The maximum risk of congenital malformations has decreased as the reported number of cases of rubella vaccination complicating a pregnancy has increased.² This division continues to collect such data and encourages the reporting of all such cases so that we may more exactly characterise the risks involved.

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¹ *Morbidity and Mortality Weekly Reports*, 1977, 26, 385.

² Modlin, J F, *et al*, *New England Journal of Medicine*, 1976, 294, 972.

³ Vaheri, A, *et al*, *New England Journal of Medicine*, 1976, 296, 1071.

⁴ McIntosh, R, *et al*, *Pediatrics*, 1954, 14, 505.

Iodine and acetone-containing plastic spray dressings

SIR,—I read with interest the letter from Dr J Morgan-Hughes and Mr R A Bray (26 August, p 639) on the hazard of using Op-Site in conjunction with tincture of iodine and Slek waterproof plaster and would like to suggest a simple solution.

The back of the patient is prepared with a solution of 0.5% chlorhexidine in 70% spirit, which is allowed to dry before tincture of iodine is applied to a small area immediately over the proposed puncture site. The epidural cannula is then inserted in the normal manner and the puncture site sprayed with Op-Site. A folded gauze swab is inserted under the catheter and the whole area which has been painted with tincture of iodine covered by another 7.5 × 7.5 cm (3" × 3") gauze swab. Slek plaster may then be applied.

This technique has two advantages: (1) If there is an unknown allergy to iodine only a very small area of skin is affected rather than the whole area of back prepared. (2) The swabs prevent contact between the skin prepared with tincture of iodine and the Op-Site and Slek plaster, thus preventing all three substances coming into contact together, which apparently is the most precipitating cause of the blistering. Using this technique, I have never seen blistering of the skin occur in patients undergoing epidural analgesia, even when the catheter has been in situ for up to five days.

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Neonatal chlamydia conjunctivitis

SIR,—Dr Pamela Davies (2 September, p 676), in her review of neonatal infections, does not mention recent evidence that neonatal chlamydial conjunctivitis is very often not eradicated by topical chlortetracycline alone, perhaps because the organism is usually also present in the nasopharynx.^{1,2} Chlamydial infection acquired at birth may also cause significant respiratory symptoms in infants more commonly than previously realised^{3,4} and it therefore seems reasonable to give systemic treatment in the form of oral erythromycin for two weeks in addition to chlortetracycline eye ointment.

Sulphacetamide eye drops may not be the best routine treatment for "sticky eyes" which are not thought to be chlamydial or gonococcal. In the early stages of chlamydia

conjunctivitis the infection may not appear different from the ordinary "sticky eye" due to other organisms. The use of sulphacetamide or chloramphenicol eye drops may produce apparent resolution of the infection, which will recur later on stopping antibiotics and may persist for weeks or months unless proper treatment is given. It is therefore important to make a positive diagnosis of chlamydial infection before giving antibiotics which may be only suppressive rather than curative. Neomycin does not suppress chlamydia and we therefore suggest that this is the logical initial antibacterial treatment of "sticky eyes" in neonates. If the conjunctivitis persists despite neomycin ointment chlamydial infection is a strong possibility and swabs should be taken for chlamydial culture.

Finally, when a diagnosis of neonatal chlamydial conjunctivitis is made the parents should also be investigated, and treated if they are harbouring the organism.

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¹ Beem, M O, and Saxon, E M, *New England Journal of Medicine*, 1977, 296, 306.

² Schachter, J, *New England Journal of Medicine*, 1978, 298, 540.

³ Harrison, H R, *et al*, *New England Journal of Medicine*, 1978, 298, 702.

⁴ Hammerschlag, M R, *New England Journal of Medicine*, 1978, 298, 1083.

Penicillamine and previous treatment with gold

SIR,—Drs M Webley and E N Coomes (8 July, p 91) recently raised an important point for clinicians treating patients with rheumatoid arthritis (RA) when they presented data which suggested that adverse reactions to penicillamine are more common in patients who have previously been treated with gold than in those who have not. This prompted a review of 117 patients with classical or definite RA treated with penicillamine, the minimum follow-up being two years. There was no significant difference in the incidence of penicillamine adverse effects between those who had previously received gold (25/59) and those who had not (21/58). However, a different picture emerged when the patients treated with gold were subdivided into those in whom gold had been stopped because it was ineffective and those in whom it had been abandoned because of mouth ulcers, dermatitis, or proteinuria. Adverse effects due to penicillamine (thrombocytopenia, pemphigus, or proteinuria) developed in 10 of the 36 patients who had had no toxic reaction to gold and in 15 of the 23 patients who had had such a reaction. This difference is significant (0.02 > P > 0.01). In this analysis other adverse effects attributed to penicillamine—notably dyspepsia, abnormalities of taste, "feeling awful," and rashes occurring in the early weeks of treatment—were discounted as they are not of serious import, lack specificity, and can often be overcome by manipulations of dose.

This analysis clearly shows that patients who have to stop gold treatment because of an adverse effect are significantly more prone to develop a major adverse reaction to penicillamine. The implication of this is that penicillamine should be used with great caution, if at all, in patients known to have reacted adversely

to earlier treatment with gold. Furthermore, since a clinician contemplating the use of penicillamine may be unaware of a gold reaction because records are incomplete or unavailable or the patient's memory unreliable, it would be prudent to follow the counsel of Webley and Coomes, who wrote, "It would be sensible to take extra care in the supervision of patients starting on penicillamine if they have had gold treatment."

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Maprotiline hydrochloride and grand-mal seizures

SIR,—The case reports of Drs G A A Shepherd and F Kerr (10 June, p 1523) document once more the occurrence of grand-mal seizures during treatment with maprotiline hydrochloride (Ludimil). Recently a similar case has been seen at this hospital.

A 20-year-old nurse had been started on maprotiline 75 mg at night by her general practitioner because of depression and poor sleep pattern. Two weeks later the dosage was increased to 300 mg at night. She developed a tremor of her hands and unsteadiness on her feet and seven days after starting the higher dosage sustained two grand-mal seizures. There was no past or family history of epilepsy and her only other medication was the contraceptive pill (Ovranette). Physical examination was normal and an electroencephalogram nearly four months later showed only a mild theta dysrhythmia with no paroxysmal features.

Grand-mal seizures after overdosage of maprotiline have been well documented.^{1,2} The increasing number of reports of convulsions occurring during treatment with recommended doses is disturbing. The incidence of this side effect among patients taking maprotiline is not yet known and is an important deficiency in our knowledge of this drug.

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¹ Meek, D, *et al*, *British Medical Journal*, 1975, 2, 275.

² Park, J, and Proudfoot, A T, *British Medical Journal*, 1977, 1, 1573.

HLA B27 and risk of ankylosing spondylitis

SIR,—Your excellent editorial on this subject (2 September, p 650) contains a sentence which might be unfortunate for many with ankylosing spondylitis if it were interpreted uncritically—namely, "Boys known to be B27-positive might select physically undemanding jobs that they would be able to keep if they developed ankylosing spondylitis."

Most physically undemanding jobs are sedentary jobs and involve sitting at a desk or in a car and are probably the worst sort of job that a patient with ankylosing spondylitis might get, particularly if he has to work overtime. Spondylitis as a group are stout-hearted individuals who successfully manage physically demanding work and appreciate the ability to move around and exercise their backs to avoid stiffening and the loss of the upright posture to which they are liable. The proper approach surely is to let B27-positive

boys (and girls) choose the jobs they want to do (they will anyway) and then use medical techniques to help them keep at it, remembering that at most only one in five will get ankylosing spondylitis and, of those who do get it, probably not more than one in 10 will be so severely affected that a physically demanding job becomes impossible. In most cases this will be because of hip involvement, and orthopaedic surgery can offer considerable help here.

Indeed, spondylitic patients often suffer more from their doctors advising them to take up sedentary "undemanding jobs." We recently had the experience of treating a young woman with ankylosing spondylitis and showing that she was able to do her chosen job of nursing the elderly, only to find that she was refused the job on health grounds by the medical adviser elsewhere. A farmer's son, keen to take over his family farm, was advised by his family doctor on no account to do this, when assessment in hospital under careful conditions showed that he was perfectly able to cope with the physical activities (and they are not so many as they used to be) that a modern farm might require. It is surely no part of the doctor's job to keep people away from work which they want to do and of which they are capable.

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Atopic dermatitis and the forefoot

SIR,—There has been renewed interest in various countries recently in a characteristic dermatosis of infancy and childhood localised to the distal soles, including the toes and particularly the big toe but sparing the toe spaces. I have certainly seen children with the condition since the 'sixties, but it has become much more common over the past few years. Since 1973 I have personally seen 46 children (24 boys, 22 girls) with the condition, all between the ages of 2 and 14 years when seen, and 20 of these had a personal or family history of atopy.

Atopic dermatitis may involve the feet as part of a widespread involvement, but it may also occur in a localised form and one site of localisation is the toes and feet.¹⁻³ However, is this dermatosis localised to the forefoot really atopic dermatitis? It seems most likely that juvenile plantar dermatosis⁴⁻⁷ and its synonyms peridigital dermatitis,⁸ atopic winter feet,⁹ shoe dermatosis in children,¹⁰ and atopic eczema localised to the forefoot^{2,3} describe not only true localised atopic dermatitis but also a frictional irritant contact dermatitis to which atopics are prone¹¹ but which may also occur in susceptible non-atopics.^{4,7,10} The diagnosis of the condition should provoke questions relating to a personal or family history of atopy. Why does the condition seemingly occur only in infancy and childhood? Presumably it is in infancy and childhood that the forefoot skin is most susceptible to irritant dermatitis, but why not young adults also? If shoes and socks made of synthetic materials and oversweating within them are relevant as causes of irritant dermatitis, as most reports suggest, how can the dermatosis be explained when it presents in babies who do not wear occlusive footwear and in persons who wear pure leather (less occlusive) footwear, open-toed footwear, and

cotton socks? Perhaps both babies and these individuals have true localised atopic dermatitis.

More studies are clearly needed to sort out this increasingly common and interesting skin condition.

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- ¹ Sulzberger, M B, Wolf, J, and Witten, V H, *Dermatology, Diagnosis and Treatment*, 2nd edn, p 198. Chicago, Year Book Publishing Co.
- ² Verbov, J, *Practitioner*, 1976, **217**, 403.
- ³ Verbov, J, *Practitioner*, 1978, **220**, 465.
- ⁴ Mackie, R M, and Husain, S L, *Clinical and Experimental Dermatology*, 1976, **1**, 253.
- ⁵ Millard, L G, and Gould, D J, *Clinical and Experimental Dermatology*, 1977, **2**, 186.
- ⁶ van Dijk, E, et al, *Nederlandsch Tijdschrift voor Geneeskunde*, 1978, **122**, 223.
- ⁷ Hambly, E M, and Wilkinson, D S, *Annales de Dermatologie et de syphiligraphie*, 1978, **105**, 369.
- ⁸ Enta, T, *Cutis*, 1972, **10**, 325.
- ⁹ Möller, H, *Acta Dermatovenereologica*, 1972, **52**, 401.
- ¹⁰ Shrank, A B, *British Journal of Dermatology*, 1978, **99**, suppl 16, p 22.
- ¹¹ Silvers, S H, and Glickman, F A, *American Journal of Diseases of Children*, 1968, **116**, 400.

Immunisation of adults against diphtheria

SIR,—The report by Dr F W Sheffield and others (22 July, p 249) suggests that there is still uncertainty about the best procedure for immunising adults against diphtheria.

The occupational health service here has been using diphtheria vaccine adsorbed BP for about 10 years, for both microbiology staff and nurses in training. If there is no history of immunisation in childhood, then a full course of two doses of 0.2 ml is given. If previously immunised then one dose of 0.5 ml is given. We have not carried out Schick testing and, according to our records, we have had no serious reactions.

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Early arrhythmias and prognosis in myocardial infarction

SIR,—Ventricular extrasystoles in the early hospital phase following myocardial infarction were previously classified in a manner believed to be of prognostic value in terms of subsequent serious arrhythmias.¹ Subsequent work has thrown doubt on this concept, for "warning arrhythmias" occur equally in those who do and those who do not develop ventricular fibrillation.²

Cardiac rhythm is not usually monitored before hospital admission, although this has been done in some studies.³ Little information is available on the significance of arrhythmias during this period. In the Brighton system of resuscitation ambulances trained attendants monitor patients en route to hospital. The information is stored on magnetic tape for subsequent analysis. During the period May 1977 to January 1978 we studied all available tapes (77) on patients admitted by resuscitation ambulance with a firm diagnosis of myocardial infarction and related arrhythmias on the tapes to subsequent hospital prognosis.

The overall mortality was 29%. This reflects the high risk in a group of which more than half were carried in response to 999 calls. The patients with disturbances of heart rhythm on the ambulance tape (48) had a four-fold higher mortality than those without (29). The mortalities of the groups were 40% and 10%

respectively. Rhythm disorders included apparently minor abnormalities such as sinus bradycardia, sinus tachycardia, and ventricular and supraventricular extrasystoles as well as the more sinister arrhythmias, including ventricular tachycardia and higher degrees of heart block. The patients with ambulance arrhythmias also had a higher incidence of significant arrhythmias in hospital (81% v 50%).

These findings suggest one method of identifying a "low-risk" group of coronary patients at a very early stage—those who show normal heart rhythm while being moved to hospital soon after the onset of major symptoms. We are now carrying out a more detailed analysis of the relationship of ambulance arrhythmias to subsequent hospital prognosis.

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- ¹ Lown, B, et al, *American Journal of Cardiology*, 1967, **20**, 494.
- ² Lie, K I, et al, *Circulation*, 1975, **52**, 755.
- ³ Pantridge, J F, and Geddes, J S, *Lancet*, 1967, **75**, 10.

Regulating blood glucose concentration in diabetes during labour

SIR,—Dr M Nattrass and his colleagues (26 August, p 599) describe a glucose-controlled infusion system for maintaining stable blood glucose concentration during labour in diabetic women.

Although it may be more physiological for insulin dosage to be regulated on the basis of blood glucose values, equally satisfactory results can be obtained using a standard insulin infusion pump. Insulin dosage can be dictated by hourly blood glucose estimations and in our experience it has been simple to maintain stable blood glucose levels below 6 mmol/l (108 mg/100 ml) without hypoglycaemia at an average infusion rate of 1.2 units of insulin an hour. This does not present the technical complexities or involve the expense of an "artificial pancreas."

Close attention to detail is vital at all stages of pregnancy and labour in the diabetic, but it need not be complicated.

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Medical care in inner cities

SIR,—As one of those elderly general practitioners who should be retiring in the next 10 years, if not sooner, I feel that I ought to comment on Dr J Robson's letter (9 September, p 766) in which he proposes "structure planning" and organisation for primary care in the inner city areas. I quite agree that rational planning of primary care facilities and future staffing, nurses, health visitors, and social service personnel, together with the skills of the full-time clinical medical officers, are very desirable and very necessary. I also agree that the problems presented by inner cities are the most demanding and complex.

But why does Dr Robson not mention even once the word "patient"? Is it not desirable