Whooping cough in the United Kingdom 1977-8

SIR,—Professor G T Stewart (9 August, p 451) is nimble both on his feet and in his mind. The great majority of doctors in this country who have worked very hard over the years to control epidemics of communicable disease in childhood have seen their successes reversed by the misguided efforts of people like Professor Stewart, Jack Ashley, MP, and one or two other people.

The toll of misery brought about by such gentlemen has been well recognised by Dr John Cunningham (a GP in Hildenborough, Kent) writing in *World Medicine*.¹ Readers of the *Daily Telegraph* will be aware that Jack Ashley had the gall to publish a letter recently² expressing his concern for child health and hoping that proper attention would be paid to the report of Mrs Renée Short's committee.

I doubt if I am alone in thinking that those people should be thoroughly ashamed of themselves. The situation will take a long time to retrieve.

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¹ Cunningham JS. *World Medicine* 1980;15 (14):10.
² Ashley J, Hannam J. *Daily Telegraph* 24 July 1980:16.

Poliomyelitis worldwide

SIR,—As you point out in your leading article (28 June, p 1555) in many Third World countries the incidence of residual paralysis from poliomyelitis is high—it may indeed be nearly 1% of all children.¹ The elimination of poliomyelitis and other diseases by use of vaccine is a priority of WHO and the Save the Children Fund. There are certainly difficulties of administration, as you say; but there are other less well-recognised dangers.

The giving of oral polio vaccine or Salk-type inactivated vaccine is exceedingly dangerous unless governments recognise that there can never be any going back. Once the passage of wild virus is interrupted the number of cases will drop: parents and politicians then consider immunisation unnecessary. Even if immunisation rates fall, it may be some years before wild virus circulates; when it does, the number of victims could be greater than if vaccine had never been used.² The reason for this increase would be that the percentage of persons susceptible to paralysis increases with age and at 10 years and above is about 10 times that at 2 years.³ Once immunisation against poliomyelitis is begun it must continue.

Therapeutic or prophylactic measures for other ills may increase the incidence of poliomyelitis by increasing the susceptibility of the individual. Thus small children given multiple injections of salvarsan and its derivatives for congenital syphilis have suffered about a 25% attack rate of paralytic poliomyelitis.⁴ High paralytic attack rates have followed injections for yaws.⁴ An epidemic among small children in a leprosarium, with 24% cases, may have been provoked by injections of dapsone.⁴ In tropical and subtropical countries the incidence of paralysis in lower limbs only ranges from 75% to 89%, whereas in temperate countries it ranged from 42% to 54%¹: injections are given in the lower limbs in tropical countries, more generally in the upper limbs in temperate countries. Large-scale campaigns to inoculate children with diphtheria, pertussis, and

tetanus and other vaccines or injections may precipitate paralytic poliomyelitis and discredit preventative medicine. The coincidence of injections followed by paralysis of that limb has been noted by doctors⁵ and parents.⁶ Large-scale use of injected vaccines must be preceded by immunity to poliomyelitis, which may not be easy to achieve. As noted in your leading article, seroconversion after oral polio vaccine may be boosted by repeated doses. Repeated doses, however, entail delay before other injected vaccines can be given, and increase the number of visits to be made and the load on the health services and budget.

We do not know how far the present incidence of poliomyelitis is linked to immunosuppression caused by malaria and malnutrition, to injections given by practitioners of Western and traditional style medicine, and perhaps to other factors.¹ It is essential that the giving of all vaccines must be carefully and completely monitored.

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¹ Wyatt HV. *Afr J Med Sci* (in press).
² Wyatt HV. *J Fam Pract* 1978;7:469.
³ Wyatt HV. *Med Hypoth* 1975;1:35, 87.
⁴ Wyatt HV. *Rep VII Int Congr Infect Paras Dis* 1978, 1, 420.
⁵ Price EW. *Br Med J* 1950;ii:1391.
⁶ Nicholas DD, et al. *Br Med J* 1977;ii:1009-12.

Outbreak of tuberculosis after minimal exposure to infection

SIR,—I write to express my concern at some of the comments in the article by Dr V R Rao and others (19 July, p 187) on an outbreak of tuberculosis after minimal exposure to infection. Experience of those of us who work in areas where tuberculosis is rather more common suggests that it is less highly contagious than the authors describe. It may be that with the progressive eradication of the disease we will in future be confronted with as vulnerable a population as apparently is found in Sandwell, but clearly many of us have not yet reached this situation.

More alarming than the comment about the infectivity are the authors' conclusions in so far as they apply to treatment. There is really no evidence to justify their statement that "on detecting a case of respiratory tuberculosis with smear-positive sputum the patient should be isolated in hospital" and that isolation in hospital for two to four weeks is desirable. Indeed, as your admirable leading article (5 April, p 962) pointed out, there is virtually no evidence to support the view that secondary cases can be diminished by hospital admission. The urgent necessity is for diagnosis at the earliest possible moment and prompt effective chemotherapy.

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Changing patterns of communicable disease in England and Wales

SIR,—Dr N S Galbraith and others in their paper on newly recognised diseases in the United Kingdom (9 August, p 427) deal with infection with *Giardia lamblia*. One of the aspects of transmission which they failed to mention was sexually acquired infection in male homosexuals.

Sexual transmission of intestinal parasites has been recognised in New York for several years.^{1,2} Kean et al² examined the stools of 126 sexually active homosexual men in New York, of whom 40% had *G lamblia* or *Entamoeba histolytica*, or both. The authors estimated that up to 50 000 people in New York may be infected with these parasites.

Recently two cases of "sexually acquired" amoebiasis were described in the United Kingdom.³ Neither patient had travelled abroad during the preceding eight years and both were homosexual males. Several cases of giardiasis in homosexual men have been seen at the Middlesex Hospital in the last few months. The last case was a man who presented with abdominal pain and diarrhoea. There was no recent history of travel abroad and stool microscopy revealed cysts of *G lamblia*.

Transmission appears to be faecal-oral, usually by oral-anal contact.⁴ In the United States the practice of inserting a hand or even a forearm into the partner's rectum is not uncommon,⁵ and such practices must result in gross faecal contamination. I am sure that in the next few years, intestinal parasites will be increasingly recognised in the male homosexual population in the United Kingdom.

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¹ Schmerin MJ, Jones TC, Klein H. *Ann Int Med* 1978; 88:801-3.
² Kean BH, William DC, Luminis SK. *Br J Vener Dis* 1979;55:375-8.
³ Public Health Services Laboratory. *Communicable Disease Report* 1980;CDR 80/31.
⁴ Meyers JD, Kuharic HA, Holmes KK. *Br J Vener Dis* 1977;53:54-5.
⁵ Sohn N, Robilotti JG. *Am J Gastroenterol* 1977;67: 478-84.

Distalgesic poisoning—cause for concern

SIR,—We are sorry that Mr P S Dwyer and Dr I F Jones (5 July, p 60) have been unable to understand the analysis presented in our paper (12 April, p 1045) on poisoning by Distalgesic (dextropropoxyphene and paracetamol). We wish to allay some misconceptions that may have arisen from the contents of their letter.

Far from attempting to conceal the fact that the majority of deaths from overdosage occur outside hospital, we again confirmed this in our paper by the figures presented. Thus in the three and a half years for which full hospital and community data were available there were nine deaths outside hospital and four in hospital. Eight of the 13 deaths were due to Distalgesic and only three due to barbiturate. These are the bare facts.

Our further calculations were designed to show that the majority of patients taking 20 Distalgesic tablets in association with another central nervous system depressant will succumb unless resuscitation facilities are available. Hence the term "potential death rate." The rationale of this analysis is fully detailed in the paper.

We also feel obliged to comment on the injunction of Mr Dwyer and Dr Jones to avoid prescribing Distalgesic to alcoholics. Given that alcoholism is frequently a carefully concealed problem, the superficial common sense of this statement has nevertheless little bearing on the reality of GP prescribing.

Needless to say, we welcome their quest for dispassionate and objective data on this difficult problem. By carrying out the first total