sulphasalazine was discontinued. The ulcerative colitis deteriorated and was not controlled by prednisolone given orally and by enema. The development of toxic megacolon in November 1978 necessitated a colectomy. Two weeks after this he was inadvertently given co-trimoxazole for a urinary tract infection. Three days later this was followed by a rapidly spreading erythematous rash, which soon became universal and scaly. His general condition deteriorated and the eruption showed no response to progressive increases in prednisolone therapy (maximum 120 mg daily). Eight weeks after co-trimoxazole had been discontinued a skin biopsy was taken and showed parakeratosis, mild papillomatosis, and permeation of the epidermis by neutrophils.

A diagnosis of erythrodermic psoriasis was made and methotrexate was begun orally once weekly. The erythroderma began to resolve after the second dose, and four weeks from the onset of methotrexate therapy abnormal findings in the skin were limited to well-defined silvery, scaled plaques over the elbows, on the scalp, and on the hands and feet. As the psoriasis came under control, the dose of prednisolone was gradually reduced and is currently at 4 mg daily.

This case may represent an example of the Koebner phenomenon, the psoriasis having been triggered by a sulphonamide drug eruption. The diagnosis of psoriasis was delayed by the absence of any previous history, the clearcut relationship of the onset of the rash to sulphonamide ingestion, and the clinically non-specific nature of the erythrodermic form of the disease.

CAMERON KENNEDY
I M LEIGH
STEPHEN GOLD

Skin Department,
St George's Hospital,
London SW1X 7EZ

Prediction of gall-stone pancreatitis by computer

SIR,—I read with interest the article "The prediction of gall-stone pancreatitis" by Mr D F Graham and Dr Frances J Wyllie (24 February, p 515), which highlighted some significant distinguishing features between acute pancreatitis of gall-stone aetiology and other causes. It is important to stress, however, that if a predictive index is to be used it is essential that the scoring system is based on data from the local population and that the data are current.

There were 57 admissions for proved acute pancreatitis to this Veterans Administration hospital over the last five years, of which 46 were first-time admissions and not for acute post-operative pancreatitis. Thirty-four case records were available for study and the aetiological factors were as follows: alcohol 15; gall stones 11; others 8.

With regard to the 10 significant differences identified by the authors between the two groups—gall stones or no gall stones—the following differences were found here:

Symptoms and signs	No stones No (%)	Stones No (%)
Pain		
Onset general	16 (70)	8 (73)
Present, right upper quadrant	3 (13)	2 (18)
Present, generalised	20 (87)	8 (73)
Jaundice		
History of jaundice	1 (4)	1 (9)
History of dark urine	1 (4)	1 (9)
Jaundiced clinically	1 (4)	1 (9)
Tenderness		
Right upper quadrant	7 (30)	4 (36)
Generalised	18 (78)	8 (73)
Rebound tenderness	5 (22)	0 (0)
Murphy's test positive	0 (0)	1 (9)

Thus, while it may be that in a population

where the predominant aetiological factor is gall-stone disease, these features will be discriminant; it is clear that in this population they will not. It is possible that the increased incidence of pain and tenderness predominantly in the right upper quadrant in those without gall stones is related to the noted tender hepatomegaly in the acute alcoholic patient. This brief examination of patients seen here in a hospital system that deals with a high incidence of alcohol-related problems shows that discriminant features are not uniform for any disease. Further, as there is evidence that the aetiological pattern in acute pancreatitis is changing in the United Kingdom,¹ these authors must be prepared to change their data base if they wish to continue with this in their programme—which, from personal experience, is a good diagnostic teaching aid.

Harry S Truman Memorial
Veterans Hospital,
Columbia, Missouri 65201, USA

¹ Imrie, C W, and Whyte, A S, *British Journal of Surgery*, 1975, **62**, 490.

Bextasol and aphthous ulcers

SIR,—Further to Dr Marianne Ganderton's letter (5 May, p 1216), may I too suggest a new use for aerosol inhalers, which may appeal to others.

I have found Bextasol Inhaler (Betamethasone Aerosol Inhalation, BNF) particularly useful in the management of aphthous ulcers, both personally and in a limited study. Usually these ulcers resolve spontaneously, of course; but while present they can often be quite troublesome. I have found that a puff of Bextasol Inhaler directed locally on to the ulcer site once or twice daily, for as long as required (rarely more than a day or so), both reduces pain and promotes early resolution. Each puff of Bextasol Inhaler contains only 100 µg of betamethasone valerate, a steroid which has particularly high topical activity—compared, for example, with Hydrocortisone (Corlan) pellets, which contain 2.5 mg of steroid and can be uncomfortable to retain in position.

In the presence of concurrent oral infection such as *Candida albicans*, when steroids would be contraindicated, a simple, soothing gel such as Bonjela is probably most useful.

NICHOLAS FISHER

Accident and Emergency Department,
Torbay Hospital,
Torquay, Devon

Hepatotoxicity of erythromycin derivatives

SIR,—In their recent article on drug-induced liver disease (14 April, p 992) Drs P W N Keeling and R P H Thompson wrote that "one, and only one, ester of erythromycin, the estolate, produces cholestasis, and so the reaction must be linked to the side chain rather than to the antibiotic itself."

Erythromycin estolate may not be the only villain of the erythromycin family.¹ We have seen a patient in whom severe abdominal pains, cholestatic jaundice, and eosinophilia occurred after the administration of erythromycin propionate; it subsided when the drug administration was interrupted and recurred when it was resumed.¹ In another patient

hepatitis followed the administration of erythromycin estolate and recurred after that of erythromycin propionate.² In still another patient, hepatitis occurred after the administration of erythromycin ethylsuccinate.³ Experimentally, erythromycin and several of its derivatives have been shown to be cytotoxic to Chang human liver cells⁴ and cholestatic in the isolated perfused rat liver.⁵ These observations suggest that not only erythromycin estolate but also other erythromycin derivatives are hepatotoxic and that the reaction may be linked to the antibiotic itself rather than to the side chain.

Clearly, it is unfair to lay all the blame upon the estolate: his propionate and ethylsuccinate brothers are scoundrels too.

D PESSAYRE
J P BENHAMOU

Unité de Recherches de Physiopathologie
Hépatique,
Hôpital Beaujon,
92118 Clichy, France

¹ Pessayre, D, et al, *Archives Françaises des Maladies de l'Appareil Digestif*, 1976, **65**, 405.

² Tolman, K G, et al, *Annals of Internal Medicine*, 1974, **81**, 58.

³ Klatskin, G, in *Diseases of the Liver*, vol IV, ed L Schiff, p 604. Philadelphia, Lippincott, 1975.

⁴ Zimmerman, H J, et al, *Proceedings of the Society for Experimental Biology and Medicine*, 1973, **144**, 759.

⁵ Kendler, J, et al, *Proceedings of the Society for Experimental Biology and Medicine*, 1972, **139**, 1272.

The future of the Health Advisory Service

SIR,—Dr A A Baker (7 April, p 967) writes that "Many of the problems in psychiatric and geriatric hospitals stem from a lack of understanding of a multidisciplinary approach to patient care." But with the increasing number of elderly patients being admitted to hospital into surgical, medical, and orthopaedic wards the Health Advisory Service ought not to limit itself purely to the elderly under the care of the psychiatrists and physicians in geriatric medicine. They should be enabled to visit all wards where significant numbers of elderly patients are admitted. Many of the general medical and orthopaedic wards lack the facilities for the comprehensive type of care that some of the elderly patients they have to admit require.

J R COX

Nether Edge Hospital,
Sheffield S11 9EL

Accident and emergency staff

SIR,—During the past few years accident and emergency has established itself as a specialty in its own right and 10 senior registrars are already in post. I consider this to be a tremendous achievement, which will result in further improvement of the service provided by the accident and emergency departments in this country. The credit for the present state of affairs must be given to those of our colleagues who fought for this specialty to be given recognition and won against all odds. The Casualty Surgeons' Association has flourished over the years and the ambitious hopes of a handful of accident and emergency surgeons have become a reality. One of the founder members of this association is Mr John Collins, who is now its president.

Despite the progress there still remains the problem of the injustice to a group of medical practitioners who are still running accident and emergency departments but who have not yet been given the recognition of con-