of exposure to sun and wind, this small group of previously affected children appears to have benefited significantly from the addition of this medication to their skin.

—I am, etc.,

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### Continuous Insulin Infusion

**Stirr**—We have read with great interest the papers by Dr. M. McB. Page and others, Dr. Warren Kidson and others, and Dr. P. F. Semple and others on the treatment of hyperglycaemia, ketoacidosis, and diabetic coma by continuous insulin infusion (29 June, pp. 687, 691, and 694). These authors rightly emphasize the importance of continuous insulin infusion in these emergency situations. Though the practice of giving large, frequent doses of insulin in these conditions has been criticized the advantages of continuous insulin infusion have not been generally recognized. Perhaps these reappraisals of infusion therapy together with recent advances in medical technology may change the situation.

Interestingly enough the value of continuous infusion as the treatment of choice for diabetic hyperglycaemia, ketoacidosis, precoma, and coma becomes obvious when one considers the working of the artificial B-cell for the autonomic control of blood glucose in diabetics. When such a system of a glucose-regulated insulin infusion (consisting of a Technicon-AutoAnalyzer, a microcomputer, insulin and glucose infusion pumps, and a teleprinter) is used the patient requires from 600 to 1,000 µU of insulin per minute for about 90 to 120 minutes—that is, so long as blood glucose levels have not returned to normal. Afterwards only small doses of insulin are needed to maintain normal blood glucose, despite the patient being allowed unlimited food intake as soon as possible. Bicarbonate and potassium are given in usual amounts. Inflow and outflow are created so far in this way no untoward side effects have been recorded, despite the rapid lowering of blood glucose produced by the technique.—I am, etc.,

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### Trasylol for Pancreatitis

**Stirr**—The leading article (20 July, p. 133) on Trasylol (aprotinin) therapy in the management of acute pancreatitis leaves one with the impression that your advocacy for the use of this expensive substance was based on the findings of a recent double-blind trial. We have previously commented on the high mortality rate of 25% in the control group of patients in that trial. We have found, in a prospective survey of acute pancreatitis, a mortality rate of 11.1% for 90 patients (out of a total 140) who met the criteria of a first attack of idiopathic pancreatitis or gall-stone-associated acute pancreatitis. These 90 patients were all managed conservatively without the use of Trasylol (or glucagon).

It is therefore our distinct impression that the case for Trasylol remains to be proved against a control group with a much lower mortality rate than 25%.

A further point, on the incidence of the disease, is worthy of comment. Our experience is that acute pancreatitis is a common cause of emergency surgical admission. The catchment population of Glasgow Royal Infirmary is about 500,000 and currently more than 50 patients a year are admitted suffering from acute pancreatitis.—We are, etc.,

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### Zoster in Three Children in Family

**Stirr**—The three children of one family, all girls, suffered an attack of varicella in 1966 at a time when the youngest may have been carrying some maternal immunity to the disease. Within a few years each developed zoster (see table).

In the 3,600-3,800 population of our general practice zoster occurs at a rate of 0.7 per 1,000 persons per year.