Scabies in a Spinal Injuries Ward

Sr,---I was recently asked to investigate an outbreak of irritating papules on the forearms and thighs of nursing staff in a spinal injuries ward. The eruption found in the case of eight nurses resembled that seen among ward staff in epidemics caused by cases of Norwegian scabies. No burrows could be found nor were mites isolated. Examination of the 20 patients in the ward revealed that five were heavily infected with Sarcoptes scabiei. All these patients had suffered fractures of cervical vertebrae 4, 5, 6, or 7 with consequent loss of cutaneous sensation.

Paterson et al.1 writing on the development of Norwegian scabies during immunosuppressive therapy subverted the pathological factors so far reported in cases of Norwegian scabies, among which was lack of cutaneous sensation occurring in leprosy, syringomelia, and tubs dorsalis. The scabies cases in this ward epidemic, though all presenting a massive infestation, in one at least amounting to many hundreds of mites, did not show the picture of Norwegian scabies. The trunk and limbs had profuse scarring of erythematous papules each surmounted by a typical burrow. There was, however, no hyperkeratosis or crusting. One young adult had multiple burrows with minimal erythema similar to that frequently seen in very young infants. I suggest that the loss of cutaneous sensation following fracture of cervical vertebrae allowed unrestricted multiplication of mites owing to lack of feeling and therefore scratching and that this tends to confirm Mellanby's observation2 that "in man it is the active finger nails of the host which keep down the parasitic population." The duration of the infestation was unknown, probably only a few months, and this was presumably too short to allow the development of the hyperkeratosis and crusting seen in true Norwegian scabies. The mites, however, were sufficiently numerous to result in a ward epidemic involving nursing staff. It was only this involvement that led to detection of the infestation.

Treatment with 1% gamma benzene hexachloride (Quellada liquor) was rapidly effective with no case of failure to respond. I am, etc.,

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Operator/Anaesthetists

Sr,---With the declaration of the President of the General Dental Council on the subject of anaesthetists (24 May, p. 453) dentists now know that they will be judged to be guilty of infamous professional conduct if they act in that capacity.

Will the B.M.A. approach the General Medical Council for a ruling relating to doctors acting as operator/anaesthetists? While this practice is not widespread, it certainly does happen—for example, psychiatrists performing electroconvulsive therapy and thoracic surgeons performing bronchoscopy under intravenous barbiturate plus a muscle relaxant, physicians performing gastroscopy under intravenous anesthetic doses of diazepam, general practitioners opening abscesses etc. under "a whiff of gas." Even the anaesthetist himself assumes the dual role if he first anaesthetizes the patient then proceeds to the rear to perform caudal or lumbar epidural puncture and catheterization.—I am, etc.,

DONALD BLATCHLEY

London W.4

Practolol, Indomarin, and Asthma

Sr,---I.C.I. have recently circulated new prescribing information recommending that in view of its side effects its use should be limited to patients with organic cardiac disease and those with asthma or bronchitis.

Practolol is cardiospecific and is less likely to cause bronchospasm than other beta-blockers, but patients with asthma often do get a troublesome increase in wheeziness or given two had to stop the drug. The average drop in P.E.F.R. for all six was 11% (range 3% to 37%). During the week on indomarin alone there was subjective improvement in both asthma and angina. When practolol was reintroduced the four patients who had complained of wheezing before were again affected and all four stopped the drug. The average drop in P.E.F.R. compared with control was 19% (range 6% to 50%).

The combination of these drugs appeared to make the bronchospasm worse. A possible explanation is that with blockage of beta adrenoreceptors the cholinergic innervation was left unopposed.

Little has been reported about increased airway obstruction in asthmatics on practolol since the early studies, but clinical experience and the observations above show that it may be a greater problem than at first suggested.—I am, etc.,

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Milk pH and Gastroenteritis in Newborn Infants

Sr,---Harrison and Pest1 reported that feeding full-term normal newborn infants with a humanized cow's milk (Similac) that had been alkalized to pH 7.2 produced a stool of low pH (mean 5.5), of reduced buffering capacity, and a bacterial flora of predominant Lactobacillus bifidus. The infants tended to regain their birth weight earlier than a control group on non-alkalized Similac. Realizing that if these findings were confirmed the feeding of such an alkalized
Results

Mean weight gain

Clostridium welchii, the control group) received parenteral intravenous 10 ml of 8.4% sodium bicarbonate added to every 100 ml of milk, bringing the pH of the milk from a mean of 6.98 to a mean of 7.37. The two groups were found to be comparable (table I). All infants received intravenous fluids during the first few days, all (except one in the control group) required oxygen for respiratory distress, and all (except one in the control group) received parenteral antibiotics during the first two weeks of life. Growth rate was measured by weight, length, skin fold thickness in three areas, and head circumference during the period from the first day after intravenous fluids were discontinued till the day of discharge from the unit (which varied from the 38th to the 55th day). Stools were examined twice a week for pH and by surface viable count on various culture media for the bacterial content. The modified, reinforced chlostridial medium of Willis et al. 1 was used for the selective isolation of L bifidus.

Lactobacilli were isolated from a small number of stools in each group (table II). Other organisms cultured were mostly Escherichia coli, Klebsiella spp., and Streptococcus faecalis but Bacteroides spp., Clostridium welchii, and non-haemolytic streptococci were isolated occasionally in both groups. There was no significant difference between the growth in any of the parameters measured.

Admittedly these infants were in no way comparable with the group studied by Harrison and Peat, but infants under intensive care, as ours were, are particularly prone to infection in all parts of the body and therefore are likely to benefit from any measures that might discourage colonization of the bowel with pathogenic organisms. Our inability to confirm the findings of Harrison and Peat in our group of infants is therefore unfortunate.—We are, etc.

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Cerebral Lupus—Wider Implications

Srn,—Your leading article (8 March, p. 537) very rightly draws attention to the fact that the choroid plexus bears many structural similarities to the renal glomerulus. Just as the central nervous system involvement of systemic lupus erythematosus is attributed to immune complexes at the choroid plexus, the spinocerebellar degeneration seen in the so-called paramyelinoid syndromes may be due to immune complexes lodged there, caused by tumorous derived antigens. Certainly the finding of such immune complexes in the kidney in patients with tumour elsewhere has been reported, 2 though unfortunately in neither case was any attempt made to study the choroid plexus of these patients at necropsy, as is technically eminently feasible. 3

It is interesting to correlate the structural similarities of these sites with a biochemical enzyme. One group involved in the γ-glutamyl cycle, 4 especially the transpeptidases, which are involved in the very first step of glutathione degradation and play such an important role in the uptake of amino acids into the cell, are found in their maximum concentration in these very organs—in the kidney and at the apical portions of the epithelial cells in the choroid plexus. It is quite simple to understand then why patients with erythrocyte γ-glutamyl synthetase deficiency and haemolytic anaemia 5 have aminoaciduria and signs of C.N.S. involvement, including psychosis and spinocerebellar degeneration.

One is then able to speculate that perhaps the immune complexes in cerebral lupus or in the paramyelinoid syndromes interfere with aminoacid transfer by obstructing the γ-glutamyl cycle at some point directly or indirectly, and if investigations along these lines, which have so far been neglected, prove fruitful the last sentence in your leading article (8 March, p. 537), "the recognition that the brain is not immunologically privileged... may have implications for the pathogenesis of other neurological diseases," would perhaps serve as a starting point to revolutionize our concepts about the enigmatic and obscure degenerative diseases of the central nervous system.—I am, etc.,

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3 Atkins, C. J., et al., Annals of Internal Medicine, 1972, 76, 60.

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Race Relations

Srn,—I read with interest your apology (17 May, p. 400) about an advertisement which you had published (3 May, p. xiv).

Is it not a crazy world we live in when a Kuwaiti oil company cannot advertise for an Arab doctor, preferably Kuwaiti, without offending the Race Relations Board?—I am, etc.,

JOHN HAWORTH
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Disaster Planning—Fact or Fiction?

Srn,—In spite of recent symposia on problems of disaster planning the suspicion remains, as you suggest in your leading article (24 May, p. 406), that preparations are far from adequate.

At hospital level a disaster may be regarded as a non-specific stress test for the whole institution. The single most important step in any plan is the mobilization of a very small number of officers in the medical, nursing, and administrative fields who have the authority and experience to make the hospital respond appropriately to the stimulus which is being applied. Provided such a control team can rapidly be mobilized, it is not difficult to elicit a maximal and controlled response by the hospital to any kind and size of stimulus.

The problem of adequate preparedness in all the emergency services throughout the whole country seems to me a somewhat similar problem—basically a problem of control and responsibility. Each of the emergency services has national headquarters, but there is no mechanism for united or co-ordinated control of the emergency services to meet disaster. Until the question of responsibility and authority is settled, it is difficult to see how the uncertainty of which you complain can be eliminated.—I am, etc.,

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B.M.A.: Need for Radical Change

Srn,—I would like to endorse everything that Dr. J. P. Lee-Potter has stated in his letter (24 May, p. 446). A great number of doctors, both members and non-members of the B.M.A., are convinced that there is a need for a radical change in the administration of the B.M.A. affairs, which appear to be out of touch with present-day problems and far too concerned with maintaining an existing and rather cumbersome pattern of administration, much of which is not related to present-day medical activities.

I was amazed to read in Pulse that the new Secretary of the B.M.A. will be nominated or "recommended" by a committee of the Association and that the post will not be advertised publicly. Indeed, Pulse went so far as to suggest that the new Secretary has already been "appointed" subject to confirmation by the full Council. Many of us have gone through a fairly