observers have noted, that night visiting rates are higher in the north of England and in Scotland.²⁻⁴

Finally, while congratulating Mr Buxton and his colleagues on their excellent paper, I consider their last paragraph to be mistaken. Each doctor must decide, and then take responsibility for, any action following a request for a night call. This will depend on his knowledge of the patient and the circumstances, and not on any 'consensus' of explicit criteria.

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- ¹ Pritchard, J N A, *British Medical Journal*, 1966, **1**, 614.
² Brotherson, J H F, et al, *British Medical Journal*, 1959, **2**, 1169.
³ Webster, G L, et al, *British Medical Journal*, 1965, **1**, 1369.
⁴ Pritchard, J N A, *Journal of the Royal College of General Practitioners*, 1976, **26**, 166 and 357.

Mucocutaneous lymph node syndrome

SIR,—I was interested in the recent reports of cases of mucocutaneous lymph node syndrome (Kawasaki disease) occurring in England (19 February, p 511; 2 April, p 883). This is probably not a new disease to Britain or anywhere else. In 1960 Forbes and Bradley described in your columns¹ a 9-year-old boy with an aneurysm of his left coronary artery. Thyne did not know the aetiology then but their case was almost identical with one seen in Canada in 1976.² Subsequent to the Japanese descriptions these cases appeared to have been rare fatal examples of Kawasaki disease.

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- ¹ Forbes, G, and Bradley, A, *British Medical Journal*, 1960, **2**, 1344.
² Wentworth, P, and Silver, M D, *Canadian Medical Association Journal*, 1976, **115**, 299.

Phenelzine and oedema

SIR,—Drs A Goonewardene and P J Toghill (2 April, p 879) describe a case of gross oedema during treatment for depression with a monoamine oxidase inhibitor (phenelzine) and a benzodiazepine (diazepam). They question whether phenelzine alone could have been responsible for this side effect.

In a series of phobic patients undergoing treatment with phenelzine ankle oedema was found to be common in adults,¹ and in a controlled drug trial with depressed patients two out of 20 developed oedema.² In a personal series³ of 22 patients with endogenous depression receiving phenelzine in varying daily dosage of 60, 75, and 90 mg severe ankle oedema was noted in four. These four subjects were all women, over 50 years of age, and receiving 90 mg of phenelzine daily. No electrolyte or other blood abnormalities were noted and the oedema did not respond to concurrent use of diuretics, subsiding only when the drug was withdrawn or its dosage reduced.

Some of the weight gain in the case reported may have been due to other factors. It has long been known that monoamine oxidase inhibitors can induce hypoglycaemia,³ and Kelly et al in their series¹ reported excessive weight gain due to a craving for carbohydrates in a number of patients.

The available evidence, therefore, would suggest that phenelzine is indeed capable of

producing severe oedema in elderly patients who are on a high dosage schedule, as was the case with the patient reported.

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- ¹ Kelly, D, et al, *British Journal of Psychiatry*, 1970, **116**, 387.
² Rees, L, and Davies, B, *Journal of Mental Science*, 1961, **107**, 560.
³ Dunleavy, D L F, MD thesis, National University of Ireland.
⁴ Cooper, A J, and Ashcroft, G, *Diabetes*, 1967, **16**, 272.

Reduced DNA synthesis in non-responsive coeliac disease

SIR,—I have read the paper by Drs P E Jones and T J Peters on DNA synthesis by the jejunal mucosa in responsive and non-responsive coeliac disease (30 April, p 1130) with great interest and would like to suggest a reason for the low DNA synthesis found in non-responsive patients. We have reported¹ six patients with non-responsive coeliac disease with very low serum zinc values ($5.7 \pm 1.2 \mu\text{mol/l}$ ($37.0 \pm 7.5 \mu\text{g/100 ml}$)). These patients showed a marked response to zinc therapy. As zinc is necessary for the incorporation of ³H-thymidine into DNA,² I would like to know the zinc status of Drs Jones and Peters's non-responsive patients.

If non-response to gluten withdrawal, low DNA synthesis, and low plasma zinc are all part of the same syndrome the estimation of plasma or serum zinc should be a quicker and cheaper method of detecting non-responders than mucosal culture and ³H-thymidine incorporation studies, valuable though these are in understanding the mechanism of coeliac disease.

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- ¹ Elmes, M, Golden, M K, and Love, A H G, *Quarterly Journal of Medicine*, 1976, **180**, 696.
² Williams, R B, and Chesters, J K, in *Trace Element Metabolism in Animals*, ed C F Mills, p 164. Edinburgh, Livingstone, 1970.

A case of dysphagia

SIR,—“Clinics in General Practice” is a series which should provide insights into how general practitioners and specialists can best interact with a particular clinical problem. Comment should be informed, instructive, and to the point. “A case of dysphagia” (30 April, p 1139) failed to show this interaction to have been in the best long-term interests of the patient.

Dr A G Donald presented the trainee's problem patient, who at 30 was unmarried and during three months with the practice consulted excessively and received two specialist referrals. She had a past history involving three specialties with largely insignificant findings. She presented her new doctor with a new symptom, dysphagia, and demanded an ENT opinion. The trainee made an initial diagnosis of a functional illness and the trainer suggested that physical causes should be excluded. But that is not enough. For a diagnosis of hysterical psychoneurosis there must be positive signs of hysterical illness and, preferably, understandable gain.¹

Mr J D K Dawes, misjudging his forum,

gave a political account of the NHS and private practice covering 10 column inches, leaving only a few inches to make such comments as, “If . . . the patient demands it referral is essential.” He agreed that “this patient is obviously under emotional stress” and that if no abnormality is found “the dysphagia for solid foods may be . . . hysterical.”

In the postscript sense at first prevails. The patient saw an ENT specialist twice who listened to her, and her symptoms evaporated without resort to any potentially dangerous procedures. But the trainee, having had his hypothesis “validated against an ENT opinion,” did not take the logical step of psychiatric referral. Referral to a psychiatric department in a general hospital would permit liaison with other specialties when, as would almost certainly happen, she produced further symptoms. She was referred to two further specialists before she finally left. Running away is one way of coping. With psychiatric help she might have discovered more adaptive ways of coping. Hysterical patients are classically demanding and will continue to demand physical explanations to psychological problems, running the risk of further referrals and consequently more and potentially dangerous investigative procedures.

It seems important to consider how differently this patient might have been treated if this series is to be of educational value.

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- ¹ Reed, J L, *British Journal of Hospital Medicine*, 1971, **5**, 237.

Alcoholic liver disease in women

SIR,—Dr A N Hamlyn, in discussing why women could be more susceptible than men to the development of alcoholic cirrhosis (23 April, p 1085), suggests that female alcoholics could be more likely to underestimate the amount of alcohol consumed. Other factors besides average daily alcohol consumption may be important. For example, for a given weekly alcohol intake women tend to drink on more occasions than men.¹ Thus the total time that blood ethanol levels are elevated above some “threshold” value rather than peak levels might determine the development of severe liver disease in alcoholic patients, and clearly this possibility should be considered in future surveys.

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- ¹ Dight, S E, *Scottish Drinking Habits*. London, HMSO, 1976.

Gluten-free diet in dermatitis herpetiformis

SIR,—I enjoyed the paper by Drs Christine I Harrington and N W Read (2 April, p 872) on the immunological consequences of gluten withdrawal in dermatitis herpetiformis (DH). It appears that in three of the 10 patients studied there was disappearance of IgA-containing cells from the lamina propria of the jejunal mucosa following gluten withdrawal. This is a surprising finding which is at variance with our early observations¹ and those of Lancaster Smith et al² that jejunal