Low Molecular Weight Dextran Infusions

SIR,—Referring to the article by Dr. Peter Lane, “Low Molecular Weight Dextran Infusions in Systemic Sclerosis with Raynaud’s Phenomenon: A report of Nine Cases” (12 December, p. 657), I should like to make some comments.

Unfortunately, the exact values of the skin-temperatures before and after the low molecular dextran were not given, but only the differences. I am afraid therefore a very fundamental and very common mistake may have been made in the interpretation of these.

If the exposure to heat gives a maximum vasodilatation in the skin, it cannot be expected that increased blood-flow will give a further rise in skin temperature. Furthermore, it is not certain when the patient’s heat regulation is intact that plasma-expansion was obtained, as the peripheral blood-flow. If the possible flow-improving effects of the low molecular dextran would cause an increased peripheral flow, this will not cause a further rise in skin temperature, but can only be detected by other measurements.

Working with the same problems, I have used an air-conditioned room at a temperature of 20°C. When the feet are cooled to room temperature, and the temperature of the thumb starts to fall because the patient’s normal heat regulation is intact, I block this by adding 25 mg chlorpromazine to 500 ml of 10% Rheomacrodex given within half an hour or three-quarters of an hour. The changes in skin temperature are then recorded.

By combining vasodilatation simulaneously with plasma expansion drops in blood pressure are usually very small; this gives information about the vasomotor activity. If the vasomotor activity is good the infusions are given during a clinical effort, a haemoglobin value has been obtained this is maintained by giving tablets of chlorpromazine 10 mg three times a day.

If there is no or very little change in vasomotor activity the chlorpromazine cannot be expected to have much effect. Anyhow, the procedure is repeated daily for 10 days, and then the skin temperatures are measured again under the same conditions as the first time.

I have then seen a patient in whom the skin temperature of the thumb at the beginning was 10°C higher than that of the feet. After 10 days’ treatment the skin temperature of the feet was 10°C higher than the temperature of the thumb before the last infusion was given. This shows a definite effect of improving the blood circulation in the lower extremities, where the vasomotor activity is still lost. The hands normally get warm before the feet.

This whole subject seems to me to be very controversial, and the results from different clinics are very difficult to compare. With our technique we have better results than those referred to in Dr. Lane’s article. This may be due to the daily treatment over a longer period of time. Naturally, we have failures too, but I wanted to draw attention to the combined attempt of making this possible vasodilatation combined with the plasma-expansion and possible flow-improving effect of the low molecular dextran. It has proved itself very useful in the treatment of shock at times when conventional shock-therapy has not yet been effective.

I wish to compliment the author on his interest in this subject. There is much to be gained, and I agree with him that larger series than his and mine are necessary before complete evaluation is possible. We probably need better diagnostic procedures as well.—I am, etc.,

BJORN ISSEN

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Metric Visualization

SIR,—The practice of indicating metric measurements in brackets is of great assistance to those readers not fully conversant with Anglo-Saxon units of measurement. In particular this enables them to better visualize patients from the quoted height and weight.

While agreeing with your correspondent (16 January, p. 174) that 124 kg (273 lb) is somewhat overweight for a woman of 210 cm (82 in.), it appears rather an exaggeration to describe her as of “gross appearance”. Perhaps “stature” would be a better description of such a woman.—I am, etc.,

R. G. CAMERON

Basel, Switzerland

Analgesics in Gynaecology

SIR,—Dr. V. R. Tindall (6 February, p. 329) states in his article on dysmenorrhoea “Acetyl salicylic acid and phenacetin and codeine, alone or in combination (proprietary or non-proprietary), are the most commonly used analgesics.”

Surely this advice is ill-founded and bad. In thought phenacetin had been shown to be (a) virtually useless and (b) positively harmful. Dr. Tindall may claim that he does not in fact recommend it, but this is by no means clear from the wording of his article. It was quite rightly ought to be more careful.—I am, etc.,

EDWARD BEYAN

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Anticonvulsant Therapy and E.E.G. Recordings

SIR,—As a result of an inquiry it has recently been drawn to the attention of the British Epilepsy Association that patients with epilepsy may sometimes be advised to discontinue their anticonvulsant therapy immediately before presenting themselves for an E.E.G. examination. Practitioners might, therefore, care to be reminded that such a practice may result in the patient having an epileptic attack and that such an occurrence is likely to create difficulties if there is any question of obtaining a driving licence.—I am, etc.,

MAURICE PARSONAGE, Chairman of the Medical Committee, British Epilepsy Association

London, W.C.1

Beri-Beri in Blackpool

SIR,—Wet beri-beri, endemic among the rice-eating populations of South-east Asia and the white-flour eating population of Labrador and Newfoundland is thought to be rare in Britain. That the disease may be commoner than generally supposed is suggested by the following histories of patients admitted to the psychiatric wards of Wesham Park Hospital.

Case 1.—An 80-year-old female, living alone since the death of her husband three years before, had become progressively morose, depressed, and self-neglectful. She slept poorly, ate little, lost a good deal of weight, was quite hopeless about the future, and thought of suicide. She had a 20-year history of anginal attacks. Because she was suspected of high output cardiac failure was made and for a few days she received digitoxin 0-25 mg t.d.s., frusemide 40 mg on alternate days, and Slow-K 1 tablet t.d.s. Intravenous investigations showed blood pyruvate 3-5 mg/100 ml (normal 0-4-0-6 mg/100 ml); haemoglobin 9.3 g/100 ml (64% of average normal); plasma proteins, albumin 2-7 g/100 ml and globulin 4-2 g/100 ml (albumin/ globulin ratio = 0·6/1). Chest x-ray showed marked enlargement in the transverse cardiac diameter. A diagnosis of depression, malnutrition, and thiamine deficiency was made.

Case 2.—A male school caretaker, aged 48, with a history of partial gasterctomy for gastric ulceration in 1950, whose wife had committed suicide two years previously, became very depressed near the anniversary of her death. The mood was aggravated by the theft of his car and disappointment in a love affair. He lost interest and appetite, and cooked little for himself. Unable to sleep without tablets and feeling life not worth while, he had been admitted to a mental hospital in February, 1970. He was depressed and apprehensive, but sensorial functions were intact. There was marked recent weight loss. Cardiovascular system was normal, but the liver was palpable three fingers below the costal margin. His lower limbs were ataxic and the calves wasted, and he had marked pitting ankle oedema. Blood pyruvate 1·7 mg/100 ml; haemoglobin 9·8 g/100 ml (67% of average normal).

On the day after admission he had two grand mal attacks. Two E.E.G’s showed no focal abnormality, and since he later admitted taking large quantities of sedatives and narcotics over several months these were regarded as barbiturate-withdrawal fits (seven days after admission his blood barbiturate level was 134 mg/100 ml). After 3·5 ml of thiamine he was free from depression, malnutrition with thiamine deficiency, and barbiturate addiction was made.

Both patients were given daily intravenous vitamin injections (Parentrovite) and oral doses of thiamine three times daily. The oedema had cleared and they had gained weight. At discharge they were well physically and mentally.

Vitamin deficiency diseases occur sporadically in the British Isles and are then usually conditioned by other factors—gastro-intestinal and psychiatric disorders, alcoholism, food-faddism, and social isolation.
among the elderly infirm. In severe depression
loss of appetite and self-neglect are almost invariable so that various forms of
anemia are seen—for example, folate deficiency4 and Wernicke’s encephalopathy
(personal observation). Mixed vitamin defi-
cency syndromes seem to be more common
than “pure” forms so that the rash of the
first patient may have been a pellagrous mani-
festation, responsive to the nicotinamide fraction of the whole vitamin B
injection.

Thiamine deficiency is frequently mis-
diagnosed and it is noteworthy that the first
patient was initially treated for congestive
cardiac failure. Beri-beri would probably be
more frequently recognized if the possibility
were considered in “at risk” patients, particu-
larly those in psychiatric and geriatric wards
with peripheral oedema (unaccom-
panied by proteinuria) unresponsive to
treatment. The rapid response of both
psychiatric and physical symptoms, exempli-
fied by the above cases, makes the exercise
the more worthwhile. —I am, etc,

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Lancs.
1 Price’s Text Book of the Practice of Medicine, 9th edn, ed. D. Hunter, p. 468. London, Oxford
University Press, 1956.

G-6-PD Deficiency and Piperazine

SIR.—We were recently confronted with
a 4-year-old African child who was diagnosed
as having a haemolytic anaemia. His
haemoglobin was 3·9 g/100 ml with 33\%.
reticulocytes, exhibiting Heinz body forma-
tion; the serum billirubin was 5·4 mg/100 ml
with an indirect fraction of 3·1 mg/100 ml.
A Coombs test and tests for cold agglutinins
were negative. The only positive findings
were that this patient had a G-6-PD de-
ciciency of the negroid variety, which was
demonstrated on several specimens of blood
taken over a two month period once his reticu-
locyte count had fallen to normal. The re-

mainder of his family, five in number, were
all normal in this regard.

We were unable to find any cause for this
episode of haemolysis, the first this patient had suffered, except that two days
prior to admission, he had taken some
Pripzen (piperazine and senna) for round-

worms. We have been unable to find any
report of this drug causing haemolysis in
association with G-6-PD deficiency, although
we feel that a causal relationship could still
exist. H. Sefel (personal communication),
who has wide experience in the use of piper-
azine in South Africa, has never come across
this problem, and makes the point that if
it were a common relationship it should
have been reported somewhere in the litera-
ture on the basis that G-6-PD deficiency and
roundworm infestation are linked geographi-

We would be most interested to know
if any of your readers, more especially in
tropical countries, have come across this
particular problem.—We are, etc,

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Gastric Acid Secretion

SIR,—I refer to the statement that “In man
acid secretion appears to be of little im-
portance, for achlorhydric patients do not
experience any clinical disadvantage from
lack of acid” quoted in your leading article “Acid Tests for Peptic Ulcer” (23 January, p. 186).

May I put in a plea on behalf of these
unfortunate patients whose dyspeptic symp-
toms are often troublesome, often inter-
mittent for years, and can become pro-
gressively worse during their fifties. One
minute of history—taking which discloses
a dyspeptic pattern of fullness and distention
after small bulk meals, episodes of burning
regurgitation described as a “boiling up
 discomfort, and difficulty in digesting food,
especially apples which tend “to stick”,
should alert one to thinking that here is
someone who is failing to digest food ade-
quately. These patients get relief from
their symptoms by taking dilute hydro-
chloric acid 3-4 min (0·2 ml) in water before
meals. Surely the reasoned answer is
that dilute hydrochloric acid assists the digestion
where the gastric mucus is failing to pro-
duce adequate amounts of acid. To me this
is the clinical picture of borderline atrophic
gastritis where treatment is well rewarded.

I am, etc,

A. M. McGregor
Ferrif, Aberdeenshire

Toungue-twisting Jargon

SIR.—Dr. P. Bye (20 March, p. 673) may be
correct in his general comments but un-
fortunately he specifically considers “osmo-
lary” and “osmolarity,” which have only a
verbal similarity; osmolality refers to the
concentration of a solution in moles per
1,000 g of solvent, whereas osmolarity refers
to it in moles per 1,000 ml of solution.

These apparently offer some value in using
these different terms where concentration is
measured from the physical properties of
solutions. The tongue twistiness (or is it
twistarity?) of such words at least means
that they become audibly differentiated because
the speaker needs to enunciate them care-
fully. Words like abdication and adduc-
tion are frequently misheard so that several of
my American colleagues pronounce them
“A.B.duction” and “A.D.duction.”

As verbal communication becomes increas-
ingly more important—be it telephonic or
tape recorded—perhaps we ought to pay
more attention to verbally confusing words,
but we can expect this of a profession which
uses the same sounds for mouth (oral) as it
does for ear (aural)?—I am, etc.,

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Endocrine and Metabolic Disorders in Bronchial Carcinoma

SIR.—I was interested in the comments
made by Drs. P. von Wichert and P. F.
Mitchell-Heggs (6 February, p. 345) on the
high incidence of hypercalcaemia in bronchial
carcinoma reported by Dr. J. G. Azzopardi
and J. S. Locks (28 November, p. 528).

In a recent series of lung carcinoma cases
studied in Jersey the serum calcium was
found to be raised in 17 of 103 patients.

There was necropsy or radiological evidence
of bone metastases in nine patients and no
clinical evidence of the hypercalcaemic
syndrome in the remaining eight. Locks1
found that in 2% of 119 lung

sion. One of Inglefinger and Kramer’s1
cases was operated upon and showed “no
evidence of inflammation or fibrosis, but
extreme muscular thickening.” Schatzki and
Gary2 report in their paper that their one
case operated upon showed no histological
evidence of “ulcer, scar or inflammation.”

The tongue is a lobulated muscle spasm
which may be associated with a hiatus
hernia, but not necessarily so; it may pro-
gress later to a fibrous stricture if there
is continued reflux oesophagitis. But when
Schatzki’s ring is present it is possible, and
under general anaesthesia, to pass an
oesophagoscope through the relaxed muscle
and into the stomach; that is what differen-
tiates it from the fibrous stricture with which
you confuse it.—I am, etc.

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10 April 1971