continuing and expanding research on the treatment of this condition, which is at present responsible for considerable personal distress and social disruption. In view of the large numbers of women between the menarche and the menopause who suffer from PMS any significant reduction in its overall incidence will be welcome and we hope that family doctors will be encouraged to treat PMS by these new approaches. Further help and support from specialised clinics in teaching hospitals and other centres will be required for some time yet, but we hope soon to publish further observations on the clinical presentation of PMS which will minimise this need.

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Anaphylaxis after dichloralphenazone treatment

SIR,—The case of anaphylactic response to the ingestion of dichloralphenazone (Welldorm) tablets (reported by Dr Steven Perl, 5 November, p 1187) is by no means unique.

Two Welldorm tablets were administered as night sedation to a 55-year-old man awaiting a minor surgical operation. Within minutes he developed severe bronchospasm and a widespread bullous skin eruption. The bronchospasm responded readily to injection of hydrocortisone and aminophylline. By the following morning there was no evidence of any lesion.

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Silk sutures in the common bile duct

SIR,—Having twice had a similar experience to that described by Mr B I Rees and Mr G Jacob (12 November, p 1265)—although on both occasions the recurrent common bile duct stone contained a thread rather than a silk suture—I was interested last year to remove three stones from the common duct of a woman who had had a cholecystectomy eight years before. Each stone contained a thread suture, and reference to the excellent original operation note produced the explanation: the cystic duct and two cystic arteries had been tied with thread.

I agree that it is important that no unabsorbable suture should be used in the vicinity of the common duct. It is not uncommon to

find that surgeons in training recognise this risk so far as the cystic duct ligature is concerned, but many are unaware that the cystic artery tie also may discharge itself into the common duct. The chances of this happening are presumably greater if an exploration of the common duct has been performed, but a small abscess around the foreign body on the artery can undoubtedly discharge into the lumen of the nearby common duct even when its wall is surgically intact.

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Anaphylactoid reactions to dextran 70

SIR,—I read with interest the report by Dr L H Fanous and others of two cases of anaphylactoid reaction to dextran 70 (5 November, p 1189).

The cases which we reported last year¹ had no history of asthma and did not develop urticarial rashes. Investigation of the immunological aspects of these cases did not reveal the cause. It is peculiar that in our hospital there have been no cases of this type reported in the general surgical or medical wards and that the syndrome appears to be associated with maternity cases.

The question of particles in the dextran solutions and bacteriological contamination of these solutions were investigated with negative results at the time. As an anaesthetist I have meanwhile continued to give dextran as a prophylaxis against deep venous thrombosis in orthopaedic cases, but more recently there has been apprehension about dextran as a precipitating factor in postoperative acute renal failure, as a result of a paper by Feest,² and the practice here now is to not give dextran to those orthopaedic patients who have a blood urea concentration higher than normal for their age.

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- ¹ Fothergill, R, and Heaney, G A, *British Medical Journal*, 1976, **2**, 1502.
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Lichen-planus-like eruption: a marker for chronic graft-versus-host reaction

SIR,—In regard to your leading article (23 July, p 211) on skin changes after bone marrow transplantation we would like to make the following comments. Since our initial report¹ of four patients with lichen-planus-like eruption (LPLE) after bone marrow transplantation we have seen seven additional cases.² We have found that the clinical spectrum of LPLE may be compared to the various clinical aspects of idiopathic lichen planus (ILP). The occurrence of LPLE after bone marrow graft not only would throw light on the pathogenesis of ILP^{2,3} but also has a practical interest in the management of patients after grafting.

Indeed, we have found that: (1) a graft-versus-host reaction always precedes development of the LPLE; (2) LPLE never occurs if the graft is rejected; and (3) LPLE always occurs in a context of "persistent graft-versus-host reaction." These data strongly support the concept of LPLE actually representing a skin manifestation of graft-versus-host disease.³ In every case the first

symptoms of LPLE were found in the mouth. This oral involvement was very similar to ILP; it can be easily recognised by a dermatologist and is quite different from drug-induced erosive leukokeratosis and from candidiasis. The oral LPLE represents, therefore, a useful early marker of chronic graft-versus-host disease and a tool for clinical evaluation and therapeutic guidance in patients undergoing bone marrow transplantation.

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- ¹ Saurat, J H, et al, *British Journal of Dermatology*, 1975, **92**, 591.
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Adverse reactions to intravenous thiopentone

SIR,—We were interested to read the article by Drs J M Evans and J A M Keogh (17 September, p 735) in which they reported three histaminoid-type reactions to the intravenous use of thiopentone. In view of the relative rarity of adverse reactions to this agent¹ we would like to report a further case.

A 33-year-old White man underwent a routine repair of a right inguinal hernia. Routine premedication with atropine plus Omnopon was given and intravenous thiopentone and suxamethonium used for induction of anaesthesia. The operation was uneventful. Postoperatively the patient developed severe bronchospasm, generalised erythema, pruritus, and gross facial oedema. His white cell count remained normal but showed a 6% eosinophilia. Treatment was instituted with high-dose steroids and the antihistamine chlorpheniramine. The bronchospasm settled rapidly, but the erythema and oedema gradually resolved over the following 72 h.

This patient had a known hypersensitivity to penicillin and tetanus toxoid and eight years previously had undergone an operation for treatment of a compound fracture of his right lower leg. In view of the common use of thiopentone for induction, it is likely that previous use had sensitised the patient to this agent, resulting in a type I hypersensitivity reaction on re-exposure.

As noted by Drs Evans and Keogh, histaminoid-type reactions are probably encountered more frequently than reported and it would seem justified to advocate the prophylactic use of an antihistamine in patients known to be hypersensitive to exogenous agents.

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- ¹ *British Journal of Anaesthesia*, 1976, **48**, 57.

Bell's palsy and herpes simplex

SIR,—Dr B E Juel-Jensen (22 October, p 1086) has taken exception to the evidence that I presented (24 September, p 829) which appeared to support the hypothesis that Bell's palsy may be associated with herpes simplex virus (HSV) infection. While his own studies, to which we are given no reference, resulted in a conclusion contrary to three of the references I cited, he is correct to confirm that there is no definite proof of the association. However, in his determination to demonstrate that the patient in my report did not have