and on both occasions a blizzard prevailed. The *Mercury*, a Hobart newspaper, reported on 21 September 1903, "They had to face a snowstorm, with a strong south-westerly wind. Many of them were dressed only in singlets and light knickers, . . . and the top sides of the mountain were covered with some feet of snow . . ." One of the participants noted some years later, "They were lying over logs, on the ground, and under trees, too exhausted to continue." Thus the deaths were a result of hypothermia, the end result of exhaustion and inadequate or wet clothing in a cold, windy environment.

It is clear that lightly clad runners are vulnerable to environmental conditions, both hot and cold, and the organisers of any community jogging events should realise that weather conditions can create a medical nightmare out of a "fun run."

JOHN R SUTTON

Department of Medicine,
McMaster University,
Hamilton,
Ontario, Canada L8S 4J9

¹ Sutton, J R, *et al*, *Medical Journal of Australia*, 1972, **2**, 127.

² Sutton, J R, and Harrison, H C, *Medical Journal of Australia*, 1977, **1**, 193.

³ Hughson, R L, and Sutton, J R, *British Medical Journal*, 1978, **1**, 1158.

⁴ Robinson, C R R, *New England Journal of Medicine*, 1971, **285**, 1267.

Canvasser's knuckle

SIR,—We are all aware of such complaints as "housemaid's knee," clergyman's knee," "student's elbow," "miner's elbow," and "weaver's bottom"; but I would like to introduce another member of this family, which I have discovered recently—namely, "canvasser's knuckle."

During the course of the recent election I knocked on dozens of doors and subsequently developed painful swelling and inflammation of the proximal interphalangeal joints of my right hand. At a conservative estimate I would say that 50% of party workers who laboured hard during the last campaign suffered from "canvasser's knuckle" and that their discomfort could be relieved by a liberal application of cold hand cream.

ADRIAN THOMPSON

University Medical School,
Leeds 2

Illness seen at menopause clinic

SIR,—The recent paper by Mr S Chakravarti and others (14 April, p 983) noted that a group of the patients presenting in a menopause clinic had symptoms which were not apparently attributable to the oestrogen deficiency of the climacteric.

Of the first 40 patients referred to a menopause clinic in Newcastle, 19 were found to be suffering from conditions requiring treatment but unrelated to oestrogen deficiency (although this was judged to be present in at least nine of the 19 on the basis of characteristic symptoms and raised plasma concentrations of follicle-stimulating hormone). The range of diagnoses included hyperthyroidism, primary hyperparathyroidism, hypertension, cardiac failure, and alcoholism, as well as depressive illness.

Undoubtedly there is a tendency for women aged around 50 to attribute any untoward

symptoms to the menopause and their doctors may sometimes accept this explanation too readily. A major function of a menopause clinic is a full diagnostic appraisal of the patient.

I WANDLESS

University Department of
Medicine (Geriatrics),
Newcastle General Hospital,
Newcastle upon Tyne NE4 6BE

Cervical cytology

SIR,—Since becoming a principal in general practice in 1973 I have been concerned about the accuracy of technicians' reports on cervical smears.

In 1977 in Gloucestershire I and a partner were running a family planning clinic in a practice of 10 000 patients. We became worried when it seemed to us that there were too many reports of squamous cells only, requesting the smear to be repeated. We collected reports on smears done on our patients over a six-month period. These smears were taken by the doctors in the Family Planning Association clinic, the consultant gynaecologists, and the partners in our practice.

We found that of the three technicians who reported, one requested a significantly higher number of repeats than the other two, and it did not seem that any one doctor was requested to repeat his smear more than another. We pointed this out to the pathology department and realised that a larger study was needed—perhaps nationally—really to prove our point, formally and statistically, that there may be a vast amount of public expenditure wasted because of mistakes in cell typing.

I am now in a smaller general practice in Yorkshire and again became worried because every single cervical smear I have taken is simply reported "no malignant cells." This is a complete contrast to my reports in Gloucestershire and I have not changed my technique. I therefore did two slides. One was of cells from my buccal cavity (stuffed squamous) and the other slide was prepared by my scraping the inside of my nose with a finger nail (mainly mucous cells, but the slide may have had some pseudostratified columnar ciliated cells or goblet cells). These were fixed and sent to Leeds as though they were smears. Each was reported as "normal smear, no malignant cells."

The reporting aspect of the national cytology service should be investigated. I and some of my GP colleagues feel we may be wasting our time and that of the patient's as well as a lot of public money.

R E G SLOAN

Castleford, W Yorks WF10 2QS

Pituitary suppression in chronic airways disease?

SIR,—We were interested to read the paper entitled "Hypopituitarism in normal-pressure hydrocephalus" by Drs S G Barker and H Garvan (21 April, p 1039), having recently discovered some similar endocrine abnormalities among 16 male patients with chronic obstructive airways disease.¹

Serum tri-iodothyronine, thyroxine, cortisol, and oestradiol levels were normal in our patients but there was depression of serum testosterone, the degree of depression apparently being related to the degree of hypoxia and hypercapnia. Normal serum luteinising

hormone and follicle stimulating hormone values suggested hypothalamic or pituitary suppression rather than testicular failure. Three of eight hypercapnic patients had high serum prolactin values not attributable to drug consumption.

As hypoxia of altitude has been shown to cause depression of adrenal and gonadal function,^{2,3} we assumed hypoxia or hypercapnia to be the likely cause of the endocrine abnormalities in our patients. However, in view of the findings of Drs Barker and Garvan it seems possible that the raised intracranial pressure known to occur in hypercapnia, even to the extent of causing an eroded pituitary fossa on x-ray,⁴ may account for our findings. We are currently involved in further studies in this field.

PETER d'A SEMPLE

G H BEASTALL

W S WATSON

ROBERT HUME

Medical Division,
Southern General Hospital,
Glasgow G51 4TF

¹ Semple, P d'A, *et al*, *Thorax*, in press.

² Pugh, L G C E, *British Medical Journal*, 1962, **2**, 621.

³ Guerra-Garcia, R, Velasquez, A, and Coyotupa, J, *Journal of Clinical Endocrinology and Metabolism*, 1969, **29**, 179.

⁴ Newton, D A G, Bone, I, and Bonsor, G, *Thorax*, 1978, **33**, 684.

Treatment of ulcerative colitis

SIR,—I was interested to read of the use of thalidomide by Dr M F R Waters and his colleagues (24 March, p 792) for the treatment of chronic ulcerative colitis. Clofazimine is another drug used for treating leprosy and erythema nodosum leprosum and this agent has been claimed to be effective in cases of pyoderma gangrenosum.¹ Clofazimine has also been used in the treatment of Buruli ulcers, the necrotising skin lesions caused by *Mycobacterium ulcerans*, and I have heard anecdotally of the successful use of thalidomide in this condition.

Buruli ulcers and pyoderma gangrenosum may resemble each other closely. If further studies are to be carried out using thalidomide in patients with ulcerative colitis, then it might be interesting to concentrate on those cases which are associated with pyoderma gangrenosum.

KEVIN M DE COCK

¹ Michaëlsson, G, *et al*, *Archives of Dermatology*, 1976, **112**, 344.

Drug eruption or psoriasis?

SIR,—In their article giving general principles for approaching the problem of a suspected drug eruption Drs R A Hardie and J A Savin (7 April, p 935) mention that antimalarials and lithium may worsen psoriasis. This association will usually be evident from the patient's history. We recently encountered a case in which a "toxic erythema" provoked by a sulphonamide evolved imperceptibly into erythrodermic psoriasis, presenting considerable diagnostic and therapeutic difficulties.

The patient was a 20-year-old black male with no past or family history of skin disease. He developed ulcerative colitis in July 1978 and was initially treated with sulphasalazine. There was a favourable response, but in October 1978 he developed an itchy symmetrical erythematous and later scaling eruption associated with fever and generalised lymphadenopathy. This subsided after

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-