because of completely unsupported views of members of a tribunal. It seems to be forgotten that convulsions are common in children, affecting 6-7% under the age of 5. It is illogical to assume that, because a fit occurs within a week or two of immunisation, that fit must be the result of the immunisation.

What is wanted is not massive, usually irrational, compensation for the small minority, but more help for all parents of severely handicapped children. There should be an adequate index-linked annual allowance for the child's care, avoiding the difficult, expensive, and time-consuming legal arguments concerning the obvious uncertainties of life expectancy. This should be one of the priorities of a modern welfare state.

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The Steve Biko case: politics and medical ethics

SIR,—At the inquest in South Africa on the black leader Steve Biko, who died in police custody in 1977, three medical practitioners who had attended him gave evidence that raised doubts about the ethics of their behaviour. They stated that they thought Biko was malingering despite the presence of hemiparesis with an extensor plantar response. Dr Ivor Lang admitted that he wrote out a "highly incorrect" medical certificate at the request of Colonel Goosen of the security police. Dr Benjamin Tucker, another district surgeon, said, "I didn't think that I was required to do so" when asked why he had not inquired of Mr Biko or the police whether the black leader had been struck on the head. From their evidence it is clear that both doctors allowed their professional concern for the patient to be overruled by the wishes of the police, and their failure to take a proper ethical stand delayed or prevented treatment that might have saved Biko's life.

On 17 June 1980 the South African Medical and Dental Council ruled that there was no evidence of improper or disgraceful conduct on the part of the three doctors concerned and that there was thus no need for a disciplinary hearing. On 19 July, p 231, you published a brave and forthright condemnation of this decision by the Faculty of Medicine of the University of Witwatersrand, in which they dissociated themselves from it and suggested that the council had not considered the Biko doctors "in a purely objective and dispassionate way."

Your readers may care to know that the chairman of the Federal Council of the Medical Association of South Africa, Professor J N de Klerk, was interviewed recently on his return from Britain, where he attended the BMA meeting in Newcastle upon Tyne. He stated, "At no stage did any individual or group within the BMA ever call our bona fides or ethics into question." He added that so far as the Biko case was concerned no one had raised the question with him throughout his stay in Britain and that "indeed, many British doctors expressed their sympathy with the profession" in South Africa (*Cape Times*, 22 July 1980). This is another example of capital being made out of silence; our failure to voice concern about the ethics of the Biko doctors is being used to justify what appears to be a blatantly

political decision by the South African Medical and Dental Council.

Those who visit South Africa and fail to speak out against (or notice?) the injustices and inequalities of the system should realise how often their silence is interpreted as approval and exploited by unscrupulous politicians, much to the frustration of those within the country who would like to see change. Our colleagues in Johannesburg have expressed their sense of shame over the Biko case. They deserve support from this country. Unless we express our revulsion in the strongest possible way, we shall appear to be condoning a system in which doctors allow their loyalties to the profession to take second place to political considerations.

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Feeding patients with advanced dementia

SIR,—The paper (27 September, p 847) about the dilemmas of "care-workers" in feeding patients with advanced dementia is replete with jargon but, more importantly, obscures the two phases of dealing with the problem once treatable causes for the dementia have been excluded.

The first phase should consist of a discussion involving the doctor in charge, nurses, relatives, and others concerned. It is the doctor's duty to be sure that a clear plan evolves, taking into account the viewpoints of others. The whole caring team must agree about aims and methods.

Secondly, the approach to the helpless, hopelessly demented patient should be to offer food and drink by spoon or feeding cup. If these are repeatedly rejected and there is no sign that the patient wants or gets pleasure from food or fluid, they should still be offered. Mouth toilet, turning, and other nursing care must, of course, continue; and if there is any sign of discomfort whatever this should be controlled by regular morphine or oxycodone suppositories.

It seems to me that the problem discussed may largely disappear if each member of the team trusts the others and there is a clearly defined plan of campaign. Death with dignity can be the order of the day without chaos and confusion among the care-workers.

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Disturbed behaviour induced by high-dose antipsychotic drugs

SIR,—Drs W R Guirguis and Susan E Bawden (30 August, p 617) comment on our recent report of disturbed behaviour in schizophrenic patients administered high-dose antipsychotic drugs (26 July, p 274) and suggest that this behaviour was akathisia. This condition has no generally accepted diagnostic criteria and it remains unclear whether both objective motor restlessness and a subjective sense of restlessness are essential for the diagnosis. The latter component may be associated with agitation and distress, and there are isolated case reports of aggression^{1 2}

and violence³ apparently associated with akathisia. Although there is doubt about whether the condition should be considered as a primarily neurological phenomenon, Drs Guirguis and Bawden are not justified in identifying akathisia solely on the basis of "excitement, restlessness, and aggression."

Their letter contains other inaccuracies and inconsistencies. Firstly, they repeatedly refer to "relapse of the schizophrenic illness" in our patients, while the main point of our report was that the episodes described were not exacerbations of their previous symptoms. Secondly, the enhanced presynaptic release of dopamine is thought to be the pathophysiological basis of acute dystonias, not akathisia.⁴ It has been recently suggested that akathisia is associated with postsynaptic dopamine blockade in the mesocortical system.⁴ Thirdly, they mention two cases of akathisia, which they apparently selected initially on the basis of behaviour disturbance, that responded dramatically to procyclidine injection. Although acute dystonias rapidly improve following anticholinergic drug administration, akathisia shows a variable and often inadequate response to these agents.^{5 6} Fourthly, we dispute that impaired consciousness is necessarily a characteristic of atropinic toxic psychosis.

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Allergy to insulin

SIR,—Dr J P Simmonds and others (2 August, p 355) report an instructive case of a systemic reaction to highly purified insulins. Frequently systemic allergic reactions to insulin are preceded by increasingly large local reactions. It therefore is advisable to clarify any local reaction to insulin to avoid more serious complications by choosing the appropriate insulin preparation.

Recently a diabetic patient was sent to our outpatient clinic with the classical picture of local insulin allergy with stinging, itching, and burning followed by local heat, erythema, and induration. By means of skin tests, however, no sensitisation to insulin of bovine, porcine, or human (synthetic¹) origin was detectable. Since the patient had also experienced an eczematous reaction due to an alcohol cataplasm several years ago, she was instructed to stop her habitual skin disinfection with "Webcol Alcohol Preps" (saturated with 70% isopropyl alcohol) and use 70% ethyl alcohol instead. With this measure the local skin reactions stopped.

Injection of 0.1 ml NaCl (0.9%) through a needle containing a droplet of isopropyl alcohol into my own subcutis also produced a stinging sensation followed by erythema and local heat (demonstrable by means of liquid crystals); induration was doubtful. This

suggests that even smallest amounts of isopropyl alcohol carried into the subcutis while injecting insulin can in some individuals lead to another "insulin" allergy besides reactions due to additives, preservatives, or zinc.²

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¹ Diem P, Teuscher A. *Schweiz Med Wochenschr* 1979; **109**:1814-6.

² Feinglos MN, Jegasothy BV. *Lancet* 1979; *ii*:122-4.

Anaphylactic reaction to desensitisation

SIR,—Dr David A Rands (27 September, p 854) reported a death due to anaphylaxis following desensitisation for allergic rhinitis. In the past, hyposensitisation was widely used in the treatment of allergic disorders; however, impressions of benefit were often based on anecdote and where controlled trials have been performed results are variable. For example, in studies of desensitisation to the house dust mite, *Dermatophagoides pteronyssinus*, in patients with asthma or allergic rhinitis no benefit was found in one study¹; the British Thoracic Association study² showed marginal benefit (not statistically significant) in patients not on steroids and no benefit in patients on steroids; and two other studies showed improvement.^{3,4}

Today newer drugs (local steroids and sodium cromoglycate) are available which control allergic symptoms in the majority of patients. These drugs, together with measures to reduce exposure to the allergens, are effective and safe and constitute the treatment of choice. Hyposensitisation, which is potentially dangerous and often ineffective, should rarely be required. Although anaphylaxis is a rare complication of hyposensitisation, Dr Rands's article provides a tragic reminder of the consequences of a potentially dangerous form of therapy in a mild disease.

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Unprecedented increase of infantile hypertrophic pyloric stenosis

SIR,—We were interested to read the recent paper by Dr Alison Kerr (13 September, p 714) reporting a remarkable increase in the incidence of infantile pyloric stenosis in Central Scotland during 1978 and 1979. We have for some time been aware of a similar increase in some parts of Wales, and colleagues in other areas of the United Kingdom have also told us of recent local rises.

The Welsh Hospital Activity Analysis, which probably represents incomplete returns, shows that a substantial increase in the numbers of children undergoing Ramstedt's operation occurred from 1976 on. It is of considerable interest that the increased incidence has almost entirely affected male

infants. The numbers of affected females in Wales remained relatively constant, and the sex ratio was not much more than 2:1 from 1970 to 1975 but was as high as 5:1 in 1977 and 1979.

We interpret these findings as indicating that there is a basic incidence in the community which is genetically determined, but that marked increases such as we are observing at the moment may occur as a result of additional environmental factors. These will operate predominantly on the more susceptible sex—that is, on the males—whereas the females, who are relatively protected by their genetic constitution, will not respond to the relatively weak environmental precipitating factor. Like Dr Kerr, we are actively looking into the possible nature of the environmental trigger, and are considering the possibility that the recent marked change in infant feeding patterns, with a resurgence of breast feeding, may be involved.

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SIR,—Dr Alison M Kerr, in reporting the dramatic rise in incidence of infantile hypertrophic pyloric stenosis in the Central Region of Scotland (13 September, p 714), emphasises the importance of knowing whether this change is mirrored elsewhere. A similarly steep localised rise in incidence has been suggested before,¹ but the study was of questionable validity because of inadequate data.

The data in the accompanying table are derived from a survey of all cases of infantile hypertrophic pyloric stenosis born in Buckinghamshire during 1975-9, with diagnoses confirmed at Ramstedt's operation. The overall incidence was 2.3 cases per 1000 live births, with no significant variation ($\chi^2=7.07$; $df=4$; $0.2 > p > 0.1$). In Oxfordshire the overall incidence during 1966-71 was 2.5 per 1000 live births.²

"Epidemics" of pyloric stenosis, localised to particular hospitals, seem to be the experience of many paediatricians. Yet, with few exceptions,² published studies have paid little attention to this aspect of aetiology. Such epidemics, whatever their cause, would offer an alternative explanation for the reported seasonal variation in incidence of pyloric stenosis,³ and reinforce the need for careful application of statistical methods. In particular, the often-used χ^2 test can at best only show lack of variability and cannot effectively be used to measure cyclical changes,⁴ especially when time intervals are arbitrarily chosen to accentuate variability.³

It is surprising, especially as infantile hypertrophic pyloric stenosis is a relatively common condition, how little is known of the aetiology and how few of its aetiological associations at present remain unchallenged. This highlights the need for further information and continuing study.

Incidence of infantile hypertrophic pyloric stenosis in Buckinghamshire (Eton and Beaconsfield Health Districts excluded) in 1975-9

	1975	1976	1977	1978	1979	1975-79
Total live births	5799	6307	6331	6962	7365	32 764
Cases of infantile hypertrophic pyloric stenosis	6	14	21	17	17	75
Incidence (cases/1000 live births)	1.0	2.2	3.3	2.4	2.3	2.3

I thank the consultant paediatricians and surgeons at Stoke Mandeville, Northampton General, Wycombe General, and Wexham Park Hospitals and in Oxford for permission to study their cases.

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¹ Murfin DE. *Br Med J* 1974; *ii*:198.

² Adelstein P, Frederick J. *J Med Genet* 1976; **13**:439.

³ Dodge JA. *Arch Dis Child* 1975; **50**:171.

⁴ Edwards JH. *Ann Hum Genet* 1961; **25**:83.

Surveillance of food poisoning and salmonella infections

SIR,—Your article (20 September, p 817) draws attention to the fact that the number of sporadic cases of salmonella infection acquired abroad is not documented, no doubt owing to the present notification system.

It may therefore be of interest that in a survey of 200 patients with salmonellosis admitted to an isolation hospital in Manchester during 1977-9 19 were found to have acquired the infection abroad. Thus approximately 10% of salmonella infections admitted to this isolation hospital were acquired abroad, although it must be noted that this is only a small proportion of salmonellosis in the community.

Analysis of the salmonella infections from abroad shows no consistent pattern either in the country of origin, organism isolated, month of admission, or severity of symptoms—these infections merged into the general picture of salmonellosis.

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Primary biliary cirrhosis: an epidemiological study

SIR,—I was interested in Dr David R Triger's figures on the incidence and prevalence of primary biliary cirrhosis in Sheffield (20 September, p 772), and his comments on the lack of information on this condition in other areas.

In Tayside there is a fairly stable mixed urban and rural population of 397 605 (post-regionalisation revision of 1971 census). A single liver clinic is held in Ninewells Hospital; there is one liver pathologist, also based in Dundee; and practically no referrals are made to or from the area. Since 1975 computerisation has assisted studies of liver disease in particular by rapid retrieval of liver biopsy reports.

In the five-year period 1975-9 inclusive 21 new cases of primary biliary cirrhosis presented in Tayside. In all cases the diagnosis was based on the well-described clinical features,¹ and antimitochondrial antibodies were uniformly present. Histological confirmation of the diagnosis was obtained in all