Butazone and quinine sulphate. The induction of platelet antibodies by quinine has been described and the mechanism of development is not entirely identical with that caused by apronal (Sedormid). The effect of phenylbutazone as a generalized bone marrow suppressor is well known and it is of interest that phenylbutazone-induced platelet antibodies have been reported previously.

The precise mechanisms involved in our case are open to some speculation, though it is known that phenylbutazone in combination with other drugs produces pancytopenia more commonly than when given alone. It seems likely that bone marrow suppression by the combination of phenylbutazone and quinine sulphate was the major factor in the pathogenesis of the pancytopenia, but the platelet antibodies must be considered to have been a contributory factor in producing such a severe degree of thrombocytopenia.

Evidence accumulates that the drug induction of antibody-mediated thrombocytopenia is not so rare as has been believed; in common with Drs. Davidson and Manohitarajah we believe that there is good reason to look for platelet antibodies in thrombocytopenias thought to be drug-induced, as their presence provides a rationale for effective therapy and a guide for subsequent reintroduction of the offending drug.

We thank Dr. K. Goldsmith of the M.R.C. Blood Groups Reference Laboratory for performing the tests for leucocyte and platelet antibodies and Professor A. Guz for permission to report his patient.

A. C. Keat
R. G. Rawbone
J. Mitra
T. R. Mitchell

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"Thou shalt not kill; but ..."

Sir,—Mr. G. Keys Smith and Mr. E. Durham Smith (27 October, p. 189) are certainly not the first and probably not the last to take Cough's lines "Thou shalt not kill; but need'st not strive Officially to keep alive" out of context to support an argument. The poem from which the lines are taken, "The Latest Decalogue," is satirical, juxtaposing in each couplet a commandment and a wrong reason for obeying it. This is obvious from the lines following those which are so commonly quoted:

"Do not adultery commit; Advantage rarely comes of it: Thou shalt not steal; an empty feast, When’s it so lucrative to cheat."

—I am, etc.

P. R. R. Clarke

Marton, Middlesbrough

Calcification in Burkitt's Lymphoma

Sir,—It is the purpose of this letter to document what appear to be the first cases of Burkitt's lymphoma with calcification in abdominal tumour masses before treatment. Over 350 cases of Burkitt's lymphoma have been reported from Ibadan, with tumour accounts for over 50% of all childhood malignancies. Abdominal involvement is present in 30-70% of cases reported from various parts of the world. In the abdomen multiple intraperitoneal and retroperitoneal masses are usually involved, commonly the kidneys, pancreas, adrenals, ovaries, gastrointestinal tract, and mesenteric and retroperitoneal lymph nodes. I have been unable to find any reported case of Burkitt's lymphoma with radiographically visible calcification within abdominal tumour masses prior to treatment. A Medlars computer search of the literature from January 1970 to May 1973 was unable to locate any citations for this entity and Dr. D. F. Burkitt is also unaware of any such case (personal communication, 1973). Whittaker1 reported cases from Kenya in which calcification developed after treatment.

Case 1.—A 7-year-old Nigerian boy presented with a brief history of abdominal dimension and pain. He had hepatomegaly and splenomegaly, and multiple masses were palpable in his fluid-filled abdomen. An intravenous pyelogram showed essentially normal renal collecting systems with some delayed drainage on the left. A cystic calcification was present in front of and slightly below the left kidney (see fig.). Cytological examination of abdominal fluid showed typical Burkitt lymphoma cells. He had a poor response to chemotherapy and died about one month later. At necropsy there was a large mass in the abdominal cavity, primarily on the left, infiltrating the spleen, left kidney, pancreas, para-aortic lymph nodes, omentum, and the wall of the colon. There were also nodular deposits in the spleen. Histological examination confirmed the diagnosis of Burkitt's lymphoma. Unfortunately the specific site of calcification within the tissue/tumour masses was not identified histologically at necropsy and tissue was not available for re-study at a later date.

Case 2.—A 12-year-old boy with abdominal swelling and a mass on the right showed deformity of the renal collecting system and ureter on the right. Bilateral calcifications were present posteriorly in a suprarenal location. Biopsy of the right kidney showed the histological and cytological appearances of Burkitt's lymphoma. The patient was then lost to follow-up.

—I am, etc.,

S. P. Bohrer
Department of Radiology, University of Ibadan, Ibadan, Nigeria


Pyridoxine and Parkinsonism

Sir,—Dr. A. B. Carter (27 October, p. 256) points out that pyridoxine-containing compounds are contraindicated in the treatment of nausea in patients who are receiving levodopa for Parkinsonism. Dr. Carter stated that he usually prescribes metoclopramide but fails to mention that this compound itself may cause Parkinsonism which will not be relieved by increasing the dose of levodopa.

—I am, etc.,

Sharon M. Carter
Nevill Hall Hospital, Abingdon, Oxon


Ideal Diet

Sir,—There has been recent correspondence ("Any Questions?" 18 August, p. 402; 13 October, p. 103) as to an ideal diet which will not elevate blood cholesterol. It was suggested that a carbohydrate-restricted diet, allowing freedom to eat "non-carbohydrate" foods, including meat, eggs, and dairy products, is suitable. These latter foods are high in saturated fats and cholesterol, which may cause elevation of the blood cholesterol. However, the claim is made that on such a diet the amounts of fat and protein are self-limiting when carbohydrate intake remains constant.

A detailed study1 has recently been undertaken in which precisely this dietary advice (described in the paper as the "Yudkin diet") was compared with a more usual calorie-restricting diet. On the low-carbohydrate diet

Fig. A: Abdominal radiograph 15 minutes after intravenous injection of pyelographic contrast material.
Fig. B: lateral view.
energy intake was reduced by only 2.6%. Cutting out the carbohydrates led to a distinct increase in protein and fat consumption. On the alternative regimen mean daily calorie intake fell from 1,800 to about 1,200 kcal/day, a reduction of 30%. Mean weight losses after six weeks were 1.0 kg and 3.1 kg respectively. On the standard calorie-restricting diet serum cholesterol fell initially from 215 mg/100 ml to 198 mg/100 ml and then returned to the original level. On the low-carbohydrate diet the serum cholesterol level rose from 208 mg/100 ml to 236 mg/100 ml and in a few individuals to levels above 300 mg/100 ml. In general, the volunteers who kept to the low-carbohydrate diet was more difficult than keeping to the calorie-restricting one, and the former regimen was estimated to be more expensive.

A critique of low-carbohydrate ketogenic weight reduction regimens has been published by the American Medical Association Council on Foods and Nutrition. I should regard two of the summary points as being most relevant:

(3) The Council is deeply concerned about any diet that advocates an ‘unlimited’ intake of saturated fats and cholesterol-rich foods. In persons who respond to such a diet with an elevation of blood cholesterol and an exaggerated stress hyperlipemia, the risk of coronary artery disease and other clinical manifestations or atherosclerosis may well be increased—particularly if the diet is maintained over a prolonged period.

(4) Any grossly unbalanced diet, particularly one which interdicts the 45% of calories that is usually consumed as carbohydrates, is likely to induce some anorexia and weight loss if the subject is willing to persevere in following such a bizarre regimen. However, it is unlikely that such a diet can provide a practicable basis for long-term weight reduction or maintenance, that is, a lifetime change in eating and exercise habits.

While a low-carbohydrate diet may be more acceptable to certain patients, such a diet will cause elevation of blood cholesterol in some people. If one is worried about cholesterol levels when planning a diet, it is prudent to limit foods high in cholesterol and saturated fat. Such a diet will still contain adequate amounts of fat-soluble vitamins.

J. I. MANN
Department of the Regius Professor of Medicine, Radcliffe Infirmary, Oxford

Cancer and the Patient

STR.—Professor G. W. Milton (27 October, p. 221) displays great understanding of the patient’s reaction to a diagnosis of cancer. He also makes a point of enormous practical importance. In Britain we tend to examine the patient and then offer to see the accompanying relative, often not in the patient’s presence. Frightened patients are thus effectively isolated from their most valuable source of support. At the same time they may never quite believe that husband or wife has been entirely honest and is not concealing further bad news in an attempt to spare the patient greater distress. The loved ones, as it were, life’s conspiracy against the patient. In their darkest moments in a sleeping house the isolation must be unbearable. But if the doctor discusses the situation with all concerned there can be no grounds for mistrust. Though this can be much more difficult, it is more humane.—I am, etc.,

E. A. MACDONALD
Hammersmith Hospital, London W.12

F.D.P. Levels in Intravascular Haemolyis

STR.—Dr. S. D. Slater and his colleagues (1 September, p. 471) suggest that chronic haemolysis does not lead to intravascular coagulation in the absence of “other precipitating factors.” I have also seen clinical cases of acute massive haemolysis, as shown by the normal levels of serum fibrinogen–fibrin degradation products (F.D.P.) and the absence of other signs of intravascular coagulation in sensitive Sardinian subjects following ingestion of fava beans. On the other hand, situations of acute haemolysis of comparable degree, such as the transfusion of incompatible blood, drowning haemoglobinemia, and ingestion of anticoagulants, may be accompanied by consumption of coagulation factors and increased F.D.P. levels. What, then, are the “precipitating factors” and why does intravascular coagulation occur in some cases and not in others?

Dr. E. N. Wardle (13 October, p. 111) is right in emphasizing the key role played by the state of functional activity of the reticuloendothelial system. This has been convincingly demonstrated by the experiments of Rabiner and Friedman, who showed that intravascular coagulation followed the infusion of lysed red cells only after depression of the reticuloendothelial system by carbon or spleenectomy. Therefore I think that the different findings in the acute attack of favism and in incompatible blood transfusion may be similarly explained by the presence of an intact reticuloendothelial system in the former and by its depression by shock in the latter.

I cannot support the suggestion of Dr. Wardle that impaired removal of fibrin by defective fibrinolysis plays a relevant role in conditioning the occurrence of intravascular coagulation after haemolytic anaemia. Unpublished observations in cases of favism in the fibrinolytic activity was very depressed and yet there was no evidence of fibrin deposition and intravascular coagulation.—I am, etc.,

P. M. MANNucci
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Muscle Cramps during Maintenance Haemodialysis

STR.—May we have the privilege of replying briefly to the letter from Dr. G. R. D. Castro and others (3 November, p. 301)?

With regard to their first point, we must disclaim any intention of suggesting that the mean inter-dialysis weight gain of 4-5 kg during isonatric dialysis (dialyse sodium = 145 mmol/l) was due mainly to the three-day interval between twice-weekly dialyses. On the basis of twice-weekly dialysis, the inter-dialysis weight gain almost doubles on isonatric dialysis compared with low-sodium dialysis. However, we have to show that if our patients were receiving thrice-weekly dialysis the mean inter-dialysis weight gain would be less. Our range of weight change would, we agree, be unacceptable on low-sodium dialysis, but a much wider range of weight fluctuation is acceptable during isonatric dialysis. Our patients are advised to limit their weight gain to a maximum of 1 kg per day between dialyses. We reiterate that all the patients in Dundee, including those on home dialysis, tolerate well both their weight gain and the increased ultrafiltration required to maintain their ideal postdialysis weight. Indeed, those who remember pre-isonatric days react with dismay to the suggestion that they return to low-sodium dialysis with its attendant symptoms of “disequilibrium.”

In fact, we have never advocated the use of isonatric dialysate for the sole and specific purpose of reducing cramps. The decrease in the incidence of cramps is a mere secondary benefit among others.3 Port et al.3 have independently demonstrated the benefit of “high-sodium” dialysate (149 mmol/l) in reducing symptoms of disequilibrium and maintaining a more normal electroencephalographic pattern during an experimental single dialysis.

We should perhaps mention that some insight and acquired skill are required in regulating the increased rate of ultrafiltration for some patients. However, once established, the routine has proved entirely satisfactory, and isonatric dialysis has remained standard practice for all patients in Dundee, including those on home dialysis, over the past three years.—We are, etc.,

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Aid to Lumbar Puncture

STR.—In performing lumbar puncture it is advisable to use as fine a needle as possible. There are now a number of manufacturers who produce a 22-gauge disposable spinal needle. With such a fine needle there are no problems as both introduction of the needle through the skin and ligaments and in ensuring that the needle travels in the desired direction. There are numerous ways of overcoming these problems and the practice of this letter is to describe a simple and convenient way of dealing with both introduction and direction of the spinal needle.

After the usual preparation an intravenous cannula of an appropriate size (I use a no. 1 Braumulc) is inserted in the selected spinal interspace until it is well placed in the ligaments. The inner needle portion is with-