orthopaedic patients receiving antibiotics.^{1,2} The doubling of incidence of pseudomembranous colitis in Birmingham between 1976 and 1977 was probably due to increased diagnostic vigilance.³

The word "invariable" has no place in nosographic data processing and accordingly your statement that "diarrhoea is invariable" requires scrutiny. While it is true that the colon is predominantly involved, the ileum can also, to a varying degree, be the seat of the disease. When the colon is completely spared—as in a recent case confirmed by necropsy—diarrhoea can be absent. Clinically this case was dominated by abdominal pain, fever, and leucocytosis. A somewhat similar case was also reported recently.⁴ In such cases sigmoidoscopic and proctoscopic examinations—usually useful methods for establishing the diagnosis—cannot be relied upon.

Bearing in mind the topography of the pathological changes, I believe that diagnostic alertness might be enhanced by reverting to the original terminology—namely, pseudomembranous enterocolitis.

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¹ Smart, R F, *et al*, *British Journal of Surgery*, 1976, **63**, 25.

² Beavis, J B, *British Journal of Surgery*, 1976, **63**, 299.

³ Kappas, A, *et al*, *British Medical Journal*, 1976, **1**, 675.

⁴ Dane, T E B, and King, E G, *British Journal of Surgery*, 1976, **63**, 305.

Intravenous diazepam and Cyclimorph

SIR,—I have recently returned from Bridgend, where a brief visit enabled me to observe the use of intravenous diazepam and Cyclimorph (morphine and cyclizine tartrates) in the casualty department and operating theatre as referred to by Mr A W Fowler (22 October, p 1088). I was impressed with the convenience, simplicity, and effectiveness of the method and have no reason to doubt Mr Fowler's assurance of its safety in many hundreds of cases. I would also endorse his choice of the more extensive use of local analgesia (27 August, p 576), a procedure I have been practising many years myself.

Where does this leave the anaesthetist now, I wonder. Some are calling for nurse-anaesthetists (why not nurse-surgeons or clerk-administrators?) while others are taking matters into their own hands so that new areas of anaesthetic work are developing without the guidance of those most qualified to exploit fully the potential of new methods and drugs. For my own part I confess to being a little uneasy on this score, the result of having been rebuffed at times for being too unconventional (or, perhaps, just in advance of current thinking), but it is important for the future of the specialty, and in the long run for patients, that junior anaesthetists receive a complete training. If there are simple methods for dealing with casualties with full stomachs, let us use them more!

A S GARDINER

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Treatment of Q fever

SIR,—Dr J R Pinto (10 December, p 1542) is quite correct when he states that in our paper on chronic Q fever¹ we did not mention the use of co-trimoxazole, but we did refer to the survival of the one patient who had

received co-trimoxazole.² However, we felt that from the literature available compelling evidence of the effectiveness of antibiotics other than tetracycline and chloramphenicol was lacking. Even in the case reported by Freeman and Hodson tetracycline had not only antedated but had also been continued during the period of co-trimoxazole administration.

I agree that further assessment of co-trimoxazole in the treatment of Q fever is necessary. Following the preparation of our paper there appeared a further report of the use of this drug in Q fever endocarditis, on this occasion associated with glomerulonephritis possibly due to an immune-complex mechanism. Despite co-trimoxazole therapy the patient survived for only three months after diagnosis.³ Reports of success in the treatment of Q fever endocarditis just one year after withdrawal of antibiotic therapy, although promising, should be accepted with caution. Other patients have died 16 months⁴ and almost two years⁵ after prolonged courses of tetracycline.

In our experience lincomycin in combination with tetracycline seemed to be more effective in controlling the disease than tetracycline alone. The patient on whom this regimen was originally employed received these antibiotics alone for just over five years. Five years after stopping antibiotic therapy she is alive and in good health, the longest survivor so far reported.⁶

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¹ Turck, W P G, *et al*, *Quarterly Journal of Medicine*, 1976, **45**, 193.

² Freeman, R, and Hodson, M E, *British Medical Journal*, 1972, **1**, 419.

³ Dathan, J R E, and Heyworth, M F, *British Medical Journal*, 1975, **1**, 376.

⁴ Tunstall-Pedoe, H D, *British Heart Journal*, 1970, **32**, 568.

⁵ Meyers, D, *British Medical Journal*, 1968, **4**, 771.

⁶ Matthews, M B, personal communication.

A misleading name?

SIR,—I think it important to bring to your attention and that of your readership the appearance on the market of a compound entitled Napsalgesic.

It may appear to the general practitioner that this is a mixture of Naprosyn (naproxen) and Distalgescic. In fact it is nothing of the sort and contains dextrapropoxyphene 50 mg and aspirin 500 mg.

It is possible that there will be major confusion, because practitioners who are satisfied with Naprosyn may feel that this new compound is better than that drug, whereas in fact it is something entirely different. I think this should be pointed out.

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Prediction of gangrenous and perforating appendicitis in children

SIR,—Following Mr D F Graham's publication (26 November, p 1375) on the prediction of gangrenous and perforating appendicitis we have applied his "clinical scoring index" to 26 children recently treated at this hospital with proved acute appendicitis. As mortality is related to peritonitis at the time of operation¹ such a prediction might be of clinical value,

and Mr Graham does not exclude children nor does he state an age range for his prospective series of 257 patients. A definition of perforating appendicitis is not included in his paper, but our patients were divided into three groups: six patients aged 3-14 years in group I with a gangrenous or macroscopically perforated appendix, five patients aged 8-12 in group II with purulent peritoneal fluid but no macroscopic perforation, and 15 patients aged 6-14 in group III with acute appendicitis but either serous or negligible peritoneal fluid. The presence of each of the following features scored one point: lower abdominal pain at onset, history exceeding 24 h, pain increasing in severity, presence of guarding and rebound tenderness, temperature over 37.5°C, pulse rate greater than 90 beats/min, and a white cell count exceeding $14 \times 10^9/l$ ($14\,000/mm^3$), giving a maximum score of 7.

The scores in group I ranged from 3 to 7 and in group II from 3 to 6. In group III only 4 of the 15 patients had a score of 2 or less and as many as 11 scored 3 or more, which, Mr Graham claims, suggests perforation or gangrene; two of these scored 4 and two 5. In particular, three of his seven features were very poor discriminants—pain increasing in severity, pulse rate greater than 90/min, and a white cell count exceeding $14 \times 10^9/l$. Only one of the six children with a macroscopically perforated appendicitis complained of increasing pain. Of the 26 children 80% had a pulse rate of over 90/min and there was no significant difference between the three groups. The white cell count was over $14 \times 10^9/l$ in 60% of group III but only 54% of groups I and II.

We accept that 26 is a small sample, but our conclusion is that this "clinical scoring index" has been of no value in distinguishing a group of children with perforated or gangrenous appendicitis.

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¹ Pledger, H G, and Buchan, R, *British Medical Journal*, 1969, **4**, 466.

Bromocriptine in presenile dementia

SIR,—We note with interest the article by Dr Christopher Lewis and others concerning the beneficial effects of levodopa in senile dementia (4 March, p 550). Mesocortical dopaminergic neurones are known to exist, and derangement of these may occur in Alzheimer's disease. However, levodopa has been used with conflicting results^{1,2} and patients with Parkinsonism and dementia usually deteriorate because of drug-induced psychiatric side effects. Improvement in intellectual function following levodopa has been reported in a few other studies³ and the possibility that bromocriptine, a dopamine receptor agonist, might have an advantageous and selective effect on mesocortical and mesolimbic systems prompted the present study.

Nine patients with early presenile dementia presumed to have Alzheimer's disease (mean age 64, mean duration of disease 3 years) took part in a single-blind trial. Higher cortical function was assessed by bedside clinical tests and by the Gresham questionnaire (for orientation, memory for past, and personal

events), the Benton Visual Retention Test, Inglis PALT, Digit Symbol and Block Design Subtests, reaction times, Mill Hill Vocabulary Test, and Raven Progressive Matrices. Computerised axial tomography, serological tests for syphilis, thyroid function tests, serum vitamin B₁₂ and folate estimations, and liver and renal function tests were performed on all patients. Two patients were found to have low folate levels, but correction of this deficiency failed to improve their dementia.

Treatment was begun with bromocriptine 2.5 mg daily and increased by 2.5 mg increments at 4-day intervals to a maximum dose of 20 mg daily. Patients were assessed clinically at fortnightly intervals and after eight weeks of maximum tolerated doses of bromocriptine psychological testing was repeated. Placebo was then substituted for bromocriptine unknown to the patient and a further assessment made after two weeks.

Bromocriptine failed to improve cognitive disabilities. Side effects including confusion and nausea were common, only six patients attaining a dose of 20 mg. The relatives of three patients, however, reported improvement in the patients' ability to cope with their disease as a result of a mild sedative effect. It seems unlikely, therefore, that presently available dopaminergic agonists will benefit the intellectual and memory deficits of presenile dementia. The effects of a dopaminergic receptor agonist cannot be entirely equated with those of levodopa and, as Dr Lewis and his colleagues suggest, further studies with levodopa on more patients with presenile dementia for longer periods would seem justified.

We are grateful to Sandoz Products Ltd for supplies of bromocriptine.

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- ¹ Drachman, A D, and Stahl, S, *Lancet*, 1975, **1**, 809.
² Kristensen, V, Olsen, M, and Theilgaard, A, *Acta Psychiatrica Scandinavica*, 1977, **55**, 41.
³ Loranger, A W, et al, *Archives of General Psychiatry*, 1972, **26**, 163.

VD journals

SIR,—I note that in your leading article on genitourinary medicine (25 March, p 740) you refer to the *British Journal of Venereal Diseases* as the only specialist journal dealing exclusively with sexually transmitted diseases.

I think that the *Journal of the American Venereal Disease Association*, started in 1974, also deals exclusively with this subject.

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Exotic diets and the infant

SIR,—Some of the problems in exotic and cult diets could be reduced if doctors and nutritionists made more use of the experience of indigenous communities eating and breeding on well-balanced vegetarian and vegan diets. We already provide such services, in the form of nutritionally assessed recipes, cookery demonstrations, and information. Immigrants in alien circumstances and young parents

wrestling with spiritual challenges but unversed in nutrition might be helped more understandingly than under the stress of a professionally clinical and uncomprehending (and, maybe, even unsympathetic) environment. Such people can honour their beliefs and enjoy the benefits of vegetarianism. Unfortunately many of the victims of malnutrition are suffering from the corrupting influences of Western junk-foods, which, alas, are demotic.

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Looking inside arteries

SIR,—There are two points in your leading article (18 February, p 389) which require comment. You are right to take a cautious and critical view of endoscopy in vascular surgery.

The paper by Towne and Bernhard¹ describes the use of a Hopkins choledochoscope for inspecting the end result of various vascular operations. Nearly half of these were carotid endarterectomies. The additional time taken was 1-5 min in 53 cases and 5-10 min in 29 cases, not important perhaps in aortoiliac procedures but probably an unjustified extension of carotid occlusion time in carotid endarterectomy. The return for this was the finding of atheromatous shreds in the internal carotid artery in two patients, but most would consider that these can be adequately recognised and removed before arteriotomy closure. The 40% incidence of distal intimal flaps in the external carotid artery can hardly be considered important in practice. Vollmar, the originator of this technique, used it mainly for inspection of arteries after closed endarterectomy, particularly in the iliac and femoral regions. Endarterectomy of the femoropopliteal segment is now rarely performed by most vascular surgeons as the results of femoropopliteal vein bypass, erroneously called saphenofemoral bypass in your article, are much better and there is little indication from Towne and Bernhard's paper that endoscopy will help in the construction of the distal anastomosis, the principal problem in this operation. Likewise, closed aortoiliac endarterectomy is being performed less frequently because of the superior results of aortofemoral grafting and it is hard to see how endoscopy could help in this procedure. Perhaps this technique might be useful for inspection of thrombectomised aortofemoral graft limbs, when it is often difficult to remove adequately the adherent neointima that forms in all prosthetic grafts. However, I suspect the authors have their doubts about the technique—expressed in the paper's subtitle: "Useful tool or interesting toy."

The second point in the article concerns available methods for determining technical faults in vascular reconstructions. In this respect, as you state, the flowmeter has little to offer as there are many other factors which govern the flow in femoropopliteal vein grafts. However, it may have a predictive value. Also flowmeters give unreliable results when used on prosthetic materials, particularly the new expanded polytetrafluoroethylene (PTFE), where the flowmeter is virtually useless.

Arteriography is certainly useful, though it adds to the length of the procedure and fails

to show many intimal flaps because it visualises one plane only. Also it is questionable whether correction of all abnormalities seen actually improves graft patency, as re-exploration produces its own problems. One method not mentioned in your article is the pulse volume recorder (PVR). This is simply a segmental plethysmographic method similar to oscillography. It is a simple, non-invasive method which requires a cuff placed on the limb distal to the reconstruction; monitoring can be continued in the recovery room postoperatively. A comparison of the preoperative and postreconstruction PVR tracing gives a good indication of the functional result achieved. It is particularly valuable when there is disease distal to the reconstruction where peripheral pulses are unlikely to be felt. Experience at this hospital suggests that the best compromise is to use the PVR in all reconstructions and to reserve angiography for technically difficult reconstructions, such as femorotibial bypass grafts, or when the PVR shows a poor response.

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- ¹ Towne, J B, and Bernhard, V M, *Surgery*, 1977, **82**, 415.

Treatment of tuberculosis

SIR,—Physicians trained or practising tuberculosis care in other parts of the world may be surprised by some of the emphasis in Dr A Seaton's summary of the current United Kingdom attitude towards this disease (18 March, p 701).

(1) Not least by the assertion that extensive controlled trials enable the practitioner to be dogmatic about treatment.

(2) By the assumption that the effects of *Mycobacterium tuberculosis* and the syndrome of the mycobacterial diseases we call "tuberculosis", including infections with *M bovis* and the so-called "atypical" mycobacteria, are the same thing. As a corollary, the mycoses are among other organisms giving rise to a similar disease.

(3) By the statement that the subdisease actually reviewed should be necessarily treated by a specialist chest physician. The principal contributions to the modern successful cure of the tuberculosis syndrome come not from the supervisory physician but from the laboratory which cultures the sputum and determines the drug sensitivity of the causative organism and from the community workers who ensure that the patient remains under adequate and appropriate therapy and free of side effects.

(4) By the unqualified advice that contacts should be "visited," especially as the final paragraph on the same subject is somewhat confused. For determining tuberculin sensitivity most non-British physicians accept the WHO advice that the intradermal Mantoux test with its quantifiable dose is the procedure of choice.^{1,2}

(5) Isoniazid side effects, especially in slow acetylators, are not rare, as the investigation of liver function at the onset of therapy will confirm.³ Death from isoniazid in the United States has occurred in young adults and is most likely with previous liver damage or in chronic alcoholism.⁴ For all the antituberculous drugs it is most important to warn the patient or family of the possible side effects and to provide immediate review should any occur.

(6) The use of costly rifampicin as a first-line drug, though now widespread, may in the long term prove unwise. It dramatically clears the sputum and it was a useful reserve drug for resistant organisms. Trials do not as yet prove that it has a therapeutically unique ability to shorten treatment. There are many contraindications to its use, including pregnancy.⁵