Whether Drs Brooks and Harrington's patient developed malignancy after the diagnosis of coeliac disease was made and some clinical improvement was obtained after gluten withdrawal or whether it was present initially, precipitating overt manifestations of gluten intolerance, it is not possible to say.

It is certainly believed that failure of a patient with newly diagnosed coeliac disease to respond to gluten withdrawal or relapse occurring after previous control by diet is suggestive of the development of malignancy.⁶ The view that intestinal malignancy may cause flattening of the jejunal mucosa and present as "the coeliac syndrome" is no longer held.⁷

I M EVANS

Gastroenterology Unit,
Broad Green Hospital,
Liverpool

- ¹ Harris, O D, Cooke, W T, and Thompson, H. *American Journal of Medicine*, 1967, **42**, 899.
- ² Holmes, G K T, et al. *Gut*, 1974, **15**, 339P.
- ³ Holmes, G K T, et al. *Gut*, 1976, **17**, 612.
- ⁴ Creamer, B, and Hellier, M D, in *The Small Intestine*, ed B Creamer, London: Heinemann, 1974.
- ⁵ Creamer, B, in *The Small Intestine*, ed B Creamer, London: Heinemann, 1974.
- ⁶ Stokes, P L, and Holmes, G K T, in *Clinics in Gastroenterology*, vol 3, No 1, ed W T Cooke and P Asquith, Philadelphia, Saunders, 1974.
- ⁷ Austad, W I, et al. *American Journal of Digestive Diseases*, 1967, **12**, 475.

Effects of ethanol-induced hypoglycaemia

SIR,—We were most interested in the paper by Dr B I Joffe and others (10 September, p 678) which emphasises that plasma insulin levels are not completely suppressed in ethanol-induced hypoglycaemia (EIH). We have reported a similar finding in a 7-year-old boy with EIH.¹ Furthermore, other additional glucoregulatory mechanisms should be considered. In our report we described a delayed pituitary-adrenal activity in the pathophysiology of EIH. If this is confirmed in further studies it could be of interest in the treatment of patients with EIH. We suggest that plasma growth hormone and cortisol levels should be included in studies on the mechanism of EIH.

C MIQUEL
J RUBIÉS-PRAT

Department of Internal Medicine,
Ciudad Sanitaria Seguridad Social
Universidad Autónoma,
Barcelona

- ¹ Rubiés-Prat, J, et al. *Annales d'Endocrinologie*, 1975, **36**, 223.

1- α -Hydroxycholecalciferol for renal osteodystrophy

SIR,—Dr A M Brownjohn and his colleagues have provided a great deal of useful information in their paper (17 September, p 721), which also confirms our two-year experience of 1- α -hydroxycholecalciferol for renal osteodystrophy.

We have used 1- α -hydroxycholecalciferol in doses ranging from 1 μ g to 2 μ g daily in 16 patients on regular dialysis treatment (10 female and 6 male) and would like to add that in addition to pruritus "red eyes" is a common feature of severe hypercalcaemia (> 3 mmol/l (> 12 mg/100 ml)). Our four patients developed a varying degree of conjunctival injection and dilatation of blood vessels. Though these patients complained of sore eyes, crystal deposits were not visible and slit-lamp

examination was not performed. This condition was reversible on temporary cessation of therapy, reduction in dosage, or both.

We concur in that no ectopic calcification was observed, but prolonged severe hypercalcaemia should be avoided and we endorse the need for careful monitoring not only of plasma calcium but also of plasma inorganic phosphorus and its meticulous titration with phosphate binders.

RASHEED AHMAD
B LARGE

Regional Urological Centre,
Sefton General Hospital,
Liverpool

Return to work after aortofemoral bypass surgery

SIR,—May I congratulate Mr K J Waters and his colleagues on their short report on this subject (27 August, p 556)? The ability of patients to take up former work or to return to modified or alternative work is something which is very often forgotten when clinical follow-up studies are designed. It is my belief that this ability is an extremely important measure of outcome, particularly when any kind of treatment, medical or surgical, is being evaluated.

On behalf of the Employment Medical Advisory Service and in co-operation with different clinical departments I am at present engaged in some similar studies detailing aspects of present and past "work history" in different physical conditions with special reference to advances in treatment. I would like to make use of your correspondence columns to urge any physician or surgeon undertaking long-term follow-up studies to include occupational status among the criteria of outcome examined. Such data, which are rarely specifically sought, would be of the greatest value not only to our own organisation but surely to clinicians whose responsibility to their patients should include informed advice on future return to work.

FELICITY EDWARDS

Health and Safety Executive,
Birmingham

Depot tranquillisers for disturbed behaviour

SIR,—The treatment of elderly people showing "antisocial behaviour" is often difficult. It is vital to exclude possible remediable factors which might be contributing to confused behaviour, both of a physical nature (for example, bronchopneumonia) or of a psychiatric nature (for example, depression). There are, however, many elderly people whose behaviour is so disturbing to relatives and neighbours and to other residents in homes and other patients in hospitals that some form of psychotropic medication seems indicated. This medication should primarily be used to ameliorate or abolish the patient's symptoms for their own benefit, but this primary obligation often blurs into a response to demands to control the patient's behaviour as a general social need and minimise pressures on other people with whom they are in contact.

Long-acting tranquillisers are occasionally useful in such patients. While they have the major disadvantage that once given side effects may develop inexorably, they may sometimes produce the very rewarding situation described by Dr H G Kinnell (27 August, p 578) in

younger patients. The elderly person becomes much calmer and happier and may not need any additional medication until the next injection of fluphenazine decanoate is required. Although this drug has to be given by injection, the patient and attendants are often very pleased that no further medication has to be given by mouth or injection for some considerable time. Our usual experience has been that doses of the order of 12.5 mg fortnightly are adequate and very rarely cause side effects.

I would reiterate the need to choose psychotropic drugs very carefully in the elderly confused patient but record that phenothiazines are sometimes indicated despite their side effects and that depot injection fluphenazine may sometimes be a very useful alternative to the more usual phenothiazines.

MICHAEL F GREEN

Department of Geriatric Medicine
(Royal Free Hospital),
New End Hospital,
London NW3

Bruising in thyrotoxicosis

SIR,—In reply to Dr E N Wardle (24 September, p 828), clinically significant bruising is uncommon in thyrotoxicosis, although the finding of a positive Hess test is quite common. Studies¹ have shown that capillary fragility is increased in thyrotoxicosis and decreased in hypothyroidism. The platelet count is usually not affected.

JOHN A THOMSON

University Department of
Medicine,
Royal Infirmary,
Glasgow

- ¹ Thomson, J A, *Clinical Science*, 1964, **26**, 55.

Complications of transvenous (transjugular) liver biopsy

SIR,—We were interested to read the account by Dr I T Gilmore and his colleagues of their experience of transjugular liver biopsy (9 July, p 100). At the present time we have performed 335 transvenous (transjugular) liver biopsies; our early experience, based on our first 100 transvenous liver biopsies, has been reported in a paper to be published shortly in the *American Journal of Digestive Diseases*.

The only serious complication directly related to the procedure that we observed in our series was a fatal intraperitoneal haemorrhage due to perforation of the liver capsule; perforation was due to excessive forward rotation applied to the needle. The reason for this manoeuvre was that the needle advancing parallel to the lumen of the vessel; therefore forward rotation, by placing the tip of the catheter against the venous wall, placed the needle obliquely, which favoured penetration into the liver parenchyma. This manoeuvre must be avoided or limited to only a slight forward rotation applied to the needle. In three other patients we have indirect evidence that the liver capsule was perforated (aspiration of ascitic fluid, aspiration of bile from the gall bladder, presence of renal tissue in the biopsy specimen), but no clinical complication resulted from the perforation; in these three patients the size of the liver was small.

These observations suggest that in patients with a small liver transvenous liver biopsy must be avoided or employed with caution—namely,