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

IgA levels remain high in DH patients regardless of diet. We have also found that IgA synthesis in organ cultures of jejunal mucosa in DH patients may be reduced but is not absent (unpublished observations). It is perhaps unfortunate that the published photomicrograph of jejunal mucosa following gluten withdrawal shows very little of the lamina propria, making it difficult to compare the number of IgA-containing cells with the "pretreatment" section.

The findings imply that the three patients have selective mucosal IgA deficiency without deficiency of the circulating IgA and that this defect is only revealed following withdrawal of gluten from the diet. While it is well recognised that the numbers of the IgA-containing cells in the mucosa may be influenced by antigenic stimulation, I am not aware of any previous reports that mucosal IgA cells disappear following withdrawal of one only of the multitude of antigens which assail the intestinal surface.

In view of the troublesome problems of non-specific staining and autofluorescence of non-lymphoid cells, especially eosinophils, in studies of intestinal mucosa I feel that the present observations, although intriguing, should be interpreted with some caution.

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¹ McClelland, D B L, *et al*, *Lancet*, 1972, **2**, 1108.
² Lancaster-Smith, M, *et al*, *Gut*, 1974, **15**, 371.

Amniotic fluid AFP in multiple pregnancy

SIR,—We share the concern of Dr A T Letchworth and his colleagues (12 March, p 689) on the interpretation of amniotic fluid alpha-fetoprotein (AFP) levels in multiple pregnancy. The possible confusion arising from maternal serum AFP screening when the levels are known to be raised will be clarified sooner if values of amniotic fluid AFP in twin pregnancy can be established. When multiple pregnancy is diagnosed before planned amniocentesis it is unusual to proceed unless the risk is exceptionally high. Hence information about values in uncomplicated pregnancy is hard to obtain.

In about 2000 amniotic fluid samples derived from mid-trimester diagnostic amniocenteses over the past three years we have encountered samples for nine multiple pregnancies. With the exception of two cases all

AFP values were within normal limits as defined for singleton pregnancies (see table). In case 3 and case 8, the sac of the unaffected fetus showed an AFP level which exceeded the mean +2 log SD limit, but did not reach the +4 log SD discriminant value. This modest elevation of AFP can be presumed to have arisen by diffusion from the anencephalic twin.

It is likely that in the patient reported by Dr Letchworth and his colleagues there was actual or impending fetal death before the amniocentesis and, as in our patients with an anencephalic fetus, high levels were obtained in the other sac. There seems no evidence as yet that twins per se cause higher liquor levels of AFP, but further information on this point is required.

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Lumbar disc surgery

SIR,—I was interested to read Mr Arthur Naylor's paper on the surgical treatment of lumbar disc protrusion (26 February, p 567) and Mr Roger Austin's subsequent letter (19 March, p 778) concerning postlaminectomy backache.

In patients whose dominant symptom is backache a less widely practised surgical procedure for degenerate lumbar disc lesions is that of anterior excision of the disc and interbody fusion, and this may be done via a transperitoneal¹ or a retroperitoneal approach,² the latter being technically less difficult.

Excellent symptomatic relief is reported by these authors, but there is as yet no certain evidence that the anterior approach is superior to the posterior approach with fusion in the long term. Anterior disc excision and fusion may be a useful salvage procedure in some patients with persistent backache following previous posterior surgery.

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¹ Freebody, D, and Bendal, R D, *Journal of Bone and Joint Surgery*, 1971, **53B**, 617.
² Hodgson, A R, and Wong, S K, *Clinical Orthopaedics and Related Research*, 1968, **133**, 56.

Amoxycillin rash

SIR,—We have seen a typical "ampicillin rash" in a patient with a glandular fever-like illness for which he was prescribed amoxycillin.

A 48-year-old man while travelling abroad developed a sore throat, fever, and malaise, and was given amoxycillin. The day afterwards, on arriving in England, he developed a universal erythema. Examined a week later his throat was very red, he had minimal lymphadenopathy and splenomegaly, and his face was grotesque with swelling from the non-scaly, diffuse erythema. This was an obvious cutaneous vasculitis in the erythema multiforme pattern, purpuric in places, on the ankles and in the groins and subgluteal folds. There was a past history of some sort of eczema and his father also had dermatitis and asthma. The eruption faded over the next 10 days, scaling profusely.

Our conclusion is that just as ampicillin plus infectious mononucleosis syndrome equals a rash in nearly every case, the same equation may apply to amoxycillin.

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Induction of labour and perinatal mortality

SIR,—Dr P W Howie and his colleagues (9 April, p 974) accuse us of missing the central point of their article (5 February, p 347)—namely, "that the value of induction of labour cannot be assessed adequately from total perinatal mortality." The text of the original article and its summary both suggested that "increased use of induction of labour has contributed to the improved perinatal mortality rate" and this aspect seemed to us to be the one to discuss first, since our reading of their figures suggested that there was no improvement in perinatal mortality rates. If anything, an earlier falling trend had been interrupted during the years with high induction rates.

Concerning "causes," and assuming that steps were taken to avoid possible bias in classification, their figures certainly show an immediate and sustained fall in the death rate in the category "mature, cause unknown" from the year the induction rate went above 30%. This rate was 2.4 per 1000 in 1969 and 0.5 per 1000 in 1975. However, deaths categorised as "premature, cause unknown" were higher than in 1969 in four of the six subsequent years and those categorised as

Amniotic fluid AFP in multiple pregnancy

Case	Indication for amniocentesis	Gestation (weeks)	AFP concentration (mg/l)			Normal singleton AFP concentration (mg/l)		Karyotype	Outcome
			Sac 1	Sac 2	Sac 3	Median	+2 log SD		
1	Maternal age 40 years	17	32	—	—	15	33	46 XY	Normal binovular twins, 1 male, 1 female
2	Balanced translocation in one parent. Known multiple pregnancy	17	16	23	—	15	33	(1) Balanced translocation (2) Unbalanced translocation	Triplet pregnancy terminated
3	Hydramnios	24	81	27	—	7	14		(1) Anencephalic female (2) Normal male
4	Anencephalic twin suspected ultrasound								
5	Previous neural tube defect (NTD)	16	24	—	—	18	35		(1) Normal male (2) Papyraceous fetus
6	Family history of NTD	15	16	—	—	19	37		Normal binovular twins
7	Hydramnios	24	7	—	—	7	14		Normal binovular twins
8	Hydramnios	26	5	—	—	6	10		Normal binovular twins
9	Previous NTD	15	42	—	—	19	37		(1) Normal male (2) Anencephalic male
	Previous NTD	14	39	—	—	22	42		Normal binovular twins