intracranial haemangioma is not "very rare," but usual, when it involves the upper part of the face.—I am, etc.,

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Hepatic Coma Due to Liver Metastases

SIR,—I doubt if hepatic failure due to liver metastases is as rare as Dr. N. R. Pal and his colleagues suggest (16 January, p. 168). Six years ago I mistook the syndrome for hepatic failure due to portal cirrhosis and have kept a wary eye open since. I now have records of five such patients—four men with carcinoma, respectively of the lung, stomach, pancreas, and colon, and one woman with carcinoma of the breast. The striking clinical features were: (1) the rapid progress of liver-cell failure (I have colour photographs of giant telangiectases which appeared in the course of a few days); (2) the presence of a hyperdynamic circulation, and in three patients portal hypertension; and (3) the enormous size of the liver—unusual in the terminal stages of portal cirrhosis.

The interesting thing is why liver failure is so uncommon in this situation. The explanation given by the authors that such patients die from other causes before the liver fails does not take account of the unusual phenomenon of hepatic enlargement; no other organ hypertrophies in response to the presence of metastases. The result is that there is usually adequate liver-cell tissue to maintain function. What one would like to know is whether there is a true increase in liver-cell mass, and, if so, the type of stimulus produced by the neoplasm. This might provide a clue to liver regeneration.—I am, etc.,

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Reactions to Intravenous Iron Dextran

SIR,—It was with some concern that we read the article by Dr. Barbara Clay and her colleagues (2 January, p. 29) on reactions to intravenous Imferon (iron dextran). Because this mode of therapy is invaluable in certain patients it would be unfortunate if their experiences prevented others from using it when necessary, particularly since—as the authors admit—their experience is not in accord with other published findings.

We note that the reactions occurred within a short time of starting the infusion, when only a very small volume of iron dextran could have been given. In a recent trial of parenteral iron therapy in pregnancy¹ we gave 153 intravenous injections of 2 ml. iron dextran as a test dose, with nausea and vomiting in only three patients, but collapse in none. We also gave 56 total-dose infusions and 191 large intravenous injections of iron dextran (15–23 ml.) without seeing reactions of a severity to cause us any anxiety, though flushing was a common feature with the large injections. In addition, prior to the trial, many hundreds of injections of 5 ml. iron dextran were given intravenously to other antenatal patients without untoward event.

The cause of the occasional reaction is not known, but multiple factors probably operate.² But the frequent reactions at Hull

suggest that their patients or their techniques were different from others. The technical aspects were investigated thoroughly without reward. Perhaps, then, their patients differed in some ways. It seems from the literature that reactions are more common in pregnant than in other patients. Because Scott³ noted reactions to intramuscular Jectofer (iron sorbitol) in patients with folic-acid deficiency, we always precede our injections with folic acid. The Hull workers make no mention of the marrow picture in their patients, and folate deficiency is common in late pregnancy. The subsequent rise in haemoglobin on oral iron in some of their patients does not exclude concomitant folic-acid deficiency.⁴

We also excluded all patients with infections from our trials, making sure that we were treating pure iron deficiency. We would be interested to know whether Clay and her co-workers were treating such anaemias. Since headaches, nausea, and vomiting occur with similar frequency with intramuscular iron dextran and iron sorbitol, it would be regrettable if the intravenous therapy, which we consider the most practicable, were abandoned because of the extraordinary findings from one centre only. Were others to record such an incidence of severe reactions, then we would obviously have to reassess our position.—We are, etc.,

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- 2 Fielding, J., *J. clin. Path.*, 1963, **16**, 12.
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SIR,—During the course of my six months' obstetrics and gynaecology house appointment at this hospital I have been involved with about 20 total-dose Imferon (iron dextran) infusions. There has not been a single case of reaction to the infusion during this time. Our method of administration is almost identical with that practised at Hull Maternity Hospital, with one important exception. We dilute the iron dextran in normal saline solution and not in 5% dextrose solution. This seems to suggest that some compound is formed between the dextrose and the iron dextran which is detrimental to the patients.

Incidentally, provided that the infusion is run in slowly, we find that the presence of the pre-eclamptic toxæmia is not a contra-indication to the use of this method.—I am, etc.,

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Suspected Reactions to Nalidixic Acid

SIR,—We were interested to read Dr. D. A. Cahal's comments (9 January, p. 130) regarding suspected reactions to nalidixic acid (Negram). Recently we have seen two patients who exhibited skin abnormalities following ingestion of this drug.

The first patient, a woman aged 25, had a past history of pre-eclamptic toxæmia and hyperten-

sion. She was seen at the artificial kidney unit, where the overall assessment was of chronic uraemia with malignant hypertension of relatively recent onset. A week prior to her admission she had been given a course of Negram. Two days after commencing this course the patient was exposed to sunlight, and shortly thereafter became aware of redness, swelling, and blistering of the exposed forearms, dorsa of hands and feet, tip of nose, and lower lip. There was no past or family history of skin disease, and the L.E., latex test, and urinary-porphyrins investigations were normal.

The second patient, a man aged 55, was referred to our department with a dry pityriasiform eruption affecting mainly the limbs, including hands and feet. The rash was psoriasiform in places, especially on palms, soles, and on the nails. On questioning, the patient related that he had been taking Negram tablets for a urinary infection prior to the onset of his skin condition. A drug eruption was diagnosed.

In both patients the eruption subsided with routine treatment.

—We are, etc.,

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Side-effects of Phenothiazine Drugs

SIR,—In your leading article (5 December, p. 1412) on the side-effects of phenothiazine drugs an irreversible syndrome of dyskinesia affecting the face, mouth, tongue, and jaw is described. It may be of interest to report the occurrence of this syndrome, characterized by severe grimacing and tongue protrusion, in a woman aged 60. This patient has been in a mental hospital for 25 years suffering from a manic-depressive psychosis. She has had repeated courses of E.C.T. during this period and chlorpromazine in an average dose of 200 mg. daily for at least two years. Following this period of phenothiazine treatment the dyskinetic syndrome developed insidiously. Cessation of drug therapy was followed by complete remission of symptoms within three months. As the syndrome was apparently reversible in this patient, chlorpromazine was restarted and the fly-catching tongue movements and grimacing again became manifest within four weeks. This therapy will now be discontinued and we would expect the syndrome to remit again.

We would agree that it is important to be on the look-out for this syndrome, but it would appear that it is not necessarily irreversible.—We are, etc.,

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J. H. S. WHYTE.

Local Analgesics

SIR,—Dr. T. N. P. Wilton (19 December, p. 1595) and Dr. J. A. Thornton (2 January, p. 59) have described the very good results obtained with the topical use of 4% prilocaine (Citanest). There is no doubt that the low toxicity of this drug makes it a valuable addition to local analgesics.

Dr. J. W. Mostert (2 January, p. 59) prefers to use mepivacaine (Carbocaine) on the grounds that it is a more potent agent than prilocaine. There is very good evidence, however, that lignocaine, prilocaine, and mepi-