Letters

Legionellosis in British Columbia

To the editor: Legionellosis is being recognized with increasing frequency. However, its laboratory diagnosis is still largely retrospective and based on serologic findings. Commercial culture media have recently been introduced that will greatly facilitate isolation and identification. *Legionella longbeachae* was first reported in British Columbia in October 1981.[1] Since then two patients have died from this infection. *Legionella* was demonstrated by Gram-staining of respiratory exudate, including sputum, with 0.05% carbol fuchsin as the counterstain.

The first patient, a 67-year-old legal secretary, was admitted to hospital in October 1981 with a 10-day history of a virus-like illness complicated by diarrhea and anuria 2 days prior to admission. She had bilateral pneumonia and died 48 hours after admission. Before she died, gram-negative bacilli were detected in a direct smear of sputum. This prompted the administration of gentamicin and erythromycin. The bacilli did not grow on routine culture media. At autopsy the bronchi were found to contain a golden mucoid exudate, and the lungs were scattered with well demarcated areas of consolidation from which pus could not be expressed. Smears from the bronchial exudate and the lungs, counterstained with 0.05% carbol fuchsin, showed many gram-negative bacilli in neutrophils and extracellularly. Culture of exudate and lung tissue on BCYE (buffered charcoal–yeast extract agar; Remel, Lenexa, Kansas) yielded a pure growth of *L. pneumophila*, serotype 1. Viral cultures were negative. The organisms could also be demonstrated in deparaffinized tissue sections treated with Gram's stain and 0.05% carbol fuchsin as the counterstain. Blood taken at autopsy had a titre of 1:64 for *L. pneumophila*.

The second case was confirmed as being caused by *L. pneumophila*, serotype 2 by direct fluorescent antibody staining of a lung section obtained at autopsy. The patient, a 44-year-old logger, died of acute pneumonia in October 1981. Again the organisms were demonstrated in the lung tissue with Gram's stain.

For rapid diagnosis direct fluorescent antibody staining is the best method but may not be widely available. However, direct Gram's staining of a smear of sputum is a routine procedure, and it is easy to substitute 0.05% carbol fuchsin for other counterstains. The recognition of the organisms on such smears in these two cases raises the possibility of early detection in other cases. Gram-negative bacilli resembling *Legionella* in a smear, in the absence of cultured *Haemophilus* or coliform bacilli, would be highly suggestive of legionellosis and should lead to appropriate culture procedures and therapy. Thus, some of the deaths from this disease might be prevented.

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CMAJ tries to publish as wide a selection of letters to the editor as possible. We can accept more letters and publish them more promptly if they are short and convenient to edit. We ask that letters be no more than two typescript pages (450 words) long, and that they be typed double-spaced with wide margins, like a manuscript.

How to read clinical journals

To the editor: Dr. Pierre Biron's bouquet (*Can Med Assoc J* 1981; 125: 699) for the series on how to read clinical journals has just caught up with me on sabbatical here in Dublin.

I bask in his praise and remind readers that the series is a joint effort with Brian Haynes, Peter Tugwell and other colleagues who share a determination to publish such work in a Canadian journal.

The series has been used to help students, house staff and practitioners learn how to be more critical in their assessment of clinical data, both at McMaster and elsewhere. The second workshop on teaching the critical assessment of clinical data will be held in Hamilton from Sept. 27 to Oct. 1, 1982. Those who want to learn more about this workshop should contact Ms. Kathy Bennett, Rm. 2C1, McMaster University Health Sciences Centre, 1200 Main St. W, Hamilton, Ont. L8N 3Z5.

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Ophthalmologists and optometrists

To the editor: I would like to correct two statements that appeared in the Publisher's Page "Ophthalmologists and optometrists" in the Feb. 1, 1982 issue of the Journal.

Optometrists do not prescribe any drugs for their patients. There are no provisions under the Health Disciplines Act for them to do so, and this legal right has not been sought. Optometrists do use topical anesthetics to facilitate the measurement of intraocular pressure and for applying contact lenses. I do not have any knowledge of optometrists prescribing drugs for their patients anywhere in Canada.

Optometrists, by virtue of their training and by law, do refer and are required to refer patients to a legally qualified medical practitioner when there is a condition of the eye or adnexa that appears to require medical attention. Failure to do so becomes a matter of professional misconduct under the Health Disciplines Act.

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Ear-crease sign and coronary artery disease

To the editor: The reaffirmation of the predictive value of the ear-crease sign by Drs. Pasternac and Sami (*Can Med Assoc J* 1982; 126: 645–649) has

prompted my response. The puzzle of this curious sign preoccupied my mind for many weeks, and eventually I came up with a possible explanation. I realized that if I went to bed at night with some silly, insoluble irritation still worrying me, I frequently laid my head down in such a fashion that the lower part of my ear was folded over so that the earlobe was creased. When I laid down to sleep with no irritations I never did this.

Notwithstanding the various ideas that have been put forward to account for this sign, may I suggest the possibility that its manifestation represents the result of a subconscious attempt to counteract the presence of stress? If so, the association of the ear-crease sign with coronary artery disease would then be indirect, via the common factor of stress.

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Nosocomial transmission of listeriosis?

To the editor: From March to September 1981 the Atlantic provinces of Canada experienced probably the largest outbreak of listeriosis on record.[1] Of the 45 cases 35 were perinatal. The last two are of interest because of the possibility of nosocomial transmission, as described in previous reports.[2,3]

The two cases involved babies born on the same day in a New Brunswick hospital. Neither case was typical in that *Listeria monocytogenes* could not be grown from samples of blood or cerebrospinal fluid.

The first mother had had a flu-like illness just before delivery by cesarean section (for fetal distress) at 34 weeks' gestation. *L. monocytogenes* was cultured from meconium-stained amniotic fluid taken from the vagina just after spontaneous rupture of the membranes. The infant had only a mild pneumonia, but the organism was cultured from axillary and throat swabs.

The second mother gave no history of illness during her pregnancy. Her infant, of 42 weeks' gestation, was also delivered by cesarean section (for cephalopelvic disproportion), but there were no signs of infection in mother or baby. Gastroenteritis developed 2 days after birth, and *L. monocytogenes* was grown in pure culture from a rectal swab.

A routine antibiotic regimen is prescribed for all mothers who deliver by cesarean section. Therefore, the negative culture results with specimens taken from the second mother after the antibiotic prophylaxis was begun could not rule out the possibility that she was harbouring the organism at the time of hospital admission. Although no specific route of infection could be incriminated, there is a distinct possibility of nosocomial transmission: the two mothers occupied the same hospital room, the same medical attendants were present at the two cesarean sections and the same nursing staff later handled the two infants in a 3-hour period.

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1. Listeriosis — Atlantic provinces. *Can Dis Wkly Rep* 1981; 7: 257–259, 262
2. CAMPBELL AN, SILL PR, WARDLE JK: Listeria meningitis acquired by cross-infection in a delivery suite. *Lancet* 1981; 2: 752–753
3. LARSSON S, CEDERBERG A, IVARSSON S, SVANBERG L, CRONBERG S: Listeria monocytogenes causing hospital-acquired enterocolitis and meningitis in newborn infants. *Br Med J* 1978; 2: 473–474

Preventing motion sickness

To the editor: I would like to relate my personal experience with a new product for preventing motion sickness (Transderm-V, CIBA Pharmaceuticals). A disc containing scopolamine is placed behind the ear and delivers medication over 72 hours for prophylaxis against nausea and vomiting.

I placed the disc behind my left ear at approximately 11 am on the first day. By 11 that night my left pupil was noticeably larger than the right. I left the disc on overnight but removed it at 8 the next morning because of a very dry mouth. By this time the left pupil was markedly dilated and my vision was slightly blurred. There was no change in the right eye. The pupil dilation persisted until approximately 9 that evening.

One other case of cycloplegia with Transderm-V has been reported in the literature to date.[1] I suggest physicians be aware of this, especially if practising in holiday resorts and emergency departments. As Chiaramonte[1] pointed out, this information is not listed in the product monograph and patients may become alarmed at its occurrence. A patient who has one fixed and dilated pupil should be checked for use of this product before being subjected to other neurologic examinations.

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Reference

1. CHIARAMONTE JS: Cycloplegia from transdermal scopolamine (C). *N Engl J Med* 1982; 306: 174

Labour pain

To the editor: Some of the views expressed in the letters to the editor from Louise Hanvey and Dr. Michael Klein (*Can Med Assoc J* 1981; 126: 354, 357) recall the 19th-century controversy among accoucheurs about the use of chloroform and ether in obstetric practice. I found it refreshing to read the reply from Drs. Melzack and Kinch (ibid: 357).

I believe it is impossible to teach "natural childbirth" without "laying on" the message that if the woman in labour "relaxes" there will be no, or at least not too much, pain. I also believe it is quite inappropriate to give that message to primiparas when it is patently untrue for most. The figures of Melzack and Kinch indicated this.

Surely it is de rigueur to be forthright about a motherhood issue!

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Hepatitis B markers in Indochinese refugees

To the editor: The article by Dr. R.K. Chaudhary and colleagues on the prevalence of hepatitis B markers in Indochinese refugees (*Can Med Assoc J* 1981; 125: 1243–1246) addresses only the results for those who were tested in the federal mass screening program for refugees. At no point in the article is the compliance of refugees mentioned. In a recent review of hepatitis B test results among refugees destined for British Columbia we determined that only 42% of refugees were actually tested for hepatitis B markers on entry to Canada. In our view, in order that the potential selection bias may be assessed by the reader it is important that the compliance with this program be analysed and stated. It should not be assumed that the refugees tested in this program were representative of the refugee movement.

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