the meninges and abducens nerve on its long intracranial course.

The sixth nerve occupies a superficial position in relation to the fourth ventricle, which communicates directly through the foramina of Magendie and Luschka with the subarachnoid space. Dye studies have shown that agents introduced into the spinal canal frequently reach the medulla, which may explain the peculiar affinity of the sixth nerve to palsy.1

The contrast agents introduced in the procedure of myelography have a toxicity of their own, and the incidence of cranial nerve palsy is higher than after merely dural puncture.2 This may be due to a previously unreported direct neurotoxicity of the contrast agent iopamidol itself.

Hypersensitivity pneumonitis induced by trimethoprim

Dr T Higgins (Department of Paediatrics) and P M Niklasson (Department of Infectious Diseases, Vaxjo County Hospital, S-385 17 Vaxjo, Sweden) write: We report on a patient who developed hypersensitivity pneumonitis induced by trimethoprim. A 43 year old woman with no history of allergy received a 25 day course of trimethoprim 100 mg/day in February 1989 for recurrent urinary tract infection. A new course was begun in September 1989. Four weeks later she presented with a two week history of a severe hacking cough and a five day history of fever, muscle pain, nausea, and headache. No other medications had been taken. The chest radiograph showed a nodular pattern of opacities (figure).

Intestitial nephritis associated with indapamide

Dr G C Newstead, R H Moore, and A J Barnes (The London Hospital, London E1 1BB) write: Acute interstitial nephritis secondary to thiadizide diuretics has been reported, but it has not been associated with the new generation of thiazides. We report a case of tubulointerstitial nephritis leading to acute renal failure associated with the use of indapamide.

A 74 year old man had been taking digoxin 0·0625 mg and one tablet of Navidrex-K (cyclo- pentiazide 250 μg and potassium 81 mmol) every morning for four years following a diagnosis of hypertension. He visited his general practitioner 35 days before admission complaining of lethargy. The dose of digoxin was doubled, and indapamide 2·5 mg every morning was substituted for Navidrex-K. Seventeen days later he developed a generalised purpuric urticarial rash. This was attributed to the indapamide, which was stopped. The rash resolved over three days. The following week the patient noticed a diminution in his urine volume, as well as progressive fatigue and anorexia. Five days before admission he developed a chest infection, which was treated with ciprofloxacin 250 mg twice daily. On admission he was clinically acidotic and ureaemic. Investigations showed haemoglobin 121 g/l, bicarbonate 9 mmol/l, potassium 5·6 mmol/l, sodium 136 mmol/l, urea 75·6 mmol/l, creatinine 1819 μmol/l, and 24 hour protein excretion 0·7 g, and ultrasound showed normal sized non-obstructed kidneys. No casts or eosinophils were seen in the urinary deposit. Later a percutaneous renal biopsy showed increased fibrosis in the interstitium with a patchy infiltrate of lymphocytes and occasional polymorphs; immunofluorescence gave negative results.

On admission probable acute tubulointerstitial nephritis was diagnosed. Haemodialysis was started and he was treated with prednisolone 60 mg every morning and cimetidine 200 mg twice daily; all other drugs were stopped. The patient required haemodialysis for eight days; his creatinine concentration subsequently fell to 130 μmol/l.

Acute interstitial nephritis has been described after treatment with thiazide drugs but no cases of interstitial nephritis due to indapamide are known to the manufacturers or to the Committee on Safety of Medicines. Hypokalaemia is the most frequent problem observed with this drug,1 and in one case of profound hypokalaemia in a 39 year old man there were also electrocardiographic changes, renal casts, marked muscular weakness, and proteinuria. Renal function, however, was normal.2

In this case the patient was admitted to hospital in a state of advanced uraemia, and a renal biopsy confirmed the clinical diagnosis of interstitial nephritis. There was no evidence of infection or obstruction or of multisystem or immunological disease. There was no history of exposure to toxic drugs, but we suggest that indapamide was responsible. The patient had been taking an alternative thiazide diuretic (cyclo- pentiazide) for four years without any side effects; the uricarial rash developed 17 days after he started indapamide and resolved after he stopped this drug; the improvement in the rash occurred while digoxin was continued at the same dose. The history suggested that the renal disturbance had antedated the admittance by two weeks, some nine days before first exposure to ciprofloxacin, and the degree of kidney disturbance on admission was too profound to have been caused by ciprofloxacin started only five days earlier. Thus the clinical evidence points to an acute drug induced hypersensitivity reaction secondary to indapamide being responsible for this patient’s acute renal failure.

Mononeuritis multiplex associated with prolonged valacyclovir treatment

Dr S Liewritz, D Golan, D Jeshurun, and M Weiss (Department of Medicine, Hadassah University Hospital-M Scopus, Jerusalem, Israel) write: Valacyclovir is the antibiotic of choice for methicillin resistant staphylococci and has relatively few side effects (fever, phlebitis, allergic reactions, ototoxicity, and neuropenia). We recently observed a patient with severe peripheral nerve toxicity after prolonged valacyclovir administration. After mitral valve replacement a 49 year old woman developed methicillin resistant staphylococcal sepsis following catheter associated infection. Her fever rapidly remitted on valacyclovir treatment, which was continued for several weeks to suspected endocarditis. Serum concentrations of valacyclovir were therapeutic. The only medications were valacyclovir and indapamide, which she had been taking for many years. After a month on valacyclovir she complained of tinnitus and weakness of her right leg. She remained afebrile, and neurological examination showed foot drop of her right leg. Nerve conduction studies confirmed right peronal nerve block and disclosed bilateral partial block of the tibial nerves, consistent with mononeuritis multiplex. On discontinuation of valacyclovir the tinnitus resolved but the foot drop persisted.

Valacyclovir can cause vestibular toxicity, but peripheral neuropathy has not been reported. Although valacyclovir can, rarely, induce a vacuolar, motor neuropathy, no such cases have been observed. Our patient showed no evidence of systemic vasculitis. We conclude that peripheral neuropathy may be an additional adverse effect of valacyclovir.