work-up before initiating treatment, defines the treatment goals, and improves control. The use of a problem-oriented summery card in addition seems to achieve most of the objectives attempted in the computer-held record system. For research perhaps manual handling of notes is still necessary, but recall of information is speeded, as compared with unstructured notes.

The problem-orientated record system has the advantage that it is very inexpensive and can be used by both general practitioners and hospitals which have no access to computers.

Abbé’s Langley, Herts

Sir,—In the discussion of their work on computer-held records of hypertensive patients Dr C J Bulpitt and his colleagues (20 March, p 677) contrast their computer system with the clerical retrieval from standard notes. However, many of the advantages they have found using the computer could be achieved using a simpler approach—for example, punched feature cards.1 We have used punched feature cards in a general practice of 10 000 patients for three years2 and, should it prove necessary, they can be used as an input to the computer.

The false logic of “a computer can solve our problems, therefore we should use a computer to solve our problems” appears to be all too common. Perhaps more attention should be paid to simple, less expensive, and more flexible information handling systems, of which punched feature cards are an outstanding example.

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Propranolol and the nephrotic syndrome

Sir,—In a recent report (12 April 1975, p 68) my colleagues and I described a patient who had developed the nephrotic syndrome in association with practolol therapy. In the same patient propranolol was substituted for practolol in a dosage of 40 mg daily for 10 months and 160 mg daily for another six months. Vague circumstanced psoriasis skin lesions on the arms and a proteinuria of 2 g/24 h were then detected. No urinary protein had been detected on routine examination during the previous six months. The proteinuria was stopped, but four weeks later the patient developed a severe normotensive nephrotic syndrome with a proteinuria of 21 g/24 h, urinaly casts, no excess of urinary red or white cells, a creatinine clearance of 70 ml/min, and a serum albumin concentration of 26 g/l. Tests for antinuclear factor in the serum were negative.

Treatment with prednisolone, initially 60 mg daily, was instituted six weeks after stopping the propranolol therapy because of persistent severe proteinuria. After three weeks the urine contained only a trace of protein and the serum albumin level was 35 g/l. Two weeks later the urinary protein was quantitatively normal and the creatinine clearance was 82 ml/min. The rash had also resolved.

It was assumed that the propranolol had induced a minimal-change glomerulonephritis, as the practolol had done. This diagnosis was not confirmed by a second renal biopsy, although it was supported by the excellent and swift improvement in proteinuria. Although practolol and propranolol are different chemically, they both act as beta-blockers and, in this man’s case, they both appear to be capable of inducing a nephrotic syndrome.

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Bottle-feeding and tummy-ache in infants

Sir,—Newborn babies commonly have tummy-ache. The infant cries incessantly, will not be comforted, flexes his legs, and continues to seek the breast, although his sucking is frequently interrupted by spasms of distress. The syndrome is conventionally ascribed (without evidence) to “wind,” and since it is maximal at about one week of age—shortly after discharge from hospital—tends not to come to the notice of the mother. The mother and her advisers frequently interpret the signs as resulting from under-feeding and hunger, and this is a major factor in the customary decision to abandon breast-feeding.

In May hospital-bred infants receive feeds of cows’ milk for the first 1-3 nights of life, even if they are subsequently to be breast-fed. Cow’s milk is antigenic and evokes an antibody response in normal, bottle-fed neonates.3 A local immune response in the gut would be associated with hyperplasia of the mesenteric lymph nodes and Peyer’s patches, with inflammation and hyperperistalsis leading perhaps in exceptionally severe cases to intussusception. The timing of the syndrome is just right for primary immune response.

Total avoidance of cow’s milk in neonatal life has been advocated4 as a means of preventing “wind.” I suggest that it would also avoid “wind” and greatly increase the likelihood of successful breast-feeding.

DAVID FRED
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Amebic meningoencephalitis in Britain

Sir,—Dr J L Griffith (17 January, p 153) has suggested that in our case of amebic meningoencephalitis1 an ameboma (which was not isolated) must have been the primary pathogen, the Naegleria gruberi which was isolated from the cerebrospinal fluid (CSF)2 being a secondary invader.

We agree that in the CSF the ameboma which were seen resembled acanthamoeba more than naegleria, although naegleriae can move slowly and produce spiky pseudopods.3 Dr Griffith suggests that the culture of ameboma from the CSF should have been done immediately. In fact, although not mentioned in our papers, this was done in this laboratory but no ameboma was isolated. Immediately after collection the first specimen of CSF from case 1 in which ameboma were seen (two weeks postmortem) was inoculated on to klebsiella-agar plates and into HeLa cell cultures, both of which had previously been found suitable in this laboratory for the growth of acanthamoeba. The surface of the agar was of a drier known to be suitable for the growth of acanthamoeba, although this degree of drierness was found subsequently to be unsuitable in the growth of naegleriae. The day after collection this CSF