

## CORRESPONDENCE

Correspondents are asked to be brief

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### Holiday Cholera and Other Vibrios

SIR,—With the approach of the summer season, your warning (8 April, p. 62) to all concerned about the hazards of holiday cholera is timely. As you rightly indicate, the clinical picture may vary from acute gastroenteritis to mild diarrhoea, or even symptomless excretion of the organisms. *Vibrio cholerae* is not, however, the only vibrio which may cause such illness in travellers returning from abroad. The actual diagnosis depends on isolation of the causative organism, and other vibrios, particularly *V. parahaemolyticus*, should also be considered.

This halophilic marine vibrio was first identified in Japan, where it is associated with the consumption of raw fish and other sea-food products, and is now the commonest cause of food poisoning in summer.<sup>1</sup> It is almost certainly widely distributed throughout the world and is becoming more generally recognized as an important or potential pathogen. Its significance as an endemic cause of food poisoning in Britain is not yet known, although its presence in various marine products has been confirmed recently.<sup>2</sup> It may also be imported not only by travellers but also commercially in sea-foods. *V. parahaemolyticus*, like cholera and other enteric pathogens, should therefore be sought in all cases of gastroenteritis in persons who have recently returned from abroad, and also from anyone who has consumed sea-foods. The possibility of cross-contamination to other foods should not be forgotten. Indeed, for the first time in Britain, *V. parahaemolyticus* has just been identified as the cause of acute gastroenteritis among airline passengers who had eaten cooked crab-meat served as hors d'oeuvres during a flight from Bangkok to London.<sup>3</sup> Apart from the Far East, food poisoning caused by this organism has recently been reported also in Australia<sup>4</sup> and the U.S.A.<sup>5</sup>

As in cholera, *V. parahaemolyticus* is ex-

creted in large numbers during illness, but the vibrios diminish rapidly with clinical recovery. The role of possible carriers is not known, but direct transfer from one person to another does not seem to be important. Adequate clinical and epidemiological information is essential to ensure that suitable cultural techniques are used for appropriate specimens. Fortunately, *V. parahaemolyticus* can be isolated by the same media and methods used for cholera organisms, though salt-colistin or glucose-salt-teepol broth may also be employed for enrichment culture.<sup>1</sup> *V. parahaemolyticus* forms large characteristic green colonies on thiosulphate citrate bile-salt sucrose (TCBS) medium in contrast to the yellow sucrose-fermenting colonies of *V. cholerae*. Whatever media used, however, any Gram-negative organisms which are motile, oxidase- and catalase-positive, and sensitive to methylene blue<sup>6</sup> and vibriostatic agent 0/129 (2, 4-diamino-6, 7-di-isopropylpterdine phosphate)<sup>7</sup> should be regarded as vibrios and further identified. If this were done, infection with non-cholera vibrios, including *V. parahaemolyticus*, might be recognized more often.—I am, etc.,

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<sup>1</sup> Sakazaki, R., in *Foodborne Infections and Intoxications* (ed. H. Riemann), p. 115. New York, Academic Press, 1969.

<sup>2</sup> Barrow, G. I., and Miller, D. C., *Lancet*, 1972, **1**, 485.

<sup>3</sup> *British Medical Journal*, 1972, **1**, 701.

<sup>4</sup> Bartey, Y. M., Wallace, R. B., Allan, B. C., and Keeffe B. M., *Medical Journal of Australia*, 1970, **1**, 430.

<sup>5</sup> *Morbidity and Mortality*, 1971, **20**, 356.

<sup>6</sup> Yan, W. K., *Journal of Medical Laboratory Technology*, 1969, **26**, 90.

<sup>7</sup> Shewan, J. M., Hodgkiss, W., and Liston, J., *Nature*, 1954, **173**, 208.

### Digoxin Dosage

SIR,—The need for individual adjustment of digoxin dosage in elderly patients is now widely recognized. It is particularly impor-

tant to reduce maintenance dosage to a minimal effective level. Even the conventional dose of 0.25 mg daily may be excessive for certain patients, and it is here that one runs into practical problems. I can prescribe either a half tablet dose—that is, 0.125 mg—or a Paediatric-Geriatric ("P-G") tablet of 0.0625 mg strength. Such complex decimals and unwieldy numbers are inconvenient and faintly ludicrous, not to say potentially hazardous. Such awkward fractions may also lead to a reluctance to prescribe sufficiently small doses of digoxin whenever indicated.

Why can we not have digoxin tablets in two distinct, sensible, and easily-written strengths—0.2 mg and 0.1 mg? Tablets of 0.1 mg would be scored so as to be easily divided into doses of 0.05 mg. The drug would then be prescribed in three strengths for adults—0.2 mg, 0.1 mg, and 0.05 mg—instead of the present clumsy doses of 0.25 mg, 0.125 mg, and 0.0625 mg, respectively. The former doses are more succinct and more sensible; admittedly they are fractionally smaller than the present standard doses but probably the better for that.

Lastly, it must always be remembered that a long-accustomed dose of digoxin in an elderly person may at any time become excessive—for example, in the presence of potassium deficiency, or as may be caused by potent diuretics, or defective renal function. It used to be said, "once digitalis, always digitalis," but is prolonged maintenance treatment always really necessary? Very often it is, albeit sometimes in an infinitesimal dose.—I am, etc.,

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### Survival of Gonococci Outside the Body

SIR,—The possibility of acquiring gonorrhoea by non-venereal contact has been considered.<sup>1-4</sup> In order to shed further light on