Epidemic Keratoconjunctivitis

Sir,—We are interested to read the account by Dr. D. L. Barnard and others (21 April, p. 165) of the outbreak in Bristol of keratoconjunctivitis caused by adenovirus type 8. Similar outbreaks occurred in the Clyde valley in 1956, 1967, and 1971.1 Because of the importance of this disease as a cause of disability and occasional reduction in visual acuity, an attempt has been made to accumulate data in the Glasgow area during the interepidemic periods to determine whether the virus smouldered inconspicuously among industrial populations or among those attending ophthalmic clinicians or whether, as in Japan,3 the reservoir of infection was in children in whom the disease was unremarkable.

To try and solve this problem virological surveillance of a sample of patients attending ophthalmic clinics with conjunctivitis and keratoconjunctivitis has been continued in Glasgow since the 1967 epidemic subsided. However, from over 1,000 conjunctival scrapings examined, only five isolations of adenovirus type 8 were found in 1968—they were obtained from members of a typical industrial group—and no further isolations were made until the latest outbreak in 1971. Thus this continued six-year virus surveillance provides no clue as to the whereabouts of adenovirus type 8 during the interepidemic period, but is compatible with the virus being periodically imported from other areas or countries—for example, by seamen, transport drivers, or other travellers.

During the 1971 outbreak, in contrast to the findings in Bristol, there was very little family spread in Glasgow. In a survey of 584 family contacts of the 200 patients involved secondary spread occurred in only 14 contacts. It is likely that this was due to the strong propaganda measures (for example, to use separate towels, etc.) which were instituted at the start of the outbreak.

It may be added that, though it should have been detectable by our methods, we encountered no case of picornaviral acute haemorrhagic conjunctivitis.5—We are, etc.,

NORMAN R. GRIESE
University Department of Infectious Diseases, Ruchill Hospital

COMMUNICABLE DISEASES UNIT, RUCHILL HOSPITAL

ELEANOR J. BELL
REGIONAL VIRUS LABORATORY, RUCHILL HOSPITAL

JEAN R. ELLIS
EVE INFIRMARY, GLASGOW

6 Lancet, 1971, 1, 86.

Serum Alkaline Phosphatase and Rickets

Sir,—As Drs. W. T. Cooke and P. Asquith mention (10 February, p. 324; 5 May, p. 302) the relationship between the serum levels of alkaline phosphatase and vitamin D activity during the adolescent growth spurt is clearly relevant in determining whether the alkaline phosphatase “flare” at puberty is due to “biochemical rickets.” Our data in 59 healthy Caucasian schoolboys, whose ages were evenly distributed between 12 and 17 years and who were sampled at the same time of year, are shown in the figure. We were unable to sample girls simultaneously.

There was no significant correlation between plasma alkaline phosphatase and 25-hydroxycholecalciferol (25-HCC) levels (r = -0.02, t = 0.161, P > 0.8). 25-HCC is very stable in human plasma, levels remaining constant when stored even in unseparated plasma at 4°C over periods of 11 days and being unaltered after separation by repeated freezing and thawing. We believe that plasma 25-HCC levels provide the most accurate available index of vitamin D nutritional status in man.

A significant inverse correlation between plasma 25-HCC and alkaline phosphatase is of course to be expected in a vitamin-D-deficient population with a high prevalence of rickets. Caucasian children are not in this category. It would also be not unreasonable to expect an increased rate of utilization of 25-HCC during the pubertal growth spurt; this could be associated with all 25-HCC levels, within the normal range, occurring at the age of peak height velocity (13 years in boys) in an adequately nourished population; studies are in progress to provide evidence on this question.

Relationship between plasma alkaline phosphatase and 25-hydroxycholecalciferol levels in 59 healthy schoolboys aged 12-17 years sampled between 27 September and 6 October 1971.

Our present findings indicate by themselves, however, that the high phosphatase levels in this age group are not produced by 25-HCC deficiency and help to confirm, as we have previously stated (14 April, p. 113), that the alkaline phosphatase flare is a normal physiological event at puberty.—We are, etc.,

T. C. B. STAMP
J. M. ROUND
University College Hospital, London W.1

Troubles with I.U.C.D.s

Sir,—Probably many of us who have fitted a number of intrauterine contraceptive devices have come across strange cases. In February 1968 I fitted a 24-year-old para-2 with a Lippes loop size C. Fitting was quite uncomplicated and simple. She returned to me in May not having had a period since the middle of April. The uterus was retroverted and though there were no signs of pregnancy she subsequently had a normal delivery. The I.U.C.D. did not loosen during labour, and five weeks after delivery she was screened with an opaque sound in the uterus. This showed that the I.U.C.D. was lying separate from and anterior to the uterus. It was decided that removal of the I.U.C.D. was necessary. This was done with difficulty. The surgeon was carefully explained to the patient and she was told that she would never see her loop again. Six months later she appeared in the surgery and handed me the loop.

It would appear that this device had perforated the uterus, probably leaving the tails in the wall of the uterus, and it had subsequently tracked back and been discharged per vaginam.—I am, etc.,

F. M. HULL
Welshburne, Warwick


Serum Alkaline Phosphatase and Rickets

Sir,—As you rightly state in your leading article (7 April, p. 2), the problem arises when, on follow-up after a coil insertion, the threads of the coil are not visible and the question of expulsion or merely retraction of the threads has to be considered. Since ultrasonography is inadvisable when there may be an early pregnancy present and as a plain x-ray will not tell whether or not the coil is in the uterus, we have found that ultrasonic location of the device (as described by Nemes and Kerényi) is helpful in confirming the intrauterine position. We would suggest that this method be used in the first instance for screening such patients.—We are, etc.,

JAMES MOWAT
ELLIS BARNETT

The Glasgow Royal Maternity Hospital, Glasgow

Serum Alkaline Phosphatase and Rickets

Sir,—At this hospital we hold an intrauterine contraceptive device clinic, in which we use mainly the Dalkon shield device (standard size). We noted that the devices were rather stiff and did not bend easily on insertion, thus causing increased pain to the patient. Since the shield is made from polyethylene, it was suggested that warming the device might make it more pliable. This was confirmed in practice, and it has therefore become our routine to immerse the Dalkon shield, with its polyethylene packet (to retain its sterility), in a jug of hot-hand water for approximately five minutes before insertion. We have found that the device is then more easily inserted and is thus more comfortable for the patient.

Recently, in error, a device was immersed in very hot water. On removal from the packet for insertion it was noticed that the device had fractured in one place and that its shape had altered. It was therefore discarded.

While we recommend warming the Dalkon shield before insertion, we warn against using too hot water, as this may damage the device.—I am, etc.,

URSULA E. MOUNTROSE
Queen Mary’s Hospital, Roehampton, London S.W.15

Prevention of Pulmonary Embolism

Sir,—Your leading article (7 April, p. 1) seeks a prophylactic method which can be
used on all patients which is “free of side effects, cheap, and simple.”

May I suggest a method which has proved infallible in that in the 21 years of its use I have had no incidents of pulmonary embolism, fatal or non-fatal, in 7,000, personal consecutive cases of major varicose vein surgery—surely a high-risk procedure? It is as follows. Before the operation patients are told that when they awake they will find the foot of their bed raised 9 in (23 cm), and that there will be a cradle in the bed to allow them free movement of their feet, so that they can carry out simple flexion and extension at the ankle. They are shown the exercises before they go to sleep and most of them wake up doing them involuntarily; the remainder are reminded by the nursing staff. They continue these simple calf muscle pumping exercises during their post-operative stay (it becomes a habit every 2-3 minutes, 3-4 times). The blood does not slow down in their legs, they do not develop venous thrombosis, and all the expensive paraphernalia of electrical and pneumatic stimulation can be avoided.—I am, etc.,

STANLEY RIVLIN

London N.W.1

Malaria Risk to Travellers

Sir,—An obligatory, unscheduled stop when flying across Africa cost the life of one of my friends, and I have, in peace-time, two acquaintance members of H.M. Forces dying of cerebral malaria. A few weeks ago I was one of a party of visiting surgeons in South Africa. Our hosts advised antimalarials to us in a game reserve. There we found two-thirds of the park excluded because of the unusually high risk of malaria caused by the wet season.

Professor B. G. Maegraith (21 April, p. 175) makes a point when he says that carriers have a responsibility to see that their passengers are warned in time. Perhaps the B.M.A. would raise the matter with the airlines.—I am, etc.,

CHARLES WELLS

Hove, Sussex

Prescribing Mandrax

Sir,—Southampton Local Medical Committee recently considered the abuse of the drug methaqualone, which is included in one of the hypotonic frequently prescribed.

The committee had been informed that addiction could be rapid and that withdrawal symptoms are just as bad as those from heroin. We are attempting in this area to impose a voluntary ban on this drug similar to that which has been operating for anhydrenes in many areas recently.

It is hoped that many other local medical committees and other groups will take a similar stand in the hope that addicts will have no easy access to methaqualone in the future.—I am, etc.,

P. R. SMITH

Southampton Local Medical Committee

Deputing Services

Sir,—I refer to recent articles and correspondence on the subject of deputing services for family doctors. I am surprised to find that no mention seems to have been made about their most important effect on the doctor who uses them frequently. If used on most or all nights and weekends, the doctor will not witness a substantial proportion of illnesses and their manifestations that occur in his practice, and this must surely result in a gradual but significant diminution in his clinical experience and judgment. In contrast, the family doctor working in a rota with other local doctors will compensate for time off duty from his own practice by being on duty for several practices at a time when his turn comes round.

This objection and the less important points about access to records, knowledge of the patient, and the image of family medicine constitute reasonable reasons restricting the use of deputizing services to exceptional circumstances. If we allow them to flourish unchecked, we shall make the Gadarene swine seem like wise old sages.—I am, etc.,

DARRYL TANT

Luton, Beds

Increased Dosage of Disodium Cromoglicate

Sir,—May I suggest a simple explanation for the failure of some asthmatic children to respond to disodium cromoglicate (Dr. J. M. Smith, 5 May, p. 303)? The gelatin capsules which enclose the powder are hygroscopic. If the tin of powder is kept in the kitchen or bathroom, or if the top is not screwed on tightly, the fine powder aggregates and assumes the consistency of grains of sand. Such a capsule fails to yield its contents.

I suggest that the advice of Dr. Smith to increase the number of capsules used each day is unnecessary if strict measures are taken to keep the capsules dry. There is a need for a desiccant sachet to be added to each tin. I have, in the past, drawn the attention of the Committee on Safety of Medicines to this matter, but no action has been taken—I am, etc.,

A. M. W. PORTER

Camberley, Surrey

Breech Management with Fetal Blood Sampling

Sir,—To test the suggestion made by one of us (27 January, p. 229) that the fall in fetal pH during breech delivery reported by Dr. B. W. Elliot and Mr. J. G. Hill (23 December 1972, p. 703) was due to placental bed retraction we have measured the pH of the mother sequentially through the delivery of the breech.

Six mothers were studied; none of them were obese and all were at term and delivered live, mature infants. The birth was measured at the umbilicus at the times during delivery that Dr. Elliot and Mr. Hill made their pH estimations—that is to say, when the breech was distending the perineum, when it was delivered less cephalic, and before delivery of the head.

At the start of the delivery the pH measurement of the six women ranged from 37 to 39.5 in (93-100.7 cm). There was a uniformly decrease in pH in all patients of 1.5 in (3.8 cm) as the breech was delivered to the umbilicus, but a further decrease of only 1 in (2.5 cm) as the infant was delivered to the head.

The greatest decrease in girth therefore occurs at the time Dr. Elliot and Mr. Hill reported the greatest decrease in fetal pH, and these results seem to substantiate their point that the pH changes during breech delivery reported by these authors were due to retraction of the placental bed rather than cord compression.—We are, etc.,

DAVID J. S. HUNTER

K. VAUGHTON

John Radcliffe Hospital, Oxford

Contraindication to Smallpox Vaccination

Sir,—The recent occurrence of smallpox in London has brought in its wake an inevitable crop of vaccinations, most of them for travel purposes. When he vaccinates against smallpox the clinician must of course think about the contraindications. If he wishes to refresh his memory about these and seek guidance in the British literature, or at any rate in that part of it which is readily accessible, he may find himself perplexed. The six authorities I consulted fall into two groups. Christie1 and Kaplan2 give no list of contraindications but caution against vaccination in pregnancy and in patients with eczema. Eight contraindications to primary vaccination but not to revaccination are listed by Price3 and the Department of Health and Social Security,4 whose edicts might lead the clinician to infer that revaccination can be given with no further disregard of the contraindications. Dixon5 explicitly, and Warin6 by implication, include revaccination as well as primary vaccination as being subject to the usual contraindications. Surely the clear advice which these authors give is the correct one.—I am, etc.,

A. S. V. STEELE

London S.W.5


Smallpox Vaccination Certificates

Sir,—I have just had a smallpox vaccination because of intended foreign travel. The vaccination was performed at my hospital by a recently appointed haematology registrar, who duly signed my International Certificate of Vaccination. All well and good, but I then had to take this certificate to the local authority for a stamp which states that the Medical Officer of Health authenticates the doctor’s signature. This, of course, nonsense. Firstly, the M.O.H. does not stamp the certificate, but a clerk does, and secondly, more importantly, even if he did he could not possibly be familiar with many of the signatures which appear on the certificates. Surely it is about time this stupid and time-wasting practice was stopped.—I am, etc.,

A. K. CLARKE

Birch, Kent