neurofibromatosis and leukemia are uncommon conditions and the above three cases suggest that there may be a link between them. It may well be merely coincidental that all three patients are males.—We are, etc.,

W. R. McWHIRTER
D. C. LEVAN
B. M. WILLIAMS
Maryfield Hospital, Dundee


Pupillary Paralysis after Tranquillizer

Sr.,—Though I accept Dr. R. Pearson’s criticism (1 September, p. 639) that the evidence in my letter (28 August, p. 530) is not proof that pinimozide caused the side effects mentioned, there are two aspects of this subject on which I would like to comment.

First, it is common experience with high doses of the phenothiazine and butyrophenone groups of drugs that blurring of vision and other side effects occurs, and that pupillary dilation and sluggish reactions are observed concomitantly. Administration of antiparkinsonian agents often alleviates the condition, though the dose of antipsychotic drug used is usually lower than that required to reduce before this side effect is removed. There is often a wide gap between the theoretical effects predicted by known pharmacology of drugs (often inferred only from animal experiments), and what is clinically observed. I would put forward the proposition that while one would expect anticholinergic agents such as benztpine and orphenadrine to cause pupillary dilation, the clinical observation remains that blurring of vision is diminished by these drugs in the complicated iatrogenic state of affairs introduced by the administration of antipsychotic agents.

My second point is that pinimozide is suggested by the manufacturers (Janssen Pharmaceutica) to have a very low incidence of side effects—and yet the case under discussion showed all the usual complications.—I am, etc.,

R. J. M. CRAWFORD
Royal Edinburgh Hospital, Edinburgh

Survival in Severe Congenital Heart Disease

Sr.—Your recent correspondents (4 September, p. 579, and 18 September, p. 701) have illustrated some of the problems facing all those trying to provide services for infants and children with cardiac lesions. Of course the situation imagined by Dr. E. T. O. Slater (18 September, p. 702) infrequently arises in such a clear manner. Medical problems in such circumstances are that of an infant who clearly must have an operation very early or die, and one therefore defers an older child who is in a less pressing situation. This was done on a sufficient number of occasions it will eventually turn out that one has guessed wrong, and an older child will suffer, perhaps irremediably. One is weighing the life of one child, whilst it may be those of several children, an equation perhaps less simply solved than Dr. Slater's.

Similar problems arise at the diagnostic stage. Cardiac investigations have to be rationed, and one does this partly by not investigating some of those who clearly can afford to wait, in the hope that some day it will be possible to deal with them, and partly by pooling investigation to those small infants who seem likely to be unsalvageable. Again one cannot always be right, but to detect each of those infants with a reasonable chance of a long and happy life after operation would also mean investigating several who turn out to be incurable. Even with such rationing many treatable infants are imperilled by unavoidable delay. The emotional consequences of these cases, therefore, is increased, and one is left to associate this work preferentially with those other services, such as neonatal surgery, which require similar expertise—particularly that of paediatric anaesthesia.

Not all administrations are able to solve these problems, and because of the expense I wonder if it is not time for some help and guidance for them from the Department of Health.—I am, etc.,

G. H. WATSON
Royal Manchester Children's Hospital, Pendlebury, near Manchester

Nephropathy of Cephaloridine

Sr.,—Dr. R. Gabriel and others (31 October, 1970, p. 283) reported reversible acute renal failure after cephaloridine. We recently encountered a case of fatal acute renal failure following cephaloridine administration and thought that this complication of the drug deserves documentation.

The patient was a 70-year-old woman with a complex cardiac condition. She was febrile and very ill. Streptococcus viridans was cultured from her blood. Though the patient was known to be sensitive to penicillin a therapeutic trial with ampicillin was attempted. This resulted in a widespread rash, and cephaloridine was therefore substituted. During the course of this treatment progressive oliguria was noted. Blood urea rose from 38 mg/100 ml to 200 mg/100 ml and creatinine reached 5 mg/100 ml. Though peritoneal dialysis brought about an improvement in serum biochemistry, the patient's general condition continued to deteriorate and she died. Necropsy was refused, but a percutaneous renal biopsy was performed within one hour after death.

All the glomeruli were intact. Many tubules were without their epithelial lining. The tubular lumina contained amorphous eosinophilic material which was in some cases granular. There were patches of tubular atrophy with interstitial oedema and lymphocytic and eosinophilic infiltration. This acute renal failure could have been determined by several causes. Subacute bacterial endocarditis may produce renal damage. However, it does not usually produce acute renal failure. Ampicillin is a fairly innocuous drug so far as the kidneys are concerned, and in any event, it had been given for one day only, while cephaloridine was given for a whole month.

Our patient was known to be sensitive to penicillin, and cross sensitivity between penicillin and cephaloridine has already been described. The clinical manifestation of sensitivity ranges widely from mild urticaria to severe renal damage and anaphylactic shock. There have been numerous reports on the aspects of nephrotoxicity of cephaloridine. These range from mild damage manifested by casts and albuminuria to the severe manifestations of acute renal failure. This drug has caused necrotic changes in the proximal tubules in experiments on animals, and these changes include hydropic swelling with fragmentation of the tubular cells.

We conclude as others before us that cephaloridine should be used cautiously. Repeated estimation of the renal function must be performed and the dose should be related to the level of renal function.—We are, etc.,

TALMA ROSENTHAL
Department of Internal Medicine, Hadassah University Hospital, Jerusalem, Israel

Diverticular Disease of the Colon

Sr.—We were interested to read Dr. J. F. Caldwell's account (12 June, p. 654) of a single case of diverticular disease of the colon in a 40-year-old Bantu female resident in Zomba, Malawi. We have recently seen a Rhodesian African female patient with this condition. This would appear to be the only reported case of diverticular disease of the colon in an African resident in Rhodesia. The patient, a 42-year-old female, underwent cholecystectomy for cholelithiasis. Multiple diverticula of the descending colon and sigmoid colon were noted at laparotomy and confirmed later with barium studies. It is important to record the rarity of a disease in a region where its incidence is much lower than that seen elsewhere. If the disease should show an increase in incidence during subsequent years, the study of features related to the change in environment of this group of people may help elucidate the cause of the particular disease.—We are, etc.,

SIMON WAPNICK
LESLIE LEVIN
University College of Rhodesia, Harare Central Hospital, Severe, Rhodesia

An XXY Individual of Average Height

Sr.—In reply to Dr. Dora Black's criticism (25 September, p. 768) we would like to make the following points.

(1) We reported the finding of an XXY