and then washed out with 1,080 ml. of fluid only.

The Table summarizes the amounts recovered in patients with barbiturate overdosage.

0-10 mg.	...	...	7 patients
11-100 "	...	...	5 "
101-250 "	...	...	4 "
251-500 "	...	...	3 "
over 500 "	...	...	3 "
		22	"

It will be seen that in no case did we fail to obtain some evidence of the drug, whereas Harstad *et al.* failed to do so in over half their cases. This may be because they used large volumes of fluid.

Dr. J. J. Alpert (19 December, p. 1593) advocates emesis. This can, of course, only be of value with a fully conscious patient, and in our experience few who have ingested significant amounts arrive in hospital early enough for this to be practical. It may have its place as a home remedy, but does not seem to us to have a place in hospital practice. We feel that at the moment the position regarding lavage should be summarized as follows—lavage with a small volume of fluid may be useful if strict precautions are taken to protect the lungs and the time since ingestion is short.—We are, etc.,

St. James' Hospital,
London S.W.12.

DAVID CARO.
E. KAWERAU.

REFERENCES

- 1 Starkenstein, E., Rost, E., and Pohl, J., *Toxicologie*, 1929, p. 24. Berlin.
- 2 Marriott, H. L., *Lancet*, 1933, 1, 962.
- 3 Harstad, E., Möller, K. O., and Simsen, M. H., *Acta med. scand.*, 1942, 112, 478.

Nephritis and Skin Diseases

SIR,—An association between nephritis and some common skin diseases is recorded by Dr. R. Summerly and Dr. P. W. M. Copeman (28 November, p. 1369). I here give brief details of a similar case.

The patient, a female of 61, consulted me with general malaise, dysphagia, fever of 102° F. (38.9° C.), and a generalized blotchy erythematous rash, urticarial in places. She blamed the illness on a horse-fly bite several days previously, as she had always before reacted severely to insect bites, though never in such a manner as this. Other factors considered as a possible cause were two Anadin tablets taken a week previously and Thermogen plaster applied to a strained back at the same time.

After two days of treatment with antihistamines her condition had deteriorated generally. Urinalysis disclosed considerable albuminuria. She was admitted to Freedom Fields Hospital, Plymouth, under the care of Dr. H. A. W. Forbes, for further investigation. Blood urea was found to be 260 mg./100 ml., with a severe acidosis. E.S.R. 65 mm./hr. Mid-stream urine, numerous pus cells, scanty red blood cells, and *Streptococcus faecalis* grown on culture. Hb 68%, blood-pressure 140/60 mm. Hg. Investigations for L.E. cells negative. Chest x-ray—heart enlarged; lung fields normal. Over the course of several months her condition slowly improved, and at the last count her blood urea was 105 mg./100 ml.

This patient had a history of scarlet fever in childhood and two general practitioners had recorded on her card in the past a high pulse pressure and aortic diastolic murmur. These signs were not elicited during the present illness, or on subsequent investigations, but do suggest the possibility of rheumatic heart disease and the streptococcal hypersensitivity discussed by Summerly and Copeman. It is also possible to

implicate the horse-fly bite as an antigenic stimulus, or, indeed, one of the components of Anadin tablets (aspirin, phenacetin, caffeine, and quinine).

—I am, etc.,

East Loos, Cornwall.

J. C. GATES.

Unusual Object

SIR,—I can recall that a house-physician had an experience similar to that described by Dr. P. N. Stanbury (26 December, p. 1660). After a residents' party, when he had consumed a quantity of alcohol, the house-physician went to the ward and drank straight down about a pint of milk. Next morning he was feeling extremely ill, and after vomiting several times brought up an object larger but similar to that described, undoubtedly solidified milk. It was thought by its shape that this object had been obstructing the pylorus, and the instant relief of all symptoms on disimpaction confirmed this view.—I am, etc.,

J. D. WHITESIDE.

Royal West Sussex Hospital,
Chichester, Sussex.

SIR,—Dr. P. N. Stanbury (26 December, p. 1660) may be interested to know that I too have had a case of a child who vomited a solid mass of caseinated milk, which appeared to have been causing an obstruction in the pylorus. In my case the child had an acute tonsillitis with a pyrexia and persistent vomiting for three days. The vomiting ceased dramatically immediately after the mass of solidified milk had been vomited.—I am, etc.,

Great Yarmouth,
Norfolk.

G. HURST.

New Dermatitis

SIR,—I am prompted by your leading article (19 December, p. 1547) entitled "A New Dermatitis" to report that we have recently seen a patient with a clinical syndrome apparently identical with that described by Sweet.¹

A 66-year-old female gave a past history of erythema nodosum in 1937 and severe osteoarthritis of hips and knees. She presented in May 1964 with a two-week history of malaise and aching in her limbs, neck, and back. A rash had appeared on her hands on the day of admission to hospital. It consisted of raised discrete patches of erythema on the dorsum of the hands and forearms, a plaque on the back of the neck and one on the right knee. General examination revealed a few small discrete cervical lymph nodes, marked hypertension, and a firm liver edge just palpable below the costal margin. She ran a remittent fever up to 102 to 103° F. (38.9-39.5° C.). Within the next few days the skin lesions, which were painful and irritating, became confluent and some areas began to develop small vesicles. Her E.S.R. was 62 mm. at one hour; total white cell count 14,300/c.mm. of which 82% were neutrophils. There was 0.3 part per 1,000 of albumin in the urine with occasional pus cells. Electrophoresis of the plasma proteins showed a moderate increase in α_1 and α_2 globulins. Blood cultures were sterile. Tests for L.E. cells and antinuclear factor were negative. Biopsy of the skin lesion showed a normal epidermis but marked dermal inflammatory reaction consisting of histiocytes and polymorphs. Culture of material from the biopsy was sterile.

Possible diagnoses considered included erysiploid of Rosenbach (although there was no his-

tory suggestive of contact with infected material), septicaemia, or a "collagenosis." A course of tetracycline followed by penicillin and streptomycin were without effect on the rash or pyrexia.

At this point Dr. P. J. Hare suggested the condition described by Dr. Sweet. Treatment was started with prednisolone, 10 mg. three times a day. The pyrexia fell to normal within 24 hours and the skin lesions faded over the next week with desquamation. After two weeks the blood leucocytosis had subsided. During the succeeding months she was gradually weaned off steroids and they were stopped in October without recurrence of symptoms.

This would seem to be a further example of acute febrile neutrophilic dermatosis.—I am, etc.,

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B. H. B. ROBINSON.

REFERENCE

- 1 Sweet, R. D., *Brit. J. Derm.*, 1964, 76, 349.

Buccal Oxytocin

SIR,—Since my return from Sweden my attention has been drawn to the correspondence in your columns on buccal oxytocin and in particular to the letter by Professor J. H. M. Pinkerton (28 November, p. 1393). A woman does not go into labour because of uterine contractions (which occur during all her reproductive life) unless they are preceded by changes in her vagina and cervix, in the composition of her blood, and probably by altered response to stimuli in her hypothalamus. These changes are associated with an increased sensitivity of her myometrium to oxytocin. It is nearly 30 years since I postulated that the hypothalamus controlled menstruation, ovulation, pregnancy, and parturition; that the onset of labour resulted from the removal of an "inhibition," not from an increase of oxytocin in the blood; and that the effective concentration of oxytocin in the blood matched the effective concentration of antidiuretic hormone (A.D.H.). The very first drip used for inducing labour was calculated on this assumption, and the amount then used (5 mU/min.) is the amount I advocate to-day.¹ Dr. Caldeyro-Barcia² agrees that the maximum amount of oxytocin given should not exceed 8 mU/min., and Dr. Hendricks³ affirms that 80% of his induction cases did not need more than 5 mU/min. of Syntocinon. The truly physiological oxytocin drip can be given to any patient deemed worthy of a trial of labour, whatever her past obstetric history. Most of those who use the oxytocin drip for inducing labour use higher concentrations of oxytocin, but it has never been shown that the pharmacological drip is more effective than the physiological one, and it is certainly less safe. Nevertheless oxytocin given into a vein can be stopped immediately, and I know of no centre in this country using this method efficiently where rupture of the uterus has occurred.

It is thus surprising that Professor Pinkerton writes: "Just how safe . . . [the buccal route] . . . is compared with the intravenous method is not yet established" notwithstanding the fact that he knows of six cases of rupture of the uterus occurring in a relatively small series of cases in which this route has been used. One wonders how many foetal or maternal deaths must occur before this point is settled.

The supposed advantages of the buccal route are: (1) that it is easy to use; and (2)