Some of the mental changes are suggestive of cerebral ischaemia. Depressed and loss of libido were found to be more frequent with strongly progestogenic low oestrogen compounds, and these have been shown to be associated with endometrial monamine oxidase activity for most of the cycle. Of the recommended pills, Anovlar, Voludan, Gynovlar, and Minilin are probably the most progestogenic and therefore likely to have a high incidence of depression. However, the dose of oestrogen is important, as Lyndiol 2.5 and Minilin cause more depression than Lyndiol, 5 mg. While the depression per se could often be ameliorated by changing to a high-dose oestrogen product, this is no longer advisable because of the increased thrombosis risk. It also does not seem wise to resort to antidepressant drugs and even, as happens, E.C.T., without first making a serious attempt to provide an acceptable alternative method of contraception. This is not simple, as the young unmarried student has based here a way of life on a "safe" method of contraception, while the older woman may be reluctant to make the effort to revert to mechanical methods or consider sterilization. Nevertheless, we cannot ignore the responsibility which is inherent in prescribing oral contraceptives because of the fear of an unwanted pregnancy.

Baumblatt and Winston advocate further research following their encouraging results for those patients who experience changes with pyridoxine, and it seems important to find out if pyridoxine can also help the vascular aspects of the syndrome.—I am, etc.,

ELLEN C. G. GRANT.

New Malden,
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References

Hepatitis Infection After Transplantation

Sir,—We write with reference to the paper by Dr. E. S. Spencer and Dr. H. K. Anderson on infections with herpes virus following renal transplantation (1 August, p. 251). It would be interesting to know whether any of the patients developing a rise in cytomegalovirus complement-fixing antibody received fresh blood preceding, or at the time of, transplantation—as transmission of cytomegalovirus by fresh blood is well documented. Further, in a series of 56 patients receiving fresh blood a fourfold rise of cytomegalovirus complement-fixing antibody was demonstrated in 38%, usually 6-8 weeks after the blood was given.

The statement that five out of seven patients with cytomegalovirus infections had virus-neutralizing antibodies in their serum before the onset of symptoms suggests that two of the patients had not previously been infected with cytomegalovirus—and therefore these could not have been due to reactivation of the virus, but must be primary infections. Our own series showed that 55% of the infected patients were seronegative to cytomegalovirus-complement-fixing antibody prior to transfusion, while 45% were seropositive. Therefore though reaction may be responsible for rising cytomegalovirus-complement-fixing antibody following immunosuppression or fresh blood transfusion our work suggests that many cases are due to primary infection. Furthermore infection with cytomegalovirus of a different strain may occur in patients with pre-existing complement-fixing antibody.

Another point of interest is the fact that these patients on immunosuppressive and steroid therapy were capable of producing antibody in response to viral infection. This no doubt explains why their symptoms were those of a healthy adult with a similar infection, and not the disseminated type of infection that tends to occur in immunosuppressed patients. —We are, etc.,

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United Bristol Hospitals.

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Frenchay Hospital, Bristol.

Hypotension caused by L-Dopa

Sir,—The hypotension produced by L-dopa during treatment of Parkinson's disease (21 February, p. 474) has been attributed by Professor J. H. Burn (7 March, p. 629) to a replacement by dopamine of some of the noradrenaline in the sympathetic fibres. This reduces the effect of the vasoconstrictor activity of the sympathetic nervous system on the peripheral resistance vessels. Recently, Dr. R. C. Duvoisin (4 July, p. 47) has described the use of propranolol in the treatment of the hypotension produced by L-dopa, on the basis that propranolol would antagonize the effect of the dopamine since "dopamine appears to have predominantly beta-adrenergic properties."

This hypothesis is not correct, and does not explain the mechanism by which propranolol might counteract the hypotension induced by L-dopa. The actions of dopamine are complex. It stimulates adrenergic beta receptors in the heart but not in the peripheral resistance vessels. The fall in systemic vascular resistance produced by dopamine results largely from renal vasodilatation. The mechanism of this is not understood but it is not antagonized by a beta-receptor blocking drug. Dopamine increases femoral vascular resistance. Consequently it would appear impossible for propranolol to antagonise the hypotension produced by L-dopa through blockade of adrenergic beta-receptors.

Before the acceptance of propranolol for the treatment of the hypotension produced by L-dopa, more detailed clinical pharmacological studies on this subject are required.—I am, etc.,

R. G. SHANKS.

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References

Pulmonary Veno-occlusive Disease

Sir,—In 1966 Brown and Harrison found eight reported cases of pulmonary veno-occlusive disease. They added a ninth, later the subject of a clinicopathological conference. In 1967 Liebow et al. presented 16 cases to the American Heart Association. We wish to report an additional case.

A 40-year-old female gave a history of childhood bronchitis and asthma. Skin tests in 1953 revealed a wide range of sensitivity. Chest X-ray was normal. In 1963 the right middle lobe collapsed. Bronchoscopy was normal and the lobe re-expanded; subsequently she noted increasing exertional dyspnoea. A bronchogram in September 1967 showed mild fusiform bronchiectasis in the right lower lobe, and by December 1967 she was admitted to hospital with severe dyspnoea. Chest X-ray showed a right pleural effusion, a generalized increase in pulmonary vascularity, and a normal heart size and shape. E.C.G. revealed right atrial and ventricular hypertrophy. Examination of the pleural effusion was unhelpful, and all significant tests were normal. The patient remained very breathless, even after aspiration of two litres of fluid. Steroid therapy produced rapid general improvement and clearance of the fluid. She was discharged on steroids but one month later (January 1968) fluid had re-accumulated. For the first time some definite bronchospasm
was detected. Further aspirations produced no benefit, but an increased dose of steroids helped. However, two weeks later she developed severe respiratory failure. At necropsy the lungs showed prominent arterial radicles, a moderate amount of oedema, and scattered, mainly subpleural, areas suggestive of chronic pneumonitis. Both latter features were more marked on the left (weight 985g) than on the right (weight 720g). Both pleural spaces contained old fibrous adhesions and bilateral yellow effusions. The heart (weight 360g) showed right ventricular hypertrophy (10mm) and dilatation; the right auricle was normal. There was no thrombosis in the systemic vessels.

The lungs were sent to Professor Herbert Spencer for examination. In his opinion they showed: (1) Some pulmonary arterial thickening; occasional arteries also showed recanalization; (2) interstitial fibrosis (Fig.) plus recent intra-alveolar fibrinous oedema; (3) pronounced dilatation of the bronchial veins; (4) enormous distortion of the alveolar capillaries in places; and (5) thrombosis of small- and medium-sized veins with evidence of recanalization.

These changes add up to thrombosis of the primary venous return with subsequent oedema, collateral channel formation, and pulmonary artery hypertension (with occasional arterial thrombosis and recanalization).

The disease was an evolving condition in this patient as is apparent from the degree of oedema and venous occlusion. Despite this activity no aetiological agent was discovered. Perhaps virus culture of the sputum would have been revealing, since Liebow suggests haemagglutination associated with pulmonary viral infections is possibly the cause of the thrombosis.

More information could have been forthcoming had the patient been diagnosed in life. The object of this report is to remind clinicians and pathologists of the disease, and to underline the opinion of previous authors that it may not be as rare as the literature suggests.—We are, etc.,

James Briggs, A. T. M. Roberts.

Frenchay Hospital, Bristol.

References

Caring for the Elderly

Sir,—The article “Evaluation of Early Diagnostic Services for the Elderly” (1 August, p. 275) sheds a welcome gleam of light on a hitherto almost unexplored field and raises a number of interesting points. As the authors showed, these are not symptomless patients, but patients with an illness looking for a doctor.

The current pessimism over early diagnosis and treatment of the elderly is unjustified. Cannot the work carried out in the survey be done almost as well by the general practitioner backed by an ordinary outpatient department? I myself, handicapped by lack of staff and time, have done something along these lines for 10 years and have obtained gratifying results.

Early diagnosis for this type of patient is just the start of a long marathon of care and maintenance which will last as long as the life of the patient—perhaps 10 or 15 years—which one hopes will avoid the invalid stage of life and, as a result of one’s efforts, enable the patients to die with their boots on. The figure of 42% improvement in these patients treated is surely too low. No mention is made of the treatments given, but one wonders if such treatments as isoxsuprine for cerebral ischaemia, verapamil and related drugs for angina, and indomethacin and ibuprofen for arthritis have been used. All these treatments may slow down or even arrest deterioration, but the results are better judged after five or even 10 years instead of mere 18 months.

Finally, it is stated that it is unlikely that general practitioners will be able to accept the burden of this type of work, and that it would be best left to the geriatricians. They will, of course, be able to do this or indeed many other types of work if any available finance which properly belongs to the primary care services is siphoned off to newly established or imaginatively remote specialist centres, which will never be able to provide the basic care this which underprivileged group of patients so desperately need.—I am, etc.,

C. G. Elliott.

East Hoohey, near Lewes, Sussex.

Primary Care of Patients with Skin Disease

Sir.—It seems that the summary (30 May, p. 535) of the B.M.A. Plaister Unit working party’s report on Primary Medical Care has given rise to alarm and despondency and protest in some parts of the country, with particular reference to its suggestion that all patients with lesions of the skin should be seen initially at a hospital clinic. It does not seem to have been appreciated that this is simply the opinion of the working party, and that it did not at any time consult the B.M.A. Dermatologists’ Group Committee or any of its members.

I would like, therefore, to disclaim any responsibility for this opinion, and to say that this in no way represents the view taken by dermatologists or their representatives.—I am, etc.,

Ian W. Caldwell, Chairman, B.M.A. Dermatologists’ Group Committee.

Southampton, Hants.

Prophylaxis of Pulmonary Embolism

Sir,—We are concerned that in the “Current Practice” article (27 June, p. 780) on the prophylaxis of pulmonary embolism, no mention was made of the various mechanical approaches to the problem where anti-coagulants have failed or are contraindicated—for example, methods such as partial occlusion of the inferior vena cava by clip, filter, or plication.

In desperately ill patients recurrent embolism may be prevented temporarily by inserting a form of umbrella into the inferior vena cava (Eicheler, Mobin-Uddin). If an operation is possible an easy, safe, and effective method is the application of an inferior vena cava clip that flattens the vessel to a slit of about 5 mm, a size that will not transmit a lethal embolus. The clip method of partial inferior vena cava occlusion is easier and more effective than either the filter or the plication, and although it seems to increase the incidence of peripheral thromboembolic disease in the short term, its prophylactic use is justified in patients who are at particular risk from embolism. Preliminary results of a prospective controlled trial indicate that it saves lives. One of us wears a caval clip.—We are, etc.,


Torbay Hospital, Torquay, Devon.

References

Acute Malaria in Newborn Infants

Sir.—Dr. N. E. Okoje’s observations (11 July, p. 108) on the frequent occurrence of congenitally acquired malaria in Enugu (Nigeria) contrast sharply with our findings in the Gambia. At our hospital we see and treat many cases of malaria in young children each year, yet in more than 20 years one of us (I. A. McG.) cannot recollect seeing any infection which seemed likely to have been acquired in this way.

We have recently completed a study of malaria infections in parturient women and their newborn infants, the detailed results of which will be published in full later. Thick films of placental, maternal peripheral, and neonatal peripheral blood were examined for the presence of malaria parasites. The bulk of the films of peripheral blood were taken from mother and child within 24 hours of birth; a few were taken at 24 and 36 hours, and one was taken at 56 hours. A hundred microscope fields were examined before any film was considered free of parasites. Two hundred and twenty-five films and one hundred and eighty-two negatives comprised the study group. Seventy-four (32%) placenta were found parasitized, some very heavily so. Parasites were found in maternal peripheral blood in 65 (28%) of cases, but were not seen in any blood film made from the infants.

It is probable that Gambian women differ from Dr. Okoje’s Nigerian patients in respect of the frequency with which they receive malarial infections and as a result of which they command to treatment facilities. One hundred and eleven of our maternal group were residents of the city of Bathurst within the precincts of which mosquito control is regularly practised and treatment facilities are readily available. These women showed a relatively low prevalence of parasitaemia in peripheral and in placental blood; the rate for each being 12%. The remaining (116) women were residents in semi-urban and rural areas of the country where mosquito control is not practised, and where treatment facilities are much less available.

Placental infection was found in 48% of these women and peripheral parasitaemia in 43%.

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