that the medical profession in Britain will urge the relevant authorities there to support this amendment. The wellbeing and probably the longevity of patients with coeliac disease is at stake.

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Toxocara infections and kennel workers

SIR,—It is now widely recognised that the embryonated ova of the common roundworm of the dog, *Toxocara canis*, are infective for man. Surveys have shown that approximately 2% of normal healthy adults in the UK possess demonstrable antibodies to toxocara antigen and in certain circumstances infection can produce clinical disease.^{1 2} Borg and Woodruff³ reported that 24.4% of 800 soil samples from public places all over Britain contained *Toxocara* spp eggs, but still heavier contamination may be found in special situations such as, for example, some breeding kennels and dog training schools.⁴

One such location was identified during a recent study of the helminth parasites of greyhounds.⁵ The establishment in question consists of a central complex of buildings, including administrative offices and residential quarters for dog handlers. These are surrounded by kennels and 56 hectares (140 acres) of exercising paddocks and walks. More than 500 adult greyhounds are kept for racing and 12.5% of these carry patent *T. canis* infection—that is, about 19m eggs are deposited on the estate each day. Examination of 10 g of soil taken from each of 12 sites on the estate revealed the presence of *T. canis* ova in 11, with up to 18 eggs per sample. In addition, grass collections from small exercising paddocks yielded up to 828 ova per kg of foliage, although only 0.7% of these were embryonated.

It was considered that this high degree of contamination might present a potential health hazard to the 70 employees working at the kennels, particularly as the majority also live on the estate. An attempt was therefore made to evaluate the degree of risk involved. Serum was collected from 34 volunteers and examined by a fluorescent antibody test using a *T. canis* larval antigen.⁶ It was found that none of the 24 people who had worked at the kennels for between 6 months and 10 years showed evidence of infection (see table), but two workers with 22 and 43 years' service respectively had positive antibody titres. A further two long-term employees were, however, negative.

Although no general conclusions can be drawn from this one small study the results suggest that, at least in this instance, infection with *T. canis* is not readily acquired by kennel

staff maintaining a reasonable standard of personal hygiene. The health hazard, although constantly present, would seem to be slight.

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¹ Woodruff, A W, *British Medical Journal*, 1970, 3, 663.

² Woodruff, A W, *Environmental Health*, 1976, 1, 29.

³ Borg, O A, and Woodruff, A W, *British Medical Journal*, 1973, 4, 470.

⁴ Jacobs, D E, Pegg, E J, and Stevenson, P, *Journal of Small Animal Practice*. In press.

⁵ Jacobs, D E, and Prole, J H B, *Veterinary Parasitology*. In press.

⁶ Bisserru, B, and Woodruff, A W, *Journal of Clinical Pathology*, 1968, 21, 449.

Local gold toxicity

SIR,—I am not wholly convinced that Dr J A N Rennie (27 November, p 1294) has in fact described one of "the more readily avoidable toxic reactions" to gold. Nor do I think that his advice to clinicians that they "should not forget to ask the basic question about local gold toxicity" is of any practical value.

Contact dermatitis due to gold has certainly been described, but it is so rare that individual case reports still make news.¹ This contrasts with the prevalence of nickel dermatitis. Nickel is said to be the commonest sensitising agent encountered by dermatologists in Britain² and is the cause of the vast majority of skin reactions associated with the wearing of gold jewellery. It would be most interesting to know the results of patch testing to nickel and gold in the patient described by Dr Rennie. One of the features of contact sensitivity to gold as previously described³ has been the persistence of the eruption for many weeks or even months after the elimination of all contact with gold. The speedy resolution of his patient's rash clearly differs from this experience.

It would be a great pity if patients who might benefit from gold were to be denied this opportunity on account of a history of sensitivity to jewellery without at least the confirmation of gold sensitivity by patch testing. I believe that the case against gold in his patient is unproved. It seems to me to be almost as likely that his patient had a recurrence of a nickel dermatitis due not to the gold in the syringe but to the nickel in the needle that delivered it.⁴

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¹ Young, E, *Dermatologica*, 1974, 149, 294.

² Calnan, C D, *British Journal of Dermatology*, 1956, 68, 229.

³ Comaish, S, *Archives of Dermatology*, 1969, 99, 720.

⁴ Stoddart, J C, *Lancet*, 1960, 2, 741.

Prevention of cross-infection

SIR,—How do we know that the methods we use to prevent cross-infection are effective? Statistics of comparative infection rates are seldom very convincing and anecdotes may be misleading. All the same, here is an anecdote.

A child who had been treated for acute leukaemia by a bone-marrow graft developed

a severe exfoliating skin condition. He occupied a positive-pressure-ventilated (PPV) cubicle, one of 10 in a protective isolation ward.^{1 2} His skin was infected with a staphylococcus, which regular bacteriological monitoring had shown was acquired when he was out of isolation at another hospital.

On 22 April 1976 the routine weekly settle plates were distributed round the unit. On that day there were three patients being nursed in protective isolation. A fourth, who would have been isolated according to her neutrophil count, had not proved psychologically suitable and was in an open cubicle, from which she walked into the corridor from time to time. The table shows the total colony count and PPV numbers of staphylococcal colonies on 3-h settle plates in the child's PPV cubicle, the three isolation cubicles, and the open cubicle. Air from all cubicles flows into the corridor, which is not monitored but which in these circumstances was probably contaminated fairly heavily.

Settle-plate colony counts

	<i>Staphylococcus aureus</i>	Total
Isolation cubicle A ..	0	11
" " B ..	0	26
" " C ..	4	18
Open cubicle ..	2	31
PPV cubicle ..	230	320

Samples of staphylococci from plates in all these areas were found to be of the same phage type (52/52A/80/81). Five days later, the patient who would have been isolated but was not, developed septicaemia. The identical staphylococcus was grown from her blood cultures.

One episode of this sort proves nothing, but the conclusion that protective isolation is valuable for susceptible patients is more likely to be right than wrong.

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¹ Jameson, B, *Proceedings of the R3 Association*, Gothenburg, 1975.

² Jameson, B, *et al*, *Lancet*, 1971, 1, 1034.

L-Tryptophan and sexual behaviour

SIR,—The recent report by Drs G P Egan and G E M Hammad (18 September, p 701) of an unusual side effect of sexual disinhibition in four male schizophrenic patients with depressive features and in one male patient suffering from manic depressive psychosis, all receiving a preparation of L-tryptophan together with their usual medication, is surprising as it runs contrary to all published evidence. In the series of depressed patients treated by us with L-tryptophan and reported earlier (21 February, p 460) we did not notice any such effect upon sexual responsiveness. Moreover one of us (ADB) has now treated over 500 patients with L-tryptophan and in no case has hypersexuality been apparent.

The somewhat unexpected response of the patients treated by Drs Egan and Hammad prompted us to review the relevant published literature. P-chlorophenylalanine (PCPA) interferes with the conversion of tryptophan to 5-hydroxytryptophan (5-HTP), and it is well documented

Results of fluorescent antibody test for infection with toxocara related to length of service of employees at greyhound kennels

Period of employment	Male*		Female†	
	No tested	No positive	No tested	No positive
<6 months ..	3	0	3	0
6 months-2½ years ..	10	0	7	0
2½-10 years ..	7	0	—	—
>10 years ..	4	2	—	—

*10 aged 16-19, 5 aged 20-30, and 9 over 30 years.

†7 aged 16-19 and 3 aged 20-30 years.