for which he or she attends. I doubt if a case for assault or trespass would readily be brought if treatment were enforced, many chronic schizophrenics suffering from a breakdown could be saved from further breakdown by enforced treatment with psychotropic drugs that maintains them reasonably well in the community and at work and is usually accepted without demur.

SEYMOUR SPENCER

Headington
Oxford OX1 7LU

Points

Treatment of cutaneous leishmaniasis

Dr Anthony Bryceson (Hospital for Tropical Diseases, London NW1 (OPE) writes: Mr Michael A Currie (15 October, p 1105) writes of his experience with curettage in the treatment of cutaneous leishmaniasis in Pakistan. Curettage was standard treatment in India until 1947 when Elkerton carried out the first controlled trial of treatment.1 He showed that intradermal injections of 5% mepracine, given on one to three occasions at three to five day intervals, healed 67%, of sores in four weeks and 100%, in nine weeks, which was marginally superior to the 86% result obtained by the more expensive Tangier. This early controlled trial ever carried out for cutaneous leishmaniasis. Mepracine is no longer generally available and the wheel has come full circle. Mr Currie’s paper emphasises the absence of any proved method of treatment that is suitable for outpatient use. No errors, methods and proper trials and procedures are sorely needed.2


Parathyroid hormone and 25-hydroxyvitamin D concentrations in elderly people

Dr Nigel Lawson and Dr Andrew J Taylor (Department of Clinical Chemistry, East Birmingham Hospital, Birmingham B9 5ST) write: We read with interest the letter from Dr Roger A Fisk (22 October, p 1225) concerning parathyroid hormone measurements and primary hyperparathyroidism. We feel that it is necessary to point out that an error in diagnosis of primary hyperparathyroidism may be made if only serum parathyroid hormone and calcium concentrations are measured. Studies in primary hyperparathyroidism have given similar results. Careful consideration of previous history, serum alkaline phosphatase activities, and the presence of osteomalacia will help to distinguish between these two forms of hypercalcaemia.

Q fever

Dr Paul M Fleiss (Los Angeles, California 90027) writes: The recommendation by Professor Alasdair G M Geddes (1 October, p 1227) that patients being prepared for heart valve replacement should be screened for Coxiella burnetii phase I antibodies should be generally accepted. C burnetii is potentially present wherever livestock are or have been congregated,1 and human infection is usually related to suppurative lesions in contact with shed goats, or cattle. It may be airborne over long distances, contaminated fields and roadways may serve as loci for airborne dissemination of the rickettsia. The organism has been isolated from milk, urine, feaces, and oral and nasal secretions of experimentally infected animals. In case of clinical Q fever in humans attributed to the ingestion of raw milk products has been reported.2 Q fever is a difficult disease to diagnose clinically and there is probably a large number of undiagnosed asymptomatic cases. Although the organism may be transmitted by other vectors, all reported clinical cases in man have occurred by inhalation of infected aerosol particles.


Possible hepatotoxicity of zimelidine

Dr C N Sawyer, Dr John Cleary, and Dr Roger Gabriel (St Thomas’s Hospital, London W8 6DZ) write: Like Dr G K Simpson and Dr N McD Davidson (22 October, p 1181) we have monitored a patient who developed systemic symptoms, fever, and abnormalities of liver function while taking zimelidine. Increase in the concentrations of alanine aspartate transaminase and alkaline phosphatase were of the same order as those recorded by Simpson and Davidson, but there was no jaundice. Zimelidine is clearly our drug of choice. The patient stopped, and symptoms abated within three days, and results of liver function tests returned to normal in five days.

During the drug fever C reactive protein reached a peak of 47 mg/l and fell to normal within 4 days of discontinuation. Since the haemopoietic activity of complement was 50%, greater than normal, the concentration of C3 35% above normal and the concentration of C4 was normal. Circulating immune complexes were present containing C1q, IgG and IgM and persisted for five weeks.

These immunological abnormalities have not previously been recorded and although zimelidine has been withdrawn from the market we understand that two or three similar compounds are at present under development. . . . Plasma concentrations of zimelidine and normetazoline were measured by courtesy of the Poisons Unit, New Cross Hospital.

Testing efficacy of proposed new consultant appointments

Professor D N Baron (Department of Chemical Pathology, Royal Free Hospital, London NW3 (H1G) writes: Your two leading articles of 29 October (“The end of clinical freedom” (p 1237) and “Nuclear medicine in district general hospitals” (p 1238)) need to be studied together. Before we appoint consultants in nuclear medicine we have to evaluate whether they are cost effective. They can provide a better service in nuclear medicine, without additional expense, than at present organised by pathologists (radioimmuno-

assays), radiologists (imaging), radiotherapists (treatment), and physicists (radiation protection)? We are in a zero-sum health service, and one more consultant in nuclear medicine means one less consultant in something else.

A National Museum of Health

R F Fisher (Park Hill Village, Croydon CR0 3NV) writes: I wish to add my support for the idea of a National Museum of Health (8 October, p 1068). Considering the large number of redundant purpose built hospitals and workhouses in Britain the provision of fabric should not be a problem. Finance could be provided to a large extent from the sale of old equipment. Some may think that this is a windfall for the NHS and private sector. The commercial world assists sport and the arts with subsidies so there is no reason why these same sort of generosity could not be extended to a museum. If the museum becomes an adjunct of the Science Museum, which it probably would, it would be able to take the same sort of collection, the problem of management could also be resolved. Between 1974 and 1983 a whole level of “management” was created and disbanded; where will the records of that exercise be 15 years from now?

Dr John Bodkin Adams

Mr Percy Hoskins (Daily Express, London EC4P 4JT) writes: Dr Michael O’Donnell (29 October, p 1311) mentions that I was a beneficiary under Dr John Bodkin Adams’s will in recognition of my “voice in the wilderness” prepared to stage for him a fair trial, despite an incredible watchdog. I think in fairness it should be added that directly the executor informed me of the legacy I donated it to the liver unit at King’s College Hospital.

Medical care in South Africa

Dr Adrian Hastings (Glyncorrwg, Port Talbot, West Glamorgan) writes: Mr M S C Neelamns (1 October, p 985) thinks the people of South Africa are happy and lucky with the medical care available to them. Luck, of course, does not enter into it. The good fortune is that we have everything else in South Africa—according to the colour of one’s skin. The wealth to provide a health service is created at all races in South Africa, but the allocation of resources is entirely controlled by whites.

I spent three years working in a health centre in Maputo, Mozambique, where many refugees from South Africa lived. They were very impressed by the efficiency and speed of the health service. We treated many South Africans who were here on one in Mozambique, which they said outstripped anything for blacks in South Africa. . . . This comprehensive health service is provided by one of the world’s poorest countries. A small fraction of the wealth so compassionately consumed by white South Africa could provide a similar service in South Africa. White South Africans will claim that my informants were biased in their attitudes. They are probably right. Many of my patients were suffering the long term physical and mental effects of torture while in detention for such “crimes” as organising political opposition to the régime.

Are herbal cigarettes a health hazard?

Dr J Renstrom (Honeyrose Products Ltd, Snowdown, Nr Saffron Walden, Essex CB11 4PQ) writes: The principal manufacturers of herbal (coltsfoot) cigarettes in the United Kingdom I read with interest the report of Dr John J A Roe (22 October, p 1202) to the question “Are herbal cigarettes a health hazard?” His answer was—as it inevitably must be—for any product—that it was a health hazard. Is it not a health hazard to assume that herbal cigarettes carry no health hazard. The important question for your readers, however, is, are cigarettes made from herbs other than tobacco less hazardous to health than those that are made from tobacco? As far as our coltsfoot—a medicinal herb—cigarettes are concerned, (a) they do not contain nicotine, the hazards of which are well documented; (b) they are not habit forming . . . (c) they help those who give up cigarettes by helping them to cope with the symptoms of nicotine withdrawal.


http://www.bmj.com/