It is therefore all the more distressing to find in the latest issue of a monthly index for medical specialties, under the heading "Ophthalmic Drugs—Locally-acting Steroid Preparations," the following indications for their use: "acute conjunctivitis, infection, and other eye irritations," "inflammatory eye infections," "conjunctivitis, corneal injuries, non-specific superficial keratitis," "infections of outer and anterior chamber," "inflammatory eye conditions," "inflammatory eye or ear conditions where infection is suspected," and "external inflammation of eyes and ears." These recommendations referred to eight preparations of various steroids, with or without assorted antibiotics. It must be conceded that in one or two cases a contraindication is mentioned, such as herpes simplex of the eye (including keratitis and ulcers) or herpes simplex: tuberculous eye infections.

Without wishing to denigrate the ability of one's colleagues, is it really reasonable to suppose that the vast majority of general practitioners, to whom these advertisements and suggestions are presumably directed, are in fact equipped to distinguish between herpes simplex of the eye, non-specific superficial punctate keratitis, and even tuberculous eye infections. Even to the ophthalmologist the diagnosis of the acute red eye is often a difficult matter.

In case it is felt that this is flogging a dying or even dead horse, it might be apposite to mention that only within the past two months have we had a case at this hospital of dendritic ulceration of the eye, treated for three weeks elsewhere with local steroids only, with resulting steady deterioration. We are fortunate in having been able to switch him over to 5-iodo-2-deoxyuridine, and the cornea is now healed—but should our patients have to rely on fortune?—I am, etc.,

Sussex Eye Hospital,
Brighton 7.

M. J. GILKES.

Too Many Vitamins

SIR,—Who will deny that we are becoming a nation of pill addicts? There can be few homes which do not contain a liberal assortment of tablets of varying shape, colour, and size; and the unrestricted sale of vitamins is swelling their number.

The public are led to believe that vitamins are a panacea for a great variety of ills. This is being accomplished by devious—and dubious—methods of advertising, including the dropping of sample tablets through the letter-box. There is in fact no evidence that vitamins given where no deficiency exists will cure or prevent any of the legions of ailments for which they are recommended.

It is generally held that vitamins are innocuous substances, and that, even if little good results from their ingestion, then at least no harm will occur. This however is not the case, as the habitual consumption of several vitamin tablets daily may result in overdosage manifesting itself in a variety of toxic effects. For example vitamin A poisoning may cause bone lesions in children, and hypervitaminosis D may cause decalcification of bones.

While gross vitamin deficiency must be rare in Britain, it has been suggested that many people may suffer from a "subclinical" deficiency state, the certain diagnosis of which is difficult; but if the diet is satisfactory and no physical abnormality is apparent, then a "subclinical" deficiency is unlikely. Even if such a deficiency does exist the correct treatment would be a well-balanced

diet. With the continuing rise in the standard of living and increasing awareness of disease by the public, more vitamin-rich foods are being eaten. Further, many foods now contain added vitamins, the addition being motivated either by a genuine desire to increase their nutritional value or as a "gimmick" to boost sales. If to this abundant vitamin intake supplementary vitamins are taken, then perhaps it is possible that many people are suffering from a "subclinical hypervitaminosis state"—a hitherto unknown condition.

Vitamins are potent therapeutic substances, and as such should be administered only by those qualified to judge their effects. I feel that unscrupulous advertising and unrestricted sales are to be condemned.—I am, etc.,

London S.E.1.

K. LANCER.

Local Hydrocortisone and Hypopigmentation

SIR,—We have been using hydrocortisone Roussel injectable (a 2.5% suspension of hydrocortisone acetate) as local injections for a variety of soft-tissue lesions like ganglion, tenosynovitis, De Quervain's disease, etc. In some of these patients a patch of hypopigmentation has developed at the site of injection. The number of patients amounts to eight. They are between 20 and 30 years of age, five being females, three males, and are otherwise normal. The hypopigmented patch appears two or three weeks after the injection and measures about 1–2 cm. in diameter. There is hypoaesthesia in the area. The other causes of hypopigmentation have been excluded. The hypopigmentation disappears of its own at the end of three to four months. This is essentially a preliminary report of this untoward effect not reported before. We have taken sections and investigated this phenomenon and studied the enzymatic activity, etc., of the affected skin. The patients are under observation and are being followed up. The patients have to be reassured that the hypopigmentation will disappear in due time, as they are much worried by it.—I am, etc.,

K.E.M. Hospital,
Bombay 12, India.

A. V. BAVADEKAR.

Pyocyanus Liver Abscess Treated with Colomycin

SIR,—Ascending cholangitis following choledochojunostomy is not an uncommon complication. Cholangitis with abscess formation due to a pure *Pseudomonas pyocyanea*, however, is rare and invariably fatal. The case reported survived with colomycin therapy after other antibiotics appeared to be ineffective.

A 39-year-old housewife was first seen with a seven-months' history of five attacks of obstructive jaundice, associated with a high temperature. The attacks lasted 7–14 days and settled without antibiotics. Clinical examination was unhelpful, the liver was not enlarged, and the gall-bladder was not definitely palpable, but a cholecystogram showed a non-functioning gall-bladder.

She was admitted for exploration of the common duct and laparotomy revealed a gall-bladder distended and opaque, with a grossly dilated common duct. Operating cholangiogram showed the duct to be almost completely obstructed at the upper border of the duodenum. Biopsy proved it to be a simple stricture. A cholecystectomy was performed, the common bile duct divided above the obstruction, which was not removed, and an end-to-side Roux-en-Y choledochojunostomy performed through the mesocolon. Liver biopsy showed evidence of early biliary cirrhosis. Penicillin and streptomycin were given for the first three

post-operative days, following which she made an uninterrupted recovery and was discharged home on the twelfth post-operative day.

After four days at home she was readmitted with a swinging temperature of 100° F.+ (37.8° C.+). She complained of shivering, and pain in the right subcostal region which radiated through to the back and which was aggravated by breathing and movement. Clinical examination revealed tenderness and guarding over the gall-bladder region, but there was no evidence of wound infection. Hb 74%, W.B.C. 11,900, serum albumin 3.3 g./100 ml., serum globulin 4 g./100 ml., serum alkaline phosphatase 70.2 units/100 ml., serum bilirubin 0.5 mg./100 ml. A differential diagnosis of either cholangitis or an intra-peritoneal abscess was made. Screening showed no evidence of a subphrenic abscess. She was given chloromycetin 250 mg. q.d.s. for 10 days, but as there was no improvement she was re-explored. No evidence of leak was found, but in the right lobe of the liver was a solitary liver abscess 4 cm. in diameter. This produced a small amount of pus on aspiration which yielded a heavy pure growth of *Ps. pyocyanea*, sensitive only to colomycin and polymyxin B. Colomycin 1 meg. unit eight-hourly intramuscularly was started with clinical improvement. As the supply of this

Clinical chart showing antibiotics given, their duration and clinical response.

drug at that time was limited, therapy was changed to polymyxin B 250,000 units four-hourly and streptomycin 0.5 g. b.d. The temperature rose dramatically to 103° F. (39.4° C.) and remained high and uncontrolled while on these drugs. A further supply of colomycin was then obtained and immediately she began to improve. The temperature gradually settled on this drug alone and she was discharged with a normal temperature. A positive blood culture was never obtained. Therapy continued at home for a further two weeks, since when the patient has remained well.

The accompanying temperature chart shows the drugs given, the duration, and the clinical response.—I am, etc.,

Birmingham.

P. DAWSON-EDWARDS.

"Weel" in the Sudan

SIR,—The condition of "Ataxic Neurological Syndrome" found in Tanganyika" reported by Dr. D. R. W. Haddock and others (December 1, p. 1442) was very interesting and prompts me to write on a similar syndrome I observed during my practice in Upper Nile late in 1961–2, as senior medical officer to the Province Hospital at Malakal in the Southern Sudan.

Although I do not recollect the complete clinical picture, I quite remember that unsteady gait and shakiness on standing were the presenting signs. The natives call it "Weel," which in their language means "ataxia." When admitted to hospital the patients used to recover on routine mixed hospital diet, but the response was more marked and quicker in those who received vitamin-B-complex injections, which substance constituted the only drug treatment used. No skin manifestations suggestive of any vitamin deficiency were observed in any of them on admission.

Although the standard native diet all over the province consisted mainly of fish and milk, with porridge and beer both made from native crops, cases used to come from certain localities in the province only.

Something about the condition was mentioned in *Annual Reports of the Upper Nile Province* for the years 1954–5 and 1955–6 by the province medical officers of health. They stated that the condition occurred in winter before crops of grain were ripe—i.e., during October to December, among the Shilluk tribe in Nikdyar and Tonga villages near the capital Malakal, and in Kodok District in the same province. It was groundlessly claimed by the natives to result from eating a certain type of fish named "aleny," or drinking native beer made from maize. The picture then described was that of unsteadiness on standing or walking, with a tendency to fall or stumble as if drunk. Another feature mentioned was laughter at trivialities. Others had abnormally increased appetite for any food whether properly cooked or not and used to steal food from a boiling pot and swallow it without any sign of feeling the scald. More severely affected patients used to lie in their houses and could hardly be awakened; others were violent and dangerous. Patients were described with convulsive fits leading sometimes to unconsciousness, blurred vision, and muttering delirium, but still with the staggering gait. The condition was believed to be contagious and a visitor to an infected family often developed the same syndrome. Thus the general custom amongst the natives was not to go or eat where the sickness existed, and the treatment adopted by them was early morning cold baths in the river.

Recently Dr. T. Baashar, senior psychiatrist to the Sudan Ministry of Health, reported certain psychiatric and neurological manifestations in these patients.

In one of the annual reports referred to above it was stated that 20 patients were once admitted to the Province Hospital and were divided into four groups on different lines of treatment with the following results: Group 1 on full hospital diet plus vitamin B complex showed dramatic response in 48 hours; Group 2 on full hospital diet only showed very slight response; Group 3 on native diet showed no improvement; Group 4 on boiled fish got worse.

It is perhaps worth mentioning that some eminent members of the Sudan Ministry of Health staff headed by Dr. A. M. Halim, senior physician to the Ministry, are showing special interest in the subject and are carrying out an organized study. It is believed that their investigations will soon give a clue to the nature of the condition and its proper management.—I am, etc.,

Khartum Hospital, Sudan.

F. N. SHAMSEDDIN.

School Medical Examinations

SIR,—May I enter a protest at the misrepresentation by Dr. G. D. Middleton (February 2, p. 332) of my reply to his inquiry about school medical examinations?

I wrote to him on September 16, 1960, forwarding a note of the wording of the Education Act, 1944, in relation to medical inspection. I quoted Sections 48(1) and 48(2) of the Act, the latter of which lays down the penalties for a failure to comply with the requirements of the Local Education Authority. In no way did I make any threat to Dr. Middleton.

Although I did inform Dr. Middleton that there was no such thing as contracting out of the obligation in this area, I also informed him that this obligation did not apply to treatment under the Act apart from the special education of children who are handicapped and the treatment of children with other defects. This last allusion, of course, referred to defects of cleanliness.

May I suggest that Dr. Middleton should direct his protests to the Ministry of Education, the body responsible for the passage of educational legislation through the Houses of Parliament.—I am, etc.,

Health Department,
Gateshead 8.

JAMES GRANT.