimposed upon the psoriasis and mistakenly thought to be an exacerbation of the psoriasis.—I am, etc.,

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Elizabeth Garrett Anderson Hospital,
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Medical Nemesis

SIR,—Congratulations on your thought-provoking leading article (7 December, p. 548) and the three well-written reviews under the same title about Ivan Illich's book¹ (7 December, p. 573).

I was reading them last night and half listening to Michael Parkinson's second interview with Muhammad Ali, which my wife had on the television. The vocal boxer was just commenting that he did not feel criticism came well about fighter's techniques from those who had never been in a boxing ring—and thinking back to my memories of schoolboy boxing three-round bouts I agreed with him. But also I felt that similar views were being expressed by your three reviewers in their own way about the criticisms of medical practice levied by Ivan Illich.

Like your reviewers I feel that the "insatiable and ill-informed" demand for much of modern medicine is from those outside the medical profession rather than from

those practising it. It is too often the politicians and academic sociologists who "shout from the rooftops appropriately festooned with television aerials the benefits and breakthroughs of modern technology."—I am, etc.,

COLIN R. PORTEOUS

Ormskirk, Lancs

¹ Illich, I., *Medical Nemesis*. London, Calder and Boyars, 1974.

Acute Calf Swelling

SIR,—We were interested to note the new physical sign of calf haematoma described by Dr. D. A. Tibbutt and Mr. A. J. Gunning (26 October, p. 204). In discussing the problem the authors do not mention another cause of acute calf swelling which may mimic deep venous thrombosis and if incorrectly treated can produce calf haematoma.

Acute synovial rupture of the knee joint with leakage of synovial fluid into the tissues of the calf can resemble the symptoms and signs of deep venous thrombosis very closely.¹ It occurs in patients with a previous history of knee arthritis and effusion when the joint is subjected to a sudden or prolonged increase in pressure such as on rising from a kneeling position.² Distinction from a deep venous thrombosis is usually possible if an arthrogram is performed shortly after the event. The patient should be exercised in the standing position and contrast medium will then be seen to pass down into the calf. Incorrect treatment of this condition with anticoagulants can produce a persistent calf haematoma.³

The condition is not uncommon in departments of rheumatology, and Jayson *et al.* have described 20 patients seen over a period of 18 months.² We have seen 10 patients with acute synovial rupture in one year in our department attached to a district general hospital. Like other authors⁴ we feel the condition of acute synovial rupture of the knee joint producing acute calf swelling is underdiagnosed. It is not well documented in the general medical literature and merits consideration in a patient with a previous history of knee effusion who presents with acute calf swelling.—We are, etc.,

B. THALAYASINGAM
A. J. SWANNELL
S. A. JAMES

Department of Physical Medicine,
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Nottingham

¹ Dixon, A. St. J., and Grant, C., *Lancet*, 1964, 1, 742.

² Jayson, M. I. V., *et al.*, *Annals of Physical Medicine*, 1969, 10, 175.

³ Tait, G. B. W., Bach, F., and Dixon, A. St. J., *Annals of the Rheumatic Diseases*, 1965, 24, 273.

⁴ Hughes, G. R., and Priddle, R. B., *Proceedings of the Royal Society of Medicine*, 1970, 63, 587.

Lorazepam Poisoning

SIR,—Lorazepam (Ativan) is a new member of the benzodiazepine group of tranquilizers which is not yet widely prescribed. We record the case of a child with moderate overdose of this drug which produced surprisingly severe effects.

A 6-year-old boy ingested some of his mother's individually foil-wrapped 1-mg lorazepam tablets and presented at hospital two hours later with drowsiness and ataxia. The maximum possible

dosage ingested appeared to be 30 mg and was probably considerably less. Careful questioning of the mother excluded the concurrent ingestion of any other drug and positively identified the tablets taken as lorazepam. Gastric lavage was carried out and no tablets were recovered from the washings. The child was admitted for observation. On examination he was drowsy but responded maximally to minimal stimuli. His pulse and blood pressure were normal but he was demonstrably ataxic. No other abnormality was present. About four hours after the self-poisoning episode the child became manifestly hallucinated, reaching out at invisible objects, grasping them, examining them, and chattering incoherently. We were unable to establish the nature of these hallucinatory objects. This behaviour continued intermittently for nine hours and examination on several occasions confirmed the movements to be purposeful and related to the hallucinated state rather than to extra-pyramidal dysfunction. The central nervous system was otherwise normal on examination, apart from generalized hyper-reflexia, and the plantar reflexes remained flexor throughout. After 27 hours the child appeared bright and alert, there were no abnormal neurological signs, and he was discharged.

We have been unable to find any other recorded case of lorazepam overdose in children. The fatal dose in an adult is thought to be around 1.85 g. Known side effects of overdose are drowsiness and stupor. Hallucinations are a recognized complication of overdose with diazepam, a more widely used member of the benzodiazepine group. On a body weight basis the fatal dose for a child of this age would be between 500 and 600 mg. It was therefore surprising to find severe toxic signs with marked hallucination in an otherwise healthy child at a fraction of that dosage. Clinicians should therefore be alert to the potential central nervous system toxicity of this drug in children with even mild to moderate degrees of overdose.—We are, etc.,

D. I. JEFFREY
M. F. WHITFIELD

Leith Hospital,
Edinburgh

The Roseolar Reaction

SIR,—Your leading article on fourth, fifth, and sixth diseases (23 November, p. 429) offers no information about the aetiology of the last of these, exanthema subitum or roseola infantum.

In 1966¹ and 1969² I published my hypothesis that this is not an infection *sui generis* due to one particular pathogen but a slow febrile immunizing reaction against many different, mainly intestinal rather than respiratory, viruses. Perhaps for this reason roseolar rashes are commonest in summer and autumn. The fast febrile immunizing reaction or "one-spike" fever is, as its name implies, all over in 24-36 hours; the roseolar reaction takes three or four days from onset to rash. Family doctors are usually called not for the illness but for the rash, sometimes ascribed to teething or possibly rubella. The rash consists of small pink macules surrounded by a pale areola; this bird's eye effect becomes more obvious as the skin cools after the child is uncovered.

In family studies I have seen a 13-month-old baby develop a roseolar reaction while her sister aged 2½ years suffered only a "one-spike" fever; from each Coxsackie A6 virus was isolated. Two other children have each had two separate roseolar rashes, two months and 13 months apart respectively. A mother was ill with fever and meningism; Coxsackie B2 virus was isolated from her

20-month-old baby, who developed a roseolar rash at the same time. Among the types of virus isolated from throat or faecal specimens from my patients at the time of their roseolar reactions were adenovirus 2, 3, and 14, echovirus 9, 11, 27, and 30, Coxsackie A6 and 9, Coxsackie B2, 4, and 5, and parainfluenza type 1.

Most children who received the earlier, less attenuated, measles virus vaccines developed a roseolar reaction as their fever subsided. This rash differed from that of measles in two respects: it began on the trunk instead of the face and it appeared as the temperature dropped and not at the start of the secondary fever.

Children who undergo either the fast ("one-spike") or the slow (roseolar) febrile immunizing reaction are as a rule otherwise healthy and free from any localizing signs of infection in the ears, nose, throat, chest, abdomen, or urine. The younger the child, the higher is the temperature likely to be. Presumably the roseolar rash is due to virus particles being neutralized in the skin at the end of a period of viraemia. Perhaps viraemia does not occur in the "one-spike" fever and so no rash appears.

Please may sixth disease now disappear from the next edition of textbooks?—I am, etc.,

G. I. WATSON

Peaslake, Surrey

¹ Watson, G. I., *Journal of the College of General Practitioners*, 1966, 11, Suppl. 1, p. 15.

² Watson, G. I., *Proceedings of the Royal Society of Medicine*, 1969, 62, 1135.

Hernias in Children

SIR,—Your leading article on this subject (31 August, p. 540) was moderately distressing to me since I described the transperitoneal probing technique 11 years ago.¹ Shortly after the article appeared I was informed by a colleague from New Jersey that he had published such a procedure in an earlier article in that state's medical journal. More recently a U.S. naval surgeon exhibited a film at a clinical congress of the American College of Surgeons without prior reference.

I suppose what this represents is an unfortunate tendency for good ideas to become buried under the tons of more current literature, so I would not be surprised to learn that some canny Scot had described the same technique in an obscure journal around the turn of the century. But, for the moment, the Colonials have it over the Danes three to one.—I am, etc.,

EDWARD O. GOODRICH JR

Santa Fe,
New Mexico

¹ Goodrich, E. O., jun., *Surgery*, 1962, 54, 432.

In Arduis Fidelis

SIR,—As a medium-brass regular R.A.M.C. officer, may I express my admiration for Sir George McRobert's fine review of Lt. Gen. Sir Neil Cantlie's stirring *History of the Army Medical Department* (12 October, p. 111) and may I express my gratitude to you, Sir, for the generous allocation of space for the review.

I write, however, to take sharp exception to a sentiment expressed in the first para-

graph—"the modern view . . . that defence medical services should consist of a regular 'core' of doctors highly trained in logistics, administration, and military planning and that consultants and clinical doctors should be obtained on a temporary basis from civil sources seems to be gaining ground." I think this view may be losing a little ground. It is most important that doctors considering joining the R.A.M.C. be not misled. The great majority of R.A.M.C. officers are engaged in the clinical care of the wounds, diseases, and injuries of members of the Army, their wives and children, and a large number of other persons entitled to treatment who include such sufferers from exotic diseases as the Chinese, Nepalese, and Cypriots.

In my experience the very highest posts in the Army Medical Service are filled by the appointment of Army doctors of clinical skill and experience who also happen to possess skill in administration, logistics, etc., whether natural or acquired. That experience in military surgery and tropical medicine is still acquired by the Army's consultants is fortunate, for these are the injuries and diseases of disasters, famines, wars, and social collapse; knowledge and experience that it is important for all ranks of the Army Medical Service to possess.

I had better add that these represent my own views and are not to be construed as the views of the Service.—I am, etc.,

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Medicine and the Common Market

SIR,—Perhaps some of the least publicized features emerging from the E.E.C. regulations on social security are the reciprocal medical treatment arrangements. These regulations go some way along the road to dispelling public sensitivity over the hitherto unilateral United Kingdom N.H.S. "good Samaritan" service. In particular, they provide that worker nationals (and members of their family) of the U.K. and other community countries who are on holiday or otherwise staying temporarily in a community country will be entitled to medical treatment for sickness or accidents which require urgent attention, on the same basis as insured nationals of that country, subject to their being armed with appropriate documentation. A welcome reciprocal tit-bit. The experiences to date of U.K. hospitals and general practitioners on this front would doubtless be interesting—or perhaps the experiences of the British public in the other member states would prove more interesting. However, nestling in the related E.E.C. regulation is a more intriguing, thought-provoking provision which demands precise quotation.

"A worker, and any members of his family . . . who is authorized by the competent institution to go to the territory of another member state to receive there the treatment appropriate to his condition, shall be entitled . . . to benefits in kind provided on behalf of the competent institution by the institution of the place of stay (or residence) in accordance with the legislation which it administers . . . the length of the period during which benefits are provided shall be governed, however, by the legislation of the competent state . . ."

"The authorization required may not be refused where the treatment in question cannot be provided for the person concerned within the territory of the

member state in which he resides." (Article 22 of Regulation/E.E.C./No. 1408/71 of the Council of 14 June 1971).

Few could deny the laudable intentions of such philosophy but, in turn, few could fail to detect palpable fundamental attendant difficulties. Inherent in such a system is the need for prearranged admission to hospitals, exchange of medical histories, the related hazards of "queue-jumping," language difficulties, disclosure of patients' records, etc. Other questions spring readily to mind. Who decides whether the treatment is appropriate to the condition—indeed, what medical significance has the expression "appropriate"? Could, for example, a rejection by one member state that certain treatment was "appropriate," though successfully practised in another member state, perhaps sour European medical rapport to some degree? Doubtless few cases have surfaced since our entry into E.E.C., but such is the profundity of the doctrine of this feature of the regulation and its practical possibilities that it seems to me timely to inquire of hospitals, consultants, and general practitioners what their experience has been in terms of general difficulties, documentation, the overall mechanics of such exercises, how much awareness they had of the regulations, and the reaction from the patients. Perhaps these columns would be a convenient vehicle for such information.—I am, etc.,

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Ethylloestrenol

SIR,—With reference to your leading article on "Fibrinolysis and Venous Thrombosis" (16 November, p. 365) I would like to correct the error made in calling ethylloestrenol an oestrogen. Though I appreciate its name may falsely suggest it to be oestrogenic, it has been shown by Junkmann and Suchowsky¹ to possess primarily anabolic, some progestogenic, and slight anti-oestrogenic properties.—I am, etc.,

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¹ Junkmann, K., and Suchowsky, G., *Arzneimittel-Forschung*, 1962, 12, 214.

Agoraphobia

SIR,—Your leading article on this subject (26 October, p. 177) dismisses the use of tricyclic compounds in the treatment of this condition somewhat abruptly, yet these compounds are frequently effective in agoraphobic conditions and they are often the first line of therapy in both general practice and psychiatric clinics. Two preparations in particular are of value—namely, clomipramine and opipramol.

In the treatment of agoraphobic patients in a busy outpatient clinic Harding¹ reports favourably on the use of oral clomipramine, describing this drug as being useful in these circumstances. Marshall and Micev² have shown the effectiveness of intravenous infusions of clomipramine in phobic disorders. No controlled trial of the use of clomipramine in phobic states has, however, been reported.

Capstick and Rooke³ in a double-blind trial of opipramol in comparison with a