of ketone bodies and lactate. The modern spectrophotometric enzymic methods have greatly simplified the determination of ketone bodies\(^6\) and lactate.\(^7\) It should also be noted that the determination of lactate in serum may lead to spuriously high values due to lactic acid production during red cell glycolysis.—We are, etc.,

H. F. WOODS.

Department of the Regina
Professor of Medicine,
Radcliffe Infirmary,
Oxford.

D. H. WILLIAMSON.

Metabolic Research Laboratory,
Nuffield Department of Medicine,
Radcliffe Infirmary,
Oxford.

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Central Venous Pressure

Sir,—Under “New Appliances” (28 December, p. 825) there was a presentation of a central venous pressure (C.V.P.) self-leveling transducer (using an expensive, elaborate, and fairly complex piece of equipment for what should be a simple and routine measurement in seriously sick patients with fluid problems). The point of reference is the most complex part of C.V.P. measuring, most taking the centre of the chest (in three dimensions) so that a patient can be nursed in any position without having to be moved for C.V.P. measurements. This usually can be explained to ward staff without difficulty, and then frequent measurements are easier, so long as the communication of the catheter is maintained and checked.

After spending many long hours with 3-ft. (90-cm.) or shorter bubble levels, broomsticks, and drip stands in comparing the C.V.P. catheter level with the right atrium (for example, centre of chest in three dimensions, antero-posterior, vertical, and horizontal) it is interesting to see such a simple principle become so complex.

It occurred to me that one could set up a loop of plastic tubing, one side running parallel to the C.V.P. on the measuring scale and the other mobile and near the patient. Enough water to cover tubing to reduce confusion) is placed in this U-tube so that, when the tube is laid roughly vertical to the patient’s side and the tube raised or lowered so that the patient’s estimated reference point is matched by the fluid level, then the remote end will reflect the height of the centre of the chest. Several measurements—say three—should be done either by the same person or by several people and the mean taken. If more than half-hourly readings are needed, then the patient is probably sick enough to have a doctor with him during these periods, as in surgical, burns, trauma, and cardiac cases. The patient may be left to sleep except for taking the blood pressure and changing the posture. The main difficulty in

TABLE I

<table>
<thead>
<tr>
<th>Family Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Died at the age of 42 years, one year after surgery for reported carcinoma of the rectum.</td>
</tr>
<tr>
<td>2. Carcinoma of the sigmoid colon diagnosed at 75 years. Diverticular disease also present. No polypli. Histology: adenocarcinoma. Died six months later.</td>
</tr>
</tbody>
</table>

Insulin Response

Sir,—The article by Dr. A. N. Rigas and others (5 October, p. 25) aroused much interest here. They suggest that chlorpropamide lowers the level of blood glucose necessary to elicit a given insulin secretion by the beta cells. A similar observation was made by Ping Chi Chiu et al.\(^1\)

We have measured plasma tolbutamide, gluce,

solvent, and non-esterified fatty acids in ten patients over 48-hour periods, both on a single, large, regular dose of tolbutamide and on the same amount given in divided doses.\(^2\) We noted a fluctuation in the blood sugar which tolbutamide set at a lower mean level. The insulin response appeared to be dependent on the glucose and not the tolbutamide levels. We postulated that tolbutamide alters the "glucostat", which determines the insulin response.

It appears then that both tolbutamide and chlorpropamide may restore the abnormal insulin response of diabetics towards normal. Whether the primary adjustment is a reduction of glucose levels or enhanced insulin secretion with secondary lowering of glucose remains to be elucidated.—We are, etc.,

A. I. VINIK.

W. P. U. JACKSON.

Faculty of Medicine,
Sub-Department of Chemical Pathology,
University of Natal,
South Africa.

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Familial Non-Polyposic Carcinoma of Colon

Sir,—Carcinoma of the colon is well known to occur sooner rather than later in families with the multiple polyposis syndrome.\(^3\) Solitary polypi which become malignant may also be an inherited condition.\(^4\) Familial carcinoma of the colon apart from polyposis is rare. I should like to describe such a family in which the mother and four out of eight of the offspring have had histologically proved carcinoma of the colon and the father is reported to have died from carcinoma of the rectum. The details are shown in the Fig. and Table.

![Table I](http://www.bmj.com/)

![Table II](http://www.bmj.com/)

![Table III](http://www.bmj.com/)

Although a case can be made for prophylactic colectomy in the, as yet, unaffected members of this family, it is proposed to follow them on a prophylactic basis with barium enemas yearly, or immediately should symptoms occur.
I would like to thank Dr. M. G. FitzGerald, under whose care the propositus was admitted, for his help and advice, and Dr. H. Thompson for reviewing the history.

—I am, etc.,

J. F. FIELDING.

General Hospital, Birmingham

REFERENCES


Scabies in Negroes

SIR,—I was interested to read of the immense gain in knowledge from Dr. F. A. Ives’ experience in West Africa and that scabies was a rare disease in Africans (14 December, p. 706). It is certainly not rare among the urban Africans in Rhodesia and it has also been reported from Kenya by Dr. R. W. Smith (15 July 1967, p. 174) that in Central Tanganyika scabies is a serious problem and in some villages almost 100% of children over 6 months old are affected.

In Salisbury we have found it necessary, as a public health department, to set up a scabies clinic in the Harari township, and the monthly total of patients treated at this clinic in the past three years has varied between 1,000 and 5,000. Bearing in mind that the total African population of the township is reputedly 236,000, this represents a fairly high endemic rate of scabies. Recurrences are frequent, particularly among single men and families in the older types of accommodation sharing ablution facilities.

While we do not examine every instance by scraping, many of these have been confirmed microscopically and respond to the usual treatment (benzyl benzoate or monocid). Some of our patients report that a similar type of skin condition has been occurring in their home reserves, so it is clear that scabies is endemic among Africans living in the township.—I am, etc.,

T. J. STAMPS.

City Health Department, Salisbury, Rhodesia.

SIR,—Dr. F. A. Ives (14 December, p. 706) has kindly invited comment on some inconsistent features of scabies as between negro and white patients. Clinical observation over 20 years in Pretoria has taught us that Dr. Ives’ puzzles are not imaginary.

In the white population the regular reservoirs of scabies were for many years the country boarding schools, inferior boarding houses, and similar crowded residences. Importation of scabies into “nice” families would come from teenage children for the holidays from these boarding schools, or from the vicinities in which they lived. When a baby or a toddler developed scabies it was never acquired from a Bantu nanny but usually from a young and helpful white friend or relative. Furthermore, scabies in whites has been extremely scarce for the last few years. Recovery of the scabies has been very easily accomplished in white patients at all times.

In the Bantu population we were wont to diagnose scabies uncritically in the early 1950s in about 5% to 6% of outpatients. After a few years we started to wonder if we had been dreaming. Follicular rashes there still were, but convincing scabies vanished. In the late 1950s the writer often challenged the registrars to produce an acarus from the negro skin, and none was forthcoming. An occasional Indian patient back from India, who had acquired scabies over there or on the boat, made us realize that a brown skin was no bar to finding the acarus. Clarke and his colleagues in Lagos, published in 1959, were almost unbelievable, since I had by then become convinced that scabies was confined to the white population. When Dr. Roger Harman found, in 1962, after his stay in Ibadan, we were eager to ask him how many acari he had seen recovered from patients. Because of his short stay there he gave a guarded answer, and could not solve the mystery. Then from about 1965 onward a slow trickle of Bantu patients with readily demonstrable scabies started coming our way. The flow gained in strength over the ensuing three years and reached a peak by the middle of 1968. At this time the skin outpatients’ department had doubled its patient turnover, 50% of the cases being scabies. The epidemic was then taken in hand by the local health department and the numbers are declining steadily.

From these experiences, hitherto unreported, we must agree fully with Dr. Ives that clinical statistics for scabies in dark skins are liable to both clinical error and genuine fluctuation. Moreover, it seems now quite probable that an epidemic affecting one population group need not by means spell over into another living in the same locality—Secondly, as pointed out by Dr. R. W. Bailey in Protection and his vicinities, Lucern and his teaching in Durban. Let me assure any doubters that if our acarus of scabies is fastidiosus, the local Treponema pallidum is not.—I am, etc.,

G. H. FINDLAY.

Department of Dermatology, University of the Witwatersrand, Johannesburg, South Africa.

REFERENCE


SIR,—Dr. F. A. Ives in his letter (14 December, p. 706) regarding the rarity of the demonstration of the acarus of scabies in Africa. Some points occur to me. There is, firstly, the changing pattern of disease, which is often quite rapid in a developing country. In 1962 I pointed out that the incidence of scabies had apparently dropped from 25% to 11% in the decade ending in 1960. The enormous sales of such toilet articles as monosulphate soap must have had some effect! Secondly, as regards the differential diagnosis from onchocerciasis. Undoubtedly the latter can mimic scabies, and this is the origin of the French term gale filaria. Although they are sometimes similar clinically it is usually easy to differentiate the two. The distribution confined to one segment of the body and residence in an endemic area are perhaps the most important clues.

Thirdly, it is certainly true that most practitioners in Africa (as probably elsewhere) do not confirm the diagnosis of scabies by finding the acarus. With vast hordes of patients there is simply not the time, and the demonstration would probably be attempted for teaching purposes.—I am, etc.,

G. H. V. CLARKE.

Manchester and Salford Hospital for Skin Diseases, Manchester 3.

REFERENCE


Amputations for Ischaemia

SIR,—Your leading article on amputation for ischaemia (11 January, p. 69) belittles the role of the team of doctors and physiotherapists whose attention "boosts the patients morale if it does nothing else." May I suggest that such a team can be of greater importance than you indicate? In these elderly patients rapid mobilization and early

able to supply the mass treatment that would obviously be preferable. We have, it is true, never isolated the acarus, not having the facilities, but the lesions are very typical, being small white papules always in the interdigital webs and very commonly spreading from the wrists and axillae to cover the trunk and lower limbs, and occasionally although very rarely, the face. They always respond to correct treatment with Scabiosis. They are very irritating to the patient, especially at night, and they commonly become secondarily infected in these people, who live in extreme poverty.

I also quote Michael Gelfand in the Sick African (without which, together with Hamilton Bailey’s Emergency Surgery, no doctor should contemplate leaving London airport), where he says, "Scabies is encountered throughout the natives of Africa"—however, perhaps he has never been to Nigeria? (14 December, p. 706)—I am, etc.,

RACHEL MACKENZIE.

St. Michael’s Mission Hospital, Via Kuruman, C.P., South Africa.

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