some studies. As an example of a possible relationship between malignant lymphoma and PMR on this ground they refer to a case described by us^{6,7} in which malignant lymphoma occurred four years after the diagnosis of PMR was made. Among our 54 patients with PMR we have recently reported another case⁸ in which chronic lymphatic leukaemia developed five years after the onset of typical PMR. In this patient lymphocytic infiltration was detected in renal, liver, and muscle biopsy specimens at the time of diagnosis of PMR, when the number of lymphocytes in the peripheral blood and bone marrow was normal. The significance of the combination of the two diseases in this patient is unclear. It may simply be the coincidental coexistence of two diseases, both relatively common in elderly people. However, the clinical course does point to a more direct relationship. Histocompatibility antigens have been studied in patients with chronic lymphatic leukaemia, but, so far as I know, no increase in any specific HLA haplotype has been shown.

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- ² Hall, G H. and Hargraves, T, *Lancet*, 1972, **1**, 48.
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- ⁵ von Knorring, J. and Wasastjerna, C, *Scandinavian Journal of Rheumatology*, 1976, **5**, 197.
- ⁶ von Knorring, J, *Scandinavian Journal of Rheumatology*, 1972, **1**, 117.
- ⁷ von Knorring, J. and Somer, T, *Scandinavian Journal of Rheumatology*, 1974, **3**, 129.
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Renal failure associated with ergot poisoning

SIR,—In their case report on "St Anthony's fire and pseudochronic renal failure" (8 October, p 935) Drs C D Pusey and D J Rainford found no reports of acute renal failure in ergotism. I would like to report a case of acute renal failure in association with ergot poisoning.

A 37-year-old woman was admitted with a history of intermittent claudication associated with a very high intake of ergotamine tartrate tablets for the treatment of migraine. Both legs were cold, with absent foot pulses. The temperature of the left great toe was 23°C. She was treated with anti-coagulants, oral tolazoline, bilateral femoral, sciatic, and tibial nerve blocks, phenolamine and sodium nitroprusside, methylprednisolone, and low-molecular-weight dextran 40. Her systolic blood pressure dropped as a result of this treatment to an average of 60 mm Hg over the next 8 h and then rose to above 100 mm Hg. During this time she was given 20 mg of intravenous frusemide and passed 1 l of urine over the next five hours. The haemoglobin and blood urea were normal on admission. After her initial diuresis her urine output ceased and she went into acute renal failure with the blood urea concentration rising to 43 mmol/l (260 mg/100 ml) on the ninth day after admission, at which point peritoneal dialysis was begun. Renal function returned to normal, as did the skin temperature in both legs. An intravenous urogram and creatinine clearance done later were both normal.

Gabbai *et al*¹ in their description of an outbreak of ergotism reported blood urea concentrations rising to 10–20 mmol/l (60–120 mg/100 ml) and, in the four patients who died, blood urea levels of more than 25 mmol/l (150 mg/100 ml).

Hypotension in association with treatment with low-molecular-weight dextran is a well-recognised cause of acute renal failure.^{2,3} It is reasonable to postulate that this was an unlikely cause for the development of acute renal failure in a patient who was young, with normal kidneys. A combination of the hypotension, dextran infusion, and renal artery narrowing secondary to the ergot poisoning is a more likely cause of the development of acute renal failure. It is difficult to be sure which of the two contributing factors was of more importance, the ergot poisoning or the hypotension and associated dextran treatment. However, the possibility exists that the ergot poisoning was the most important of the contributing factors.

I would like to thank Dr Victor Parsons of King's College Hospital for allowing me to publish details of this case.

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Mobilisation after myocardial infarction

SIR,—Your leading article on this subject (10 September, p 651) does not emphasise the ease with which a rehabilitation programme can be set up in a district general hospital.

We at Lewisham have, over the past 18 months, had 150 patients through our rehabilitation unit, and, although it is quite true that 20% or so usually drop out at some stage during the course, the majority gain considerable psychological benefit. Their increase in physical fitness and morale is testified to by all who come in contact with them, particularly their immediate family. Our unit is run by one of the physiotherapists with a doctor who meets once a week with a member of the medical team to iron out particular problems. It does not require any particular resources and has certainly not put any great strain on the finances of the hospital.

The enthusiasm of many of the participants has been such that they have started, with the help of the Inner London Education Authority, a coronary rehabilitation class at night school, which is well attended, and we hope to extend this aspect of the programme.

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Bilateral injuries in childhood: an alerting sign?

SIR,—You published a letter from Dr A R Buchan and me last year (16 October 1976, p 940) giving a preliminary warning of the possible suspicious nature of bilateral minor injuries in children under 5. At that time we reported the total absence of bilateral injuries in daily inspections of 481 children on the register of the 10 day nurseries in Leicestershire.

This research has now been completed and, although many aspects are not of general interest and are being published elsewhere, the final figures showed that during the 13-week

period from 1 November 1975 to 31 January 1976 20 896 inspections were made and 3709 injuries noted. Of these, only one was bilateral and it was clearly seen to be non-accidental and one of a series of incidents within that family.

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Treatment of depression

SIR,—I feel that your leading article on this subject (29 October, p 1105) left the unfortunate impression that the only treatment of depression is physical. The psychological aspects of depression are wholly ignored. Leading articles like this can only increase the over-prescribing of antidepressants which various recent studies have pointed out. All too frequently medications and physical treatments are used as a quick and short answer to the overwhelming needs of patients whose medical symptoms of depression have their roots in alienation, loneliness, or unhappiness in their lives. Perhaps the article should have been retitled "Physical treatments of depression."

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Propranolol and thyroid surgery

SIR,—We read your recent leading article (22 October, p 1039) with interest and believe your view as regards the use of propranolol as a preoperative measure in thyroidectomy for Graves' disease is ultra-cautious.

Our experience over the past 18 months is, admittedly, limited to some 15 cases. Propranolol was used as the sole preoperative measure in all, with satisfactory results. Technically, the gland is easier to handle at operation. The total time of the "illness" is cut to about ten days, which includes preoperative preparation and hospital stay.

If this drug is used it is important that a dose be given on the morning of operation and that it be continued postoperatively for some 5–7 days.

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Noxythiolin-resistant organisms

SIR,—I was interested to read Dr B Chattopadhyay's article (29 October, p 1121), but his conclusions cannot remain unquestioned.

Sensitivity discs are a test of sensitivity to antibacterial agents; resistance cannot be inferred. Sufficient concentration of noxythiolin may not be achieved by diffusion from discs to inhibit growth of those bacterial strains with a high minimum inhibitory concentration relative to noxythiolin. That such "resistant strains" are killed by relevant concentrations of noxythiolin was elegantly demonstrated by Dr Chattopadhyay. Employing dilutions of noxythiolin in broth culture to "simulate urinary tract infection" he found "resistant" organisms to be totally killed at a concentration of 1.25% noxythiolin. This is half the concentration recommended for treatment of

significant bacteriuria. In use the bactericidal activity of noxythiolin is dose- and time-dependent; thus effective concentrations should be used in the management of stubborn infections. Inadequate exposure of organisms to noxythiolin should not be interpreted as resistance of the type threatening to compromise much conventional antibiotic use.

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Vertigo in children

SIR—Your leading article on vertigo in children (5 November, p 1173) correctly states that "the fact that the child is experiencing vertigo may not be recognised" but omits to explain it. Children do not often complain of certain labyrinthine stimulations because they enjoy them, and you do not complain of what you enjoy.

On fairgrounds one can see large numbers of children queuing to pay for labyrinthine stimulations by swings, dippers, etc, which are totally unacceptable to adults because they would cause vertigo, and most adults would be prepared to pay for *not* having to endure them. It is this component of enjoyment (it ends with puberty) which complicates the issue, and which is most probably responsible for the standard textbook of paediatrics you quote not even mentioning vertigo in its index.

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Hot flushes after hypophysectomy

SIR,—With reference to the discussion by Mr G P Mulley and his colleagues of the cause of hot flushes during the menopause (22 October, p 1062), the following case may serve as an illustration.

A 31-year-old woman had started having headaches at the age of 12. She improved slightly after glasses had been prescribed but at a routine eye examination three years later bitemporal hemianopia was found and a pituitary tumour diagnosed. She underwent an uncomplicated transfrontal removal of a chromophobe adenoma and irradiation with 3900 R was given. For the next nine years she was fairly well but did not menstruate.

At age 24, when we saw her for the first time, she was childish and pale, without either mammary gland tissue or axillary hair, and had only scanty pubic hair. The visual field defects (bitemporal hemianopia) had remained unchanged since the operation. She had partial hypopituitarism. Urinary steroids were low, without metyrapone response but normal ACTH response. The serum growth hormone concentration was low and did not rise after arginine infusion. The serum luteinising hormone (LH) concentration was slightly elevated at 7.9 $\mu\text{g/l}$. Thyroid function was normal. Replacement therapy with cortisone 12.5 mg and diethylstilboestrol 0.5 mg daily was initiated. Eight months later, after satisfactory feminisation, the stilboestrol therapy was changed to cyclic administration with the addition of norethisterone on the last five days of the 21-day period of treatment. With cyclic therapy she has since had regular vaginal bleeding.

After seven years the diethylstilboestrol treatment was temporarily stopped so that prolactin secretion could be examined. Almost exactly 14 days later she suddenly experienced hot flushes 5-6 times daily lasting for a few minutes. The flushes were also noted by her friends, who teased her

about "the change of life." She could not remember having experienced hot flushes either before operation or during the nine years that had elapsed between operation and the start of substitution therapy. The serum concentrations of LH, follicle-stimulating hormone (FSH), and prolactin were measured during and two weeks after the withdrawal of substitution therapy. The LH and FSH values were within normal limits on both occasions; that of prolactin was elevated (36 $\mu\text{g/l}$) when the patient was on oestrogen but fell to normal (11.5 $\mu\text{g/l}$) later.

Our patient supports the theory that lack of oestrogen and not gonadotrophin excess is the cause of hot flushes during the menopause. It has to be noted, however, that the hot flushes occurred in a previously "well-oestrogenised" woman and were absent before oestrogen therapy was instituted (even if the LH level then was slightly elevated).

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Doctors and the global population crisis

SIR,—Dr Peggy Norvis and the World Federation of Doctors Who Respect Human Life (29 October, p 1154) seem to be confusing two different concepts. To "respect human life" and to "maintain the utmost respect for life from the moment of conception" are not different expressions of the same belief, nor will they lead to the same course of action. Those doctors who welcomed the 1967 Abortion Act cannot be dismissed conveniently as denigrators of human life or deviators from the conventional code of medical ethics. It is precisely their respect and concern for the life of the woman and the potential life of the fetus which are major determinants in their decision to perform an abortion.

Similarly, it is this respect and concern for human life which is the motive behind those doctors who are pressing for further liberalisation of abortion in this country. Even in those parts of the United Kingdom where abortions are relatively easy to obtain the decision to allow the abortion remains in the hands of the medical profession. Our respect for human life leads us to believe that the decision about abortion should be made by the woman herself, and we strongly advocate legislation for a woman's choice on abortion.

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Treatment of hepatic hydatid disease

SIR,—We read with interest the article by Dr A Bekhti and others (22 October, p 1047) on the treatment of hepatic hydatid disease with mebendazole. We have undertaken several therapeutic trials of hydatidosis with different drugs and have treated one patient with flubendazole, a fluoro derivative of mebendazole.

The patient, a 31-year-old Algerian, was operated on in November 1976 for multiple hepatic and peritoneal cysts. At operation total removal of the existing cysts was not possible. Before operation the titre of antibodies by passive haemagglutination was 6400 (positive, >1600) and the arc 5 specific

for hydatidosis was demonstrated by immuno-electrodiffusion. Specific hydatid IgE antibodies were measured by a radioimmunoassay using tube-bound antigen¹ and were found to be normal. Tests for immune complexes by precipitation of radiolabelled C1q by polyethylene glycol² and the Raji cell assay³ showed them to be absent.

No changes were seen in the levels of specific IgE antibodies or immune complexes in the serum samples obtained monthly from the patient; there was, however, a significant decrease in the titre of antibodies by haemagglutination six months after the surgical intervention (800).

In July 1977 the patient was treated with 1 g of flubendazole daily by mouth for 14 days and this treatment was repeated in August. The last serum sample obtained in October showed a rise in the titre of antibodies by haemagglutination to 12 800; the level of specific IgE remained unchanged and immune complexes were always absent. Clinically there appeared to be an improvement in the patient's general health after treatment. However, the rise in the level of antibodies by haemagglutination suggested that the hydatid cysts were not in a state of regression.

The difference in efficacy of treatment compared with the cases reported by Dr Bekhti and his colleagues could be due to the different localisation of the cysts in our patient, since the cases reported by those authors had only hepatic cysts. Another possibility is that owing to the reported poor absorption of the drug the dose given was insufficient.

The suggestion by Dr Bekhti and his colleagues that specific IgE antibodies and immune complexes are useful for assessing the efficacy of treatment remains to be confirmed since in our study of 30 cases of clinically confirmed hydatidosis only 30% had raised specific IgE antibodies and immune complexes in their serum. It would thus seem that these criteria can only be used in a small proportion of patients with hydatid disease.

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¹ Richard-Lenoble, D. In preparation.

² Nydegger, U., et al., *Schweizerische medizinische Wochenschrift*, 1974, **104**, 126.

³ Theofilopoulos, A N, et al., *Journal of Clinical Investigation*, 1976, **57**, 169.

Relapse in leprosy

SIR,—As a leprosy field worker in India I found your leading article on relapse in leprosy (8 October, p 914) very interesting. The problem of dapsone resistance is real, as highlighted by the recent symposium on dapsone resistance in the *Leprosy Review* (June 1977). Some very important issues have been raised. However, one wonders if your article is aimed at developed countries with little leprosy and large resources or at those areas of the world where leprosy is still a major problem and where limited resources are the hard facts of life. Does what is "permissible" differ in the two areas? I wonder if, in many control programmes in the developing countries of the world, you leave us with a choice between what is no longer "permissible" and what is not possible.

Considering the high costs, multiple drug therapy of patients in many cases may not be feasible. We should note that we do not yet have sufficient results of long-term combination drug trials convincing us of their cost-effectiveness and whether they will effectively