Correspondence

Hypoglycaemia and the Mind

SIR,—I read your leading article on "Hypoglycaemia and the Mind" (*Journal*, January 18, p. 150) with special interest, because many cases with indefinite symptoms for which no obvious cause can be found are referred to me with the diagnosis of spontaneous hypoglycaemia. In the majority, investigation under proper conditions of diet reveals no abnormality in carbohydrate metabolism, and the diagnosis of hypoglycaemia is found to have been made as a result of a failure either to appreciate the limits of a normal blood-sugar curve or the difference between total reducing and absolute glucose values. In this connexion it would be a good thing if pathologists were to state on blood-sugar reports not only the time of day at which the blood was taken but also the method of blood-sugar estimation used.

In my opinion the rather low figures which are sometimes found in patients labelled functional spontaneous hypoglycaemia are usually not responsible for the clinical picture, but only a common finding in association with certain types of emotional disorder, and I have found good psychotherapy sometimes more effective than low carbohydrate diet or buffer meals in correcting the blood-sugar level. Indiscriminate blood-sugar curves are no substitute for a careful history which would have revealed the true cause of the trouble—namely, *petit mal*—in the last two cases of so-called spontaneous hypoglycaemia who came to see me, complete with the usual bundle of biochemical investigations.—I am, etc.,

London, S.E.5.

WILFRID OAKLEY.

Respiratory Infections in the Family

SIR,—The authors of the paper on "Family Studies of Respiratory Infections" (*Journal*, January 18, p. 119) surely deserve congratulations on an exemplary and painstaking study of a most important subject. As a throat and ear surgeon I was particularly interested in Table XVIII and in the comments on this at the end of the "Summary and Conclusions." Many readers will be left with the impression that the figures prove the futility of tonsillectomy in these cases, at least from the clinical point of view and so far as the disorders listed are concerned.

It seems to me that the reverse can be argued equally well. The children whose tonsils had been removed cannot properly be compared in this connexion with those whose tonsils remained. It is reasonable to suppose that the former group was more liable to these disorders prior to operation than the latter and that it was this increased susceptibility which determined the decision to operate. Is it not a logical inference that tonsillectomy—and/or removal of adenoids, no doubt—had succeeded by rendering these children no more liable to the disorders studied than the erstwhile healthier group in which the question of this operation had not arisen?—I am, etc.,

London, S.E.1.

L. F. W. SALMON.

Sickle Cells and Salmonellae

SIR,—Your annotation "Sickle Cells and Salmonellae" (*Journal*, December 28, 1957, p. 1537) should stimulate interest in the curious and puzzling association between sickle-cell anaemia and salmonella infections. On reading it I was reminded of a paper by Cuadra¹ in which he records that patients suffering from Oroya fever (the haemolytic stage of bartonellosis) have a peculiar susceptibility to salmonella infections, and it would be interesting to know if there are records in the literature of salmonellosis complicating other forms of haemolytic anaemia.—I am, etc.,

London, N.W.1.

W. H. JOPLING.

REFERENCE

- ¹ Cuadra, C. M., *Texas Rep. Biol. Med.*, 1956, 14, 97.

Wheat, Antibiotics, and Intestinal Symptoms

SIR,—The unpleasant gastro-intestinal symptoms which so frequently follow treatment with chlortetracycline, and less frequently with the other antibiotics, have been attributed to many causes. An unsuspected aggravating cause of these symptoms is the eating of wheaten products. I have now observed five cases in whom the eating of bread excited severe cramp and diarrhoea, associated with a sometimes remarkable degree of intestinal flatus. In all cases pruritus ani was also present, but appeared to be unrelated to the eating of bread. The effects of eating wheaten products were related to the amount eaten, and each patient was able to find for himself the amount which could be tolerated. This condition is similar to the intestinal carbohydrate dyspepsia described by Hurst.¹ It is a simple matter to test this possibility as a cause of the symptoms, and one may be able to give the patient complete relief by restricting the amount of bread eaten.—I am, etc.,

London, N.W.3.

J. PEPYS.

REFERENCE

- ¹ Hurst, A., *British Encyclopaedia of Medical Practice*, 1937, 4, 370.

Fatty Liver of Endocrine Origin

SIR,—One of the experiments described by Drs. Joseph Gillman and Christine Gilbert in their paper on the fatty liver of endocrine origin (*Journal*, January 11, p. 57) shows that prolonged treatment of hypophysectomized baboons with cortisone can result in intense fatty infiltration of the liver. This prompts us to draw attention to the finding of a fatty liver in a case of Cushing's syndrome. The case was reported to the September meeting of the Association of Clinical Pathologists.¹ The patient was a woman aged 42 years and there was evidence of great overactivity of both the adrenal cortex and the pituitary. (Daily excretion of 17-ketogenic steroids was 110 mg. and the patient was deeply pigmented.) An operation for adrenalectomy was carried out and it was noticed that the liver appeared abnormal. A small biopsy was taken which on section revealed a very considerable fatty infiltration (see Fig.). There was also a slight but definite increase in the periportal fibrous tissue.—We are, etc.,

Section of liver stained for fat with Sudan IV. The central vein is shown and a portion of the portal area (x50).

P. N. COLEMAN.
A. W. B. EDMUNDS.

Northallerton, Yorkshire.

REFERENCE

- ¹ Edmunds, A. W. B., McKeown, K. C., and Coleman, P. N., *J. clin. Path.*, in press.

Plasma-cell Mastitis

SIR,—Mr. B. N. Colabawalla is to be congratulated on his report (*Journal*, December 7, 1957, p. 1352) of a typical case of plasma-cell mastitis which came under his observation. The paucity of cases recorded in the literature to date suggests that this condition is still continuing to pass unrecognized more than a quarter of a century after its original description.

The clinical picture was brought to light by Dr. Max Cutler¹ in 1931 following a study of 10 cases from the records of the Memorial Hospital in New York, and it was sufficiently characteristic to establish the condition as a clinical entity. The aetiology was clarified by Rodman and Ingleby,² of Philadelphia, in 1939, who claimed that it was a chemical irritation of the periductal tissues caused by products of lactation which had been retained in the milk ducts of the breast. They were able to reproduce the

histological picture experimentally by injecting pancreatized milk into the breast of virgin rabbits and pancreatic extracts into the breast of lactating rabbits. In 1941, along with Dr. M. B. Dockerty,¹ reported 24 cases of plasma-cell mastitis from material at the Mayo Clinic. The findings in this study confirmed the accuracy of Dr. Culter's original description and served to emphasize that the disease occurred only in parous women and frequently in those who for some reason or another had been unable to put the infant to the breast.

The characteristic clinical sequence of plasma-cell mastitis is that of a minor inflammatory episode in the non-lactating female breast, followed later by the discovery of a lump bearing all the hall-marks of malignant disease. Some of the patients, however, give no history of prodromal inflammation and present themselves with a history and findings indistinguishable from those of cancer of the breast. Accurate diagnosis is possible only by biopsy. Even where the clinical picture is complete, guesswork is too dangerous. Frozen sections are as accurate as the pathologist who interprets them. A pathologist accustomed to this technique can differentiate between plasma-cell mastitis and malignant disease by means of frozen sections, and in the majority of cases he should be able to identify the condition by the recognition of the typical low-grade inflammatory response, characterized by periductal infiltration of plasma cells, epithelial autonomy, the appearance of giant cells, and the phagocytosis of fat. The only condition for which plasma-cell mastitis is likely to be mistaken is mammary tuberculosis, and this error can be avoided by remembering that plasma-cell mastitis involves the ducts and periductal tissues while tuberculosis has a perivascular and perilymphatic distribution. Furthermore, in tuberculosis typical tubercles are nearly always found and they may contain caseous centres. In plasma-cell mastitis the tubercles are artifactual and caseation is not discernible.

There is no evidence to suggest that plasma-cell mastitis is related in any way to malignant disease, and treatment should be conservative. Until now the majority have felt that no special treatment is indicated in the early inflammatory stage and that in the later stage, after the diagnosis has been established by biopsy, local excision of the lump is all that is required. No harm has resulted where part of the exudate has been left behind after local excision, and radical surgery is definitely contraindicated, especially in the acute stage of the disease.

In 1949, Dr. Cutler⁴ reported a case—on which I commented⁵—in which very rapid regression of the mass in the breast had followed therapy by irradiation and suggested that irradiation should be tried in the acute stage with reasonable expectation that the lesion would regress and become more localized, thus facilitating surgical removal of the remnant. He also suggested the possibility that irradiation alone might suffice to resolve the lesion. In 1950, following this report, I referred a married woman of 28 years, mother of one child, with a typical plasma-cell mastitis of the left breast, confirmed by biopsy, for irradiation therapy. The condition regressed rapidly and there has been no evidence of recurrence in nearly eight years. The breast, however, is somewhat shrunken and the overlying skin is telangiectatic as a result of the irradiation.

We have, therefore, two means whereby this condition may be treated, surgery and irradiation. A third possibility is the use of steroid hormones. The causal irritant in plasma-cell mastitis is apparently a chemical one, and it seems probable that it would respond readily to the cortisone derivatives. I have not encountered a new case of plasma-cell mastitis since these hormones became available, and I would be greatly interested to hear the results in a case where they have been employed.—I am, etc.,

Ottawa Canada.

C. D. L. CROMAR.

REFERENCES

- 1 Cheate, G. L., and Cutler, M., *Tumors of the Breast*, 1931, pp. 298-304. A. Arnold, London.
- 2 Rodman, J. S., and Ingleby, H., *Ann. Surg.*, 1930, 109, 921.
- 3 Cromar, C. D. L., and Dockerty, M. B., *Proc. Mayo Clinic*, 1941, 16, 775.
- 4 Cutler, M., *Brit. med. J.*, 1949, 1, 94.
- 5 Cromar, C. D. L., *ibid.*, 1949, 1, 363.

Moulded Handles for Disabled

SIR,—Expanded handles for knives, forks, and spoons are widely used for patients with weak grip or deformed hands suffering from such conditions as hemiplegia, multiple sclerosis, or rheumatoid arthritis. Some handles are clumsy,

other devices have crevices difficult to clean. Those moulded to the individual patient's hands are to be preferred, but if professionally made by a three-stage process they are costly. Plastic wood is also used, but hardens too quickly, is apt to chip, and enamel or lacquer finish flakes off. A material was therefore sought which could be moulded by the patient gripping the handle in actual use, and which once hardened would present a clean smooth surface sterilizable by boiling and resistant to detergents and weak acids and alkalis likely to be found in food. "Vinagel" has been found to be most satisfactory for the purpose. It is made in two grades, soft (VG116) and hard (VG118), the softer being preferable. It is white, and, being of the consistency of plasticine, it can be moulded at leisure and smoothed off, retaining the main impressions of the patient's grip. The article is then heated in an oven at 150–160° C. for 20 to 30 minutes. The handle comes out a cream colour and has a slight resilience like hard rubber. Handles of table-ware made in this way have remained unchanged after several months' use in the wards with routine washing-up. Heating was done in ovens used for the sterile syringe service, but it can easily be done in a domestic oven by anyone. I am informed by the gas company that the approximate oven setting would be "C" or 2–3, but it can easily be found by trial and error. Undercooked, the handle will not be set; overcooked, it will turn brown.

I am indebted to Mr. R. Patterson, Curator, Castle Museum, York, for bringing vinagel to my notice; to Vinatex Limited, Devonshire Road, Carshalton, Surrey, for a sample supply; and to Mr. A. G. Deeks, Chief Pharmacist, City Hospital, York, for the use of sterile syringe service ovens and for testing the handles for resistance to detergents, acids, alkalis, etc.

—I am, etc.,

York.

E. GORDON WILKINS.

N-Phthalyl Glutamic Acid Imide (K 17)

SIR,—We read with interest the paper by Drs. J. McC. Murdoch and G. D. Campbell on the antithyroid activity of N-phthalyl glutamic acid imide (K 17) (*Journal*, January 11, p. 84), for we too have begun a similar investigation using a similar method. Drs. Murdoch and Campbell suggest that "it would seem unjustifiable to use the drug for long-term sedative or hypnotic therapy, pending the results of a more detailed study of its long-term effects in a larger series of patients, and notably those suffering from mild or moderately severe hyperthyroidism."

By good fortune we began with hyperthyroid patients and our results are therefore complementary to theirs. We are not yet ready to pronounce a final judgment, but our preliminary results suggest that the effects of the drug on the uptake of radioiodine in thyrotoxic patients, using single doses of 100, 300, or 400 mg., or divided doses of 300 mg. a day, for five days are negligible compared with those of carbimazole. We can confirm, as a result of experience still meagre, the sedative effects of the drug and the absence of "hangover"; but is it not a little unfair to describe as "side-effects" these actions for which the drug was introduced?—We are, etc.,

RAYMOND GREENE.

HELEN FARRAN.

London, N.W.3.

Recovery after Long-term Depressive Attack

SIR,—Dr. G. M. Woddie's article (*Journal*, December 14, 1957, p. 1412) and Dr. F. T. Thorpe's letter (*Journal*, December 28, 1957, p. 1542) show not only similarity from the psychiatric point of view of the cases described but also—as far as stated—from the physical point of view, as both patients, though over 60 at the time of their recovery, displayed no signs of arteriosclerotic changes. No more was said about their physical condition, though biochemical investigations, for example of the behaviour of the internal glands, especially the thyroid, during the period of illness and after the recovery, would be of considerable interest and could perhaps help to elucidate the cause of their disorder and/or their recovery.