BRITISH MEDICAL JOURNAL 28 JULY 1973

with but a single fold and this, it is sug-
gested, is acceptable pending the general
adoption of A5 size papers. It also in-
corporates a useful Gusset of about 6 mm
to allow for expansion and would give a most
useful increase in writing area as regards
continuous writing. The large scale on
the Services would suggest possibilities of
economies in its production for the N.H.S.
and in filing systems.—I am, etc.,

Penn, Bucks

L. D. CHURCH

Sir,—Among all the burning enthusiasm for the new general practice record files, I would like to know how it is proposed to finance the capital outlay required for the storage of these. Our practice have in their filing cabinets the records—frequently bulky, especially those of recent newcomers—of 13,500 patients. We have tried open
filing and prefer the cabinet system, we shall keep other means of storage if it is suggested,

Penn, Bucks

**Alan J. Reeves

**Attention is drawn to the footnote to the letter from Dr. J. J. Carmack (9 June, p. 613). The D.H.S.S. has said that when the report of the working party set up to consider this matter has been received con-sideration will be given to whether any special arrangements will need to be made to meet the costs of conversion of storage equipment and premises.—Ed., B.M.I.

Dangers of Corn Starch Powder

Sir,—Further to your recent leading article on corn starch powder hypersensitivity (2 June, p. 502), we wish to make a pre-li-
mary report concerning the breakdown of an
abdominal wound apparently as a result of this phenomenon.

An 11-year-old boy with bilateral testicular
disabled was admitted for right orchio-
ectomy in January 1973. Recovery was uneventful, although the scar was not as bulky as was
advised, and was discharged on the fourth postoperative day with
the wound in a satisfactory condition. However, he had to be readmitted later following the develop-
ment of a considerable wound discharge. Swabs
from the wound were repeatedly sterile. Despite
regular wound toilet, healing did not progress
and one month after the second operation he was
returned to the theatre for wound débridement.
This was necrotic and the subcutaneous fat
and external oblique aponeurosis. This tissue, with all
remaining categ and nylon suture material, was
removed and the wound closed with stainless steel
wire. Specimens were sterile on culture but
histological examination showed the presence of
foreign body granulomas. The wound healed but
two weeks later broke down again. The possibility
of starch hypersensitivity was then entertained.
Granulomatous tissue was taken for biopsy and the
slides, together with those from the previous
débridement, were examined under polarized
light. Crystals with the typical "Maltese cross"
pattern were seen at the centres of numerous foreign
body granulomas. Finally, two months after
the left orchioectomy, the wound was again excised and its
contents removed. The surgical team did not
receive any other cases. We believe this is the first
report of this phenomenon.

Cambridge, Worcestershire

J. S. P. M.

Sir,—Without wishing to dissuade prac-titioners from prescribing penicillamine (Distamine) for their patients with severe and active rheumatoid disease, I would
like to sound a note of caution. From
several of the inquiries I have recently re-
ceived about penicillamine it is clear that
some prescribers are unaware of the abso-
lute necessity (1) of starting with a small
dose and (2) of doing white blood cell and
platelet counts weekly or fortnightly at first
and monthly thereafter for as long as a patient
is maintained on the drug. To pro-
ceed otherwise is to involve patients in a
game of Russian roulette, for fatal aplastic
anaemia and agranulocytosis have been re-
ported in the past. Some unpredictable de-
pression of white cells and platelets is not
at all unusual and responds rapidly to with-
drawal of penicillamine. This drug re-
quires as much discretion in its use as does,
for example, gold.

There is now a good deal of published work about penicillamine, and if anyone who proposes to use it would care for a review and bibliography I will send him one.—I am, etc.,

W. H. LYLE

Penicillamine in Rheumatoid Arthritis

Chase Farm Hospital, Letchfield, Middlesx

Max PEMBERTON

Mr. Mark Johnson

Sir,—There is much interest in the possi-
ble use of penicillamine in the treatment of
rheumatoid disease, but it is not generally
accepted that this drug possesses a unique
position in this condition. Lack of specific
side effects and ease of administration are
important factors which make this drug stand
out from many of its competitors. The drug
should be regarded as a powerful additive, the
use of which in rheumatoid arthritis should not
be limited to patients in whom other drug
regimen isiste not been or is not likely to be
successful.

Fleming Road, Spikes, Liverpool

W. H. LYLE

Medical Director, Distal Products, Ltd

Cubital Tunnel Syndrome

Sir,—I refer to Dr. C. F. Bolton’s letter
(19 May, p. 424). Feindel and Stratford1
described the anatomy of the cubital tunnel
in 1958 and I have elsewhere quoted their
excellent work.2 To keep the history of the
cubital tunnel syndrome in perspective one
should mention that Osborne3 in 1957
demonstrated lesions of the ulnar nerve due
to compression by the arcuate ligament when
the muscle of the tunnel was contracted.

Dr. J. R. Williams and I described the
Cubital tunnel syndrome in a simple case in
1967.4 We focussed attention on a condition occurring in hospital practice which is ill-recognized, potentially serious, and probably avoidable. At this time a classification of ulnar com-
pression neuropathy at the elbow, such as we have given, should add to the recognition and understanding of a sometimes crippling condition.

Dr. Williams and I have attempted to contribute to the knowledge of the cubital tunnel syndrome and have been supported by
a number of well-recognized authorities.—I am,

LONDON W.1


2 Wether, T. G., Clinical Orthopaedics and Related Research, 1972, 86, 127.


Subclinical Brucellosis

Sir,—Dr. Eirian Williams (23 June, p. 717)
wonders "how many clinicians would agree that
in practice subclinical brucellosis is always a perfectly obvious state." I cannot speak for others, but in my practice I find that patients are frequently sent to hospital in a state of perfect health with no history of illness in the past shows a high level of antibody in his blood, then I think most clinicians would agree that the antibody is simply a response of the body to a previous infection. I would not use the term subclinical, as is
suggested, where antibody titres remain positive after recovery; nor if during an earlier acute illness the diagnosis was not made. In either case the term would be inappropriate.

It is not clear to me how the veterinary surgeons in my series who were visited, and who are histories recorded, should be not designated as examples of subclinical infection because they were not examined. In the absence of a history of recent or past illness may one not relate their antibody level to subclinical infection? Dr. Williams also asks why "another label" for the great majority of veterinary surgeons (to whom may be added dairy farmers, slaughterers,
and their families) who despite laboratory findings are well. I do not propose the use of anther label, merely that of a well-known, widely recognized, and long-established term in clinical medicine.—I am, etc.,

R. J. HENDRICK

Public Health Laboratory, Royal Infirmary, Worcester

Lomotil Intoxication in Children

Sir,—Your leading article (23 June, p. 678)

is commendable in drawing attention to the possible hazard of Lomotil poisoning in children. However, I would urge that in such a situation the treatment should be as simple as possible.

To suggest that the appropriate dose of naloxone is "5 to 10 mg/1.73 m²" implies that every practitioner can easily, accurately, and rapidly calculate body surface area. One is faced with coating the unclothed surface area with white either with silver paper or wax
impregnated garments, which are subse-
quently removed and cut up and weighted.
Alternatively one could use the formulæ of (1)

(1) Du Bois: S = 0.007144 x W x H² / 3.6

(2) Muth: S = 0.0000923 x W x H, where S =

surface area (m²), W = nude weight (kg), and

H = height (cm).

Even to use a nomogram necessitates

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knowledge of the height and nude weight of the child and ready access to the normogram itself. These surface area formulae are themselves subject to considerable error and discrepancy. To relate the dose of nalorphine to 1/73 m² surface area entails further complications, since not even the most precocious child is likely to have a surface area approaching that figure.

Let us leave mathematics to the mathematicians and allow clinicians faced with respiratory depression due to Lomotr to ventilate with oxygen and to give the antidote based on the less complicated measurement of body weight.—I am, etc.,

C. E. BLOGG
London E.3

Prevention of Hyaline Membrane Disease

SIR,—Further to your leading article (14 April, p. 65) delayed clamping of the cord after delivery may also be important in the prevention of the respiratory distress syndrome. It is estimated that (particularly if ergometrine is given to the mother and the cord is not clamped) a baby can receive a volume of blood from the placenta equivalent to as much as half its entire blood volume after delivery. Hypovolaemia seems a logical cause for failure of pulmonary expansion which this simple precaution helps to prevent. The baby (especially if prematurity or dysmaturity) should be held at or beneath the level of the vulva, and if the cord is pulsating well it is important not to cut it off from this significant, warm, oxygenated blood transfusion.

Though rarely practised, this is not a new idea, and Erasmus Darwin wrote in 1803 that "another thing very injurious to the child is the tying and the cutting of the navel string too soon..."—I am, etc.,

LOUIS D. COURTNEY
Department of Obstetrics and Gynaecology,
Ladysmith Hospital,
County Cavan, Eire

Intrathecal Streptomyacin and Deafness

SIR,—The article by Dr. J. Stevenson (19 May, p. 411) on bacterial and tuberculous meningitis has deservedly drawn much attention (23 June, p. 716).

As a person who became totally deafened at the age of 50 years I cannot allow to pass unchallenged the statement by Dr. Stevenson that "many experienced clinicians still favour the use of intrathecal streptomycin in the earliest stages" of tuberculous meningitis. Meningitis is also made of drug resistance and hypersensitivity necessitating a change to one of the newer drugs.

There would seem no essential difference between the management of childhood tuberculous meningitis and that in the adult—in both the prognosis is more favourable when early diagnosis is made and adequate chemotherapy given (with the tubercle bacillus in mind). I await the results of culture in order to establish the diagnosis.

The ototoxicity of the neomycin group of drugs, including streptomycin, is well documented (for example, by Berg). The sequel of deafness, particularly when acquired early in life before auditory memories are established, is a tragedy of the first degree. I doubt whether this risk is worth taking. I am persuaded from my comparatively wide reading in the field of sensory neural deafness that streptomycin should not be used intrathecally. This I understand, is the opinion of most of the experts since newer drugs have become available for the treatment of this critical illness. The fact that deafness as a result of intrathecal streptomycin may occur in only a minority of cases is no justification for its use even as a life-saving measure when these newer drugs may be tried.—I am, etc.,

MABEL L. HAIGH
Wetherby, Yorks

Behçet's Syndrome and Venous Thrombosis

SIR,—Since reading the two case reports by Drs. T. Chajek and M. Fainaru (31 March, p. 782) we have treated a 21-year-old man who presented with a deep vein thrombosis and features suggesting Behçet's syndrome—recurrent mouth ulcers, acne, pustuloma, and intermittent epididymitis but without genital ulceration. The plasma fibrinogen titre was 1/128 and plasma fibrin-fibrinogen related antigen was 12 μg/ml.

Ten days before admission the patient had joined his left hip slightly while playing with a child. Two days later the whole limb began to swell. On admission ascending venography revealed an extensive femoral vein thrombosis. Intravenous streptokinase was given, 600,000 U in the first 30 minutes followed by 100,000 U hourly for 96 hours. Treatment was accompanied by an unusually severe febrile response (temperature up to 41°C). Intravenous infusion sites had to be changed frequently because local phlebitis developed rapidly. Warfarin was given after 60 hours' streptokinase infusion. Owen's one-stage prothrombin time was 14% of normal at 96 hours. Clinically there was a dramatic reduction in size of the leg associated with the development of dilated superficial veins over the thigh. However, a second venogram showed extension of the femoral thrombosis and presence of thrombus in several tibial veins that had been clear previously.

The improvement in Drs. Chajek and Fainaru's cases of superior vena caval occlusion treated with fibrinolytic agents was assessed solely by clinical examination. While appreciating that failure of recanalization of an occluded superior vena cava is less likely to be accompanied by a marked clinical improvement, we would emphasize that physical signs of improvement may not indicate disappearance of thrombus. Our patient's leg probably improved because of dilatation of collateral veins at a time when thrombus was actually extending. In Behçet's syndrome the thromboflebitis frequently develops at venepuncture sites and this too was a feature in our patient. Caution is needed, therefore, in the absence of convincing evidence of thrombolysis, before advocating the use of intravenous fibrinolytic agents. The treatment of venous thrombosis in this rare syndrome may require a different approach from that considered appropriate in other circumstances. Our understanding of the problem would be improved by further case reports, especially since enough cases are unlikely to be available for the purposes of a clinical trial.—We are, etc.,

D. A. TIBBUTT
D. T. DURACK
J. T. MACFARLANE
P. J. TEDDY
Radcliffe Infirmary,
Oxford

Smallpox

SIR,—I must congratulate Dr. A. B. Christie on his recent article on smallpox (23 June, p. 539).

As rightly brought out in the article, it is the variola sine eruptione which proves a challenge in diagnosis, but equally important are the very mild modified cases of smallpox which if not detected early keep the torch of a smallpox epidemic burning. While instilling the "expanding ring technique" for the diagnosis of smallpox, it is most important to keep a vigilant watch on the most immediate contacts who.

Lunger's line, after Dixon. Reproduced by courtesy of Messrs. Churchill Ltd.