Mortality from Whooping-cough.—Dr. Paul de Bellefeuille (Ottawa, Ontario, Canada) writes: Many paediatricians will differ with the answer on mortality from whooping-cough ("Any Questions?", October 30, p. 747) on the matter to be treated as. In the convulsant child "lumbar puncture is certainly useless." Perhaps, but I have seen protracted convulsing cease immediately upon relieving pressure thus. In the answer antibiotics are advised only in the treatment of secondary infection; in fact, without delay, especially if seen fairly early enough, well to streptomycin, the tetracyclines, and chloramphenicol (the latter is perhaps preferred), and such therapy should not be withheld from the infant whooper. But even more important is selection of the patient using either hyperimmune serum of rabbit hyperimmune serum, whereby death in infancy and troublesome bronchial disability in the future may be avoided.

The last statement in the answer, on the uselessness of vaccine therapy once an attack has developed, should be modified by adding that an injection of vaccine to a child who has previously been vaccinated will have an early “booster” effect and help the child in fighting the infection.

Our expert replies: In a carefully controlled trial, conducted by the Medical Research Council,1 chloramphenicol and chlorotetracycline, both shown to have a slight beneficial effect in whooping-cough cases, were given in the first eight days of the disease—i.e., often before the whoop had developed. After this stage they were shown to have no effect and they should therefore not be given as a routine to children suffering from whooping-cough. There are perhaps contacts of obvious cases when the disease can be suspected in the pre-whooping stage. The pathology underlying the severe type of convulsions is complex and the cerebrospinal fluid pressure is not always raised. Convulsions which clear up following a lumbar puncture can still be due to the severe brain damage which often causes coma lasting for weeks, if not death: probably every patient has a lumbar puncture carried out by a house officer, but the writer bases his opinion of its uselessness on over 20 years’ experience of such cases. It would be worth while to prove that hyperimmune serum prevents death or future pulmonary disability without a control trial on a vast scale, for, after all, death is a comparative rarity in whooping-cough and pulmonary disability more often an exaggeration of the disease. Experiences with live H. pertussis provided by an attack of the disease would be at least as potent a booster as an injection of dead vaccine. A large number of doubtful remedies for whooping-cough have been tried in the last 20 years with varying degrees of enthusiasm. I tried in my answer to give realistic suggestions for prevention and treatment of the causes of mortality from the disease.

Reference

1 Medical Research Council, Lancet, 1953, i, 1109.

Extra Skin Crease.—Dr. R. D. Lawson (Kingston, Ontario, Canada) writes: Congenital dislocation of the hip is once more being discussed (Journal, June 14, p. 1432; July 5, p. 589; September 20, pp. 743 and 753). Interest is centred on the early diagnosis of this condition because delay in diagnosis frequently leads to a tragic aftermath. It so happens that I have just completed a review of the literature and thought it would be useful to establish a background for further investigations into its aetiology. As a result of my findings, I consider the reply by your expert to the comment of Mr. H. H. Nixon ("Notes and Comments," September 20, p. 753) to be worth more than just a corner of a page. Your expert states: "Abnormal skin creases and limited abduction are in themselves not inapplicable but are certainly most suggestive." Exactly so. They are the very signs which a doctor too often ignores in the guidance of an experienced orthopaedic surgeon. From my recent studies I am certain that to cast away any sign which may lead to an early diagnosis of congenital dislocation of the hip would be sheer folly.

Mr. H. H. Nixon (London, W.) writes: I would like to take up a few points arising from your expert’s reply to my letter ("Notes and Comments," September 20, p. 753). I will heartily agree that everything possible should be done to diagnose congenital dislocation of the hip as early as possible. I still maintain that asymmetry of skin creases is an unsuitable test and that limitation of abduction is more suitable. The two cases your expert mentions from Caffey’s paper did indeed have normal abduction at first and yet subluxated later. He did not mention that they also had asymmetric skin creases so that neither test would have discovered them. I am not surprised at this, because the paragraphs show that the subluxation only occurred when it developed so that its physical signs. Early tests can be expected only to diagnose congenital dislocations. Post-natal dislocation will still need to be sought later. The relative frequency of these types is not yet known. Nor is there any reliable criterion of "dysplasia" or the inherited potential dislocation. Regarding the 44.2% of babies with limitation of abduction in Caffey’s figures, it should be noted that most of them were slight limitations and that only 8.2% had limitation to 60%, and only 3.8% had true unilateral limitation. In my experience the limitation of congenital dislocation has been marked. It has been my practice to have x-rays of all such cases. In milder degrees of limitation the mother has been shown abduction exercises and the child checked again in three months. If the condition is simple what Denis Browne calls an asymmetric pelvis then dislocation has become freer. If it was a dislocation then persistence of the limitation would lead to an X-ray which would reveal it without undue loss of time. In fact, none of these milder asymmetries has yet proved to have a dislocation. Dr. E. Lowenstein-Kuester’s letter (Journal, September 20, p. 743) reminds us how important this condition is. My anxiety is that enthusiasm may lead to a spate of unnecessary (and not necessarily harmless) pelvimetric, radiographic, and even unnecessary treatment of alleged "preluxations."

Reference


Our expert replies: The further comments of Mr. Nixon and of Dr. Lawson are of interest. It is appreciated that there are difficulties, but, like Dr. Lawson, I feel that the occasional skin crease is an indication for examination, and if necessary radiology, to avoid the tragedy of late diagnosis of congenital dislocation of the hip.

Corrigenda.—Dr. M. J. Tarch writes: My attention has been drawn to certain historical inaccuracies in my summary of the background of the Hebrew University Medical School (Journal, September 6, p. 605). The British Mandate in fact ended on May 14, 1948, and not in 1947. Dr. Ben Gurion declared the existence of the State of Israel on the next day. The year of intermittent fighting: this is not my mistake. It is a correction from this date and is usually referred to as "The War of Liberation." The combined Arab attack to which I referred started also on May 15, 1948. Mount Scopus was and still is an area of great strategic importance.

There was a mistake in Figure 1 in the article entitled "The Physiological Activity of D-Thyroxine" by Dr. Raymond Greene and Miss Helen E. A. Farran (November 1, p. 1057): under "Dosage," in the bottom right-hand corner of the figure, the squares denoting L-thyroxine and D-thyroxine should be interchanged.

In the article "Rationale of Antithiaminic Therapy in Thermal Injury" by Drs. D. L. Wilhelm and Miss Brenda Mason (Journal, November 5, p. 1141), line 31 of the first column on page 1142 should read: "... was graded ± +, ± +, ± +, + +, + +, + + +, and the last line of the first column on page 1142 should read: "... as little as 10 μg/kg to + (Fig. 1)."

Collective Articles from the "British Medical Journal"

The following books are available through booksellers or from B.M.A. Publishing House, 71 Southwark Street, London, S.E.1: "Medical Dictionary," 2 vols., 1957. The prices, which include postage, are now the same for both inland and overseas.

Emergencies in General Practice (26s., 9d.)

Refresher Course for General Practitioners, Volumes 2 and 3 (26s., 9d.).

Clinical Pathology in General Practice (22s. 3d.)

Any Questions?, Volumes 2 and 3 (8s. 3d. each).


All communications relating to the management of the Journal or to details of advertisements should be addressed to the Advertisement Department, B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1. Telephone: EUSTON 4699. Telegrams: Britmedads, Westcent, London.

Members’ Subscriptions should be sent to the Secretary of the Association, Telephone: EUSTON 4699. Telegrams: Medsecure, Westcent, London.