normal. Mental status examination revealed poor self care, hyperactivity, vacant smiling, excessive talking, grandiose ideas which were not very prominent, mildly elated affect and insomnia in a clear sensorium with impaired insight. Investigations including hemogram, urinalysis, LFT, SGOT, SGPT, Blood sugar (fasting and post-prandial), blood urea, serum creatinine, VDRL, skull radiograph and funduscopy were within normal limits. With a diagnosis of unspecified psychosis he was treated with Tab Trifluoperazine (5mg) 1 TDS. Tab Carbamazepine (200 mg) BD was added wef 14 Mar 97 and increased to 1 TDS wef 20 Mar 97. Patient's mental status gradually stabilised. On 13 April 97 onwards he developed successive crops of multiple erythematous rashes all over the body associated with superficial ulcerated lesions in oral cavity, lips and glans penis along with fever and burning sensation all over the body.

On examination temperature was 103.8° F and pulse 114/min. Systemic exam was normal. Dermatological exam showed numerous, discrete, erythematous, maculopapular lesions with target lesions in between and central cyanosis, symmetrically distributed all over the body including trunk, extremities, palms and soles.

Multiple superficial ulcerated lesions in buccal mucosa, lips and glans penis were also present. Repeat hemogram, urinalysis, X-ray chest PA view and ELISA for HIV were within normal limits. All medications were stopped. He was treated with oral and parenteral steroids, antibiotics and other supportive measures and gradually recovered over the next four weeks. Thereafter he was stabilised with Tab Trifluoperazine.

Erythema multiforme is more commonly precipitated by various infections and therefore many instances may have been wrongly blamed on drugs. In the present case, however, no infection was present. Clinically macular, papular or urticarial lesions, as well as the classical iris or 'target lesions' sometimes with central vesicles, bullae or purpura, are distributed preferentially on the distal extremities but may involve the palms or trunks as seen in our patient. Involvement of conjunctival, corneal, iris, buccal, labial and genital mucous membranes occurs in the Stevens-Johnson syndrome [1].

In a prospective study of erythema multiforme, only 10% were drug related [2], but re-exposure has confirmed a drug cause in many instances. Since re-exposure to a drug suspected of causing the reaction has resulted in fatality, it should not be carried out for

diagnostic purpose [1], and therefore was not attempted in our patient.

Studies on carbamazepine in psychiatry have mostly reported its efficacy in different mental disorders, but its adverse effects in psychiatric patients have found little attention [3]. The belief that adverse effects in psychiatric patients are as frequent as in neurological patients is not true [3]. The 10-15% incidence of skin rashes reported in psychiatric patients on carbamazepine [4,5] is much higher than the 3% incidence in neurological patient[1,3].

Similarly the observation about the rarity of erythema multiforme in neurological patients while on carbamazepine therapy may not hold good for psychiatric patients.

Regardless of its frequency, the occurrence of a potentially fatal side-effect like erythema multiforme highlights the fact that carbamazepine treatment carries potential risks which should be weighed against its benefits before initiating therapy especially in psychiatric patients.

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MEHTA'S PERIOSTEAL ELEVATOR-A NEW SURGICAL INSTRUMENT

Dear Editor,

The usual instruments employed to raise the mucoperiosteum in nasal and septal surgery are the Freer's and Joseph's periosteal elevators. Surgical procedures in this highly vascularised area result in haemorrhage which tends to obscure the plane of dissection and requires constant suctioning to clear the operative field.

To obviate the need for dual instrumentation in narrow confines of the nose and the actions of periosteal elevation and suction have been combined into one instrument (Fig 1).

The instrument is made of stainless steel. It consists of a hollow tube one end of which is bevelled to serve the purpose of an elevator. The other end is knob shaped to which a flexible suction tubing can

be attached. It has a handle for firm grip and a small opening midway for suction control (Fig 2).

This instrument has very successfully been tried during Septoplasty, rhinoplasty and mastoidectomy. It can very comfortably be used for palatal surgeries, thyroid cartilage surgeries and in any situation where profuse haemorrhage is expected during periosteal elevation.

Lt Col AK MEHTA

Classified Specialist ENT, President SMB, C/o Military Hospital, Bhopal.

Fig. 1 : Mehta's periosteal elevator

Fig. 2 : Sectional drawing of periosteal elevator

MEHTA'S MODIFICATION OF NASAL DRESSING FORCEPS

Dear Editor,

Anterior nasal packing is the usual method of controlling epistaxis. The nasal pack is put in place using Tilley's nasal dressing forceps. Presence of profuse epistaxis hampers proper placement of the anterior nasal pack and simultaneous suction has to be done to clear the operative field.

To obviate the need for dual instrumentation a separate suction channel has been incorporated into the nasal dressing forceps (Fig 1). The upper limb of the standard nasal dressing forceps has been removed and replaced by a hollow tubing which is continued down along the handle of the forceps and has an adaptor attached to it for connecting to suction machine. The proximal end is flattened and grooved to provide better grip of the nasal pack and a small opening is made at a convenient site along the hollow tubing for finger control of the suction (Fig 2).

Fig. 1 : Modified nasal dressing forceps

This instrument has been tried successfully at our hospital.

Lt Col AK MEHTA

Classified Specialist ENT, President Special Medical Board, C/o Military Hospital, Bhopal.

Fig. 2 : Diagrammatic representation of nasal dressing forceps