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