LETTERS

Dissension in the ranks

To the editor: Dissension in the ranks of any society is always cause for concern. Left unchecked it can erode and destroy the fabric of even the strongest organization. Who would have dreamed that the mighty Montreal Canadiens would succumb to dissension and drop out of the Stanley Cup race so early this year?

At a time when the medical profession is facing a declining public image and increasing government intrusion into our freedom to practise we can ill afford to have dissension within our ranks.

The recent, rather heated dispute between the Canadian Federation of Medical Students and the College of Family Physicians of Canada (CFPC) over the elimination of the practice eligibility route to certification in the college has given rise to such concern that the Board of Directors recently directed the executive of the Canadian Medical Association (CMA) to meet with the executive of the CFPC to examine the argument. The problem is not simple, and it has political and economic overtones that make both sides reluctant to soften their position. The CFPC is committed to provide residency training programs in family medicine that will sustain and improve the professional qualifications of members of the medical profession who are engaged in family practice in Canada. Nobody would quarrel with this objective. However, the manner in which the college seeks to attain this goal has the students and many rank-and-file members of the CMA, as well as some certificants of the CFPC, concerned.

The students see certification in the college as a prerequisite to hospital appointment in the not too distant future. The fact that at present only a few hospitals have such regulation and that the CFPC does not advocate such a policy does little to allay the students' fears.

Family practice residency positions are limited. There are not enough places available to handle the projected number of applicants. It is highly unlikely that, in this time of fiscal constraint, government will provide the necessary funding for additional residency positions. That the students are used as pawns in a political power play to achieve these aims is unfair. They are angry and have spoken out. There is much sympathy for their cause — and so there should be.

To the CFPC we ask: Is it worth forging ahead with the 1980 cut-off date and alienating many of the young men and women who should be the backbone of your college in a few short years? There is still time to reconsider your decision and avoid dissension among the ranks.

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President
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Contributions to the Letters section are welcomed and if considered suitable will be published as space permits. They should be no longer than 1½ pages typewritten double-spaced. They may be edited and abridged.

Treatment of rabid-bat bite

To the editor: On June 24, 1980 a 41-year-old telephone company employee, while opening the door of a telephone tower, was attacked by a bat and bitten on the right hand; blood was drawn. When the bat came in for a second attack the man knocked it down and killed it.

The following day the animal pathology laboratory of the Department of Agriculture in Sackville, NB reported that the silver-haired bat (*Lasionycteris noctivagans*) had rabies. The man's family physician immediately instituted a 14-day regimen with duck embryo vaccine. After 2 days of treatment rabies immune globulin and human diploid cell vaccines were substituted for the duck embryo vaccine. The human diploid cell vaccine was administered on the 3rd, 7th, 14th, 28th and 90th days, according to accepted recommendations.

Arrangements were made with the virus laboratory of the Ontario Ministry of Health for rabies antibody determinations. The antibody titres are given in Table I. They indicate a favourable response to the treatment now available to persons who have been bitten by rabid animals.

Two other individuals in this health region were bitten by grey bats, which are common in New

Table I—Rabies antibody titres in serum of man bitten by rabid bat on June 24 and treated with duck embryo vaccine for 2 days, then with rabies immune globulin and human diploid cell vaccine

Date blood collected	Titre
July	
2	< 1:8
15	< 1:8
29	1:16
August	
1	1:16
8	1:64
29	1:64
September	
2	1:32
5	1:64
15	1:32
22	1:64
29	1:64
October	
8	1:64

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Brunswick. Treatment was instituted but discontinued when the bats were found to be free of rabies.

I thank the physicians, nurses and technicians for the treatment and serum collections, and Mrs. D. Pukitis of the virus laboratory in Toronto, who analysed the serum for rabies antibody.

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Potentially lethal interaction of cimetidine and morphine

To the editor: We wish to report a potentially lethal side effect due to interaction between cimetidine and morphine.

Case report

A 46-year-old patient undergoing long-term hemodialysis was in hospital from May to October 1980 because of several problems, including repeated difficulty with access to blood vessels, septicemia, bleeding from the upper gastrointestinal tract, cardiac failure and an intertrochanteric femoral fracture.

He was receiving hemodialysis three times a week and 100 mg of phenytoin by mouth every 8 hours because of grand mal seizures in the past. He required large amounts of parenterally administered analgesics for hip and leg pain, and in June 1980 he received 10 mg of morphine intramuscularly every 3 hours for a total of nine doses; no side effects were noted.

On Sept. 9, 1980 oral therapy with cimetidine, 300 mg three times daily, was begun because of a bleeding gastric ulcer. Four days later, treatment with morphine, 15 mg intramuscularly every 4 hours, was resumed when his hip pain worsened. Shortly after the sixth dose of morphine, on Sept. 14, he became apneic, with a respiratory rate of 3/min, and had a grand mal seizure. He was given naloxone, 0.4 mg intravenously, and his respiratory rate increased to 12/min. He remained confused and disoriented, and was noted to have generalized twitching, more marked in his face. Cimetidine therapy was stopped and 100 mg of phenytoin was given intravenously twice a day. Over the next 80 hours he remained confused and agitated, and had muscle twitching and periods of apnea that always responded to naloxone (he required a total of eight doses). Respiratory acidosis developed, the carbon dioxide pressure in arterial blood reaching 68 mm Hg. Hemodialysis was performed twice in this period, for 5 hours on each occasion, to remove circulating cimetidine; a Gambro H dialyzer (Lund, Sweden), with a blood flow of 200 ml/min, was used. No change in his clinical status was noted after each dialysis session.

After recovering from this episode without sequelae he required no further analgesics, despite having needed parenteral analgesic therapy almost continuously for 2 months.

No cimetidine was found in a blood sample (kindly analysed by Dr. S.J. Soldin, Hospital for Sick Children, Toronto) drawn on Sept. 16, 36 hours after the patient had received his last dose of the drug; dialysis had been performed the previous day. His symptoms, however, persisted for a further 36 hours.

When surgical revision of a leg stump was required in October oral cimetidine therapy was restarted, but at a much lower dosage — 150 mg twice daily. Postoperatively the patient received seven doses of Pantopon (total opium alkaloids), 15 mg intramuscularly every 3 to 6 hours. After the last dose he became apneic, confused and disoriented, and had diffuse muscle twitching. He responded to naloxone (though acute paranoid psychosis developed after he received one dose) and required four 0.4-mg doses over the next 24 hours. He then recovered fully.

Comments

The side effects observed in this patient were identical to those reported by others for cimetidine.[1] They were clearly not related to high blood concentrations of this drug, for in the first episode they persisted for 36 hours after cimetidine was no longer detectable in the blood, and the dosage of cimetidine was much lower when the