rash and diarrhoea on November 12 and all drugs were discontinued on November 15. As there had been no improvement, she was admitted to hospital on November 18.

On examination she was grossly thyrotoxic, being extremely restless and excitable. The pulse rate was 120 per minute. The whole body was covered with a profuse, red maculo-papular rash. Some of the papules were follicular, but there was no purpura. The mouth and throat were erythematous, with numerous small areas of ulceration. No lymphadenopathy or splenomegaly was present. There was no pyrexia on admission. The white cell count was 1,700/c.mm., 47% being neutrophils (800/c.mm.). Treatment with promethazine hydrochloride, 50 mg. twice daily, and A.C.T.H. gel, 50 units daily, produced no change in the rash, but the mouth lesions did improve rapidly with cortisone hemisuccinate "linguets." She remained grossly thyrotoxic despite the administration of Lugol's iodine, 2 minims (0.1 ml.) four-hourly. The diarrhoea continued, stool culture being negative. On the fifth day after admission a pyrexia of 101° F. (38.3° C.) developed and continued between 101° and 103° F. (38.3°–39.4° C.), although no abnormality in the chest or urine was found. Crystalline penicillin was given. Her thyrotoxic state was unaffected by oral reserpine, 0.25 mg. 6-hourly, but some temporary improvement appeared to follow chlorpromazine, 25 mg. intramuscularly. On the seventh day the rash started to desquamate. The following day her temperature reached 104.8° F. (40.45° C.). Evidence of consolidation was now found at her left lung base. Following tetracycline, 250 mg. 4-hourly, the pyrexia subsided. Intramuscular reserpine, 0.25 mg. 6-hourly, was also started, and there was a gradual improvement in the thyrotoxic state, her pulse rate, which had risen to 140 per minute even while asleep, settling to 96 per minute. On the fourteenth day, oral reserpine was substituted. Her general condition remained satisfactory, but it was noted that her pulse rate again increased to 120 per minute. The desquamation gradually disappeared, the skin returning to normal.

With a fairly extensive use in this department of potassium perchlorate (in daily dosage of 600–1,200 mg.) in the treatment of thyrotoxicosis during the past 18 months, the only toxic effects of this drug observed have been transient gastro-intestinal upsets and two mild skin rashes. In this patient, therefore, we felt that the sensitivity reaction was more likely to have resulted from the barbiturate therapy. Although thyrotoxicosis might have been partly responsible for the diarrhoea, it was difficult to explain the leucopenia and mouth lesions. It was therefore thought that these might well have been caused by the potassium perchlorate, and indeed that this drug might have been responsible for the whole sensitivity reaction. An intradermal skin test with potassium perchlorate solution gave a rapidly positive erythematous reaction. The similarity of this case to that reported by Drs. Fairhurst and Hollingworth also suggests that the potassium perchlorate was indeed the sensitizing drug. The failure to respond to antihistamines and A.C.T.H. is surprising. This patient is also of interest, as she showed the value of intramuscular reserpine as part of the treatment of incipient or actual thyrotoxic crisis.—I am, etc.,

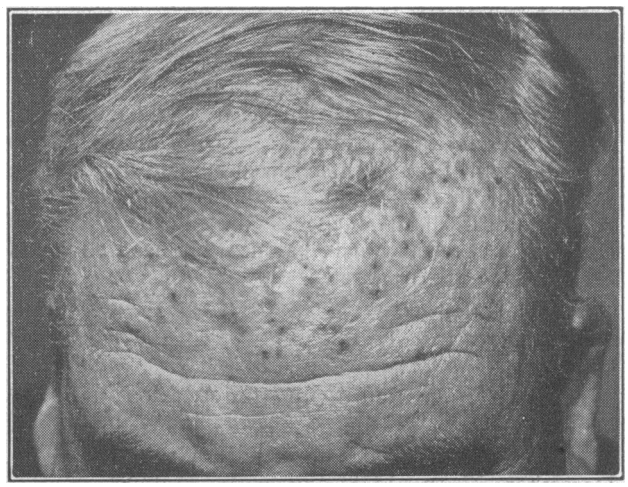
Department of Endocrinology, Glasgow Royal Infirmary. I. P. C. MURRAY.

Acne Necrotica due to Phenylbutazone

SIR,—I wish to report a case of acne necrotica due to phenylbutazone.

H. D., aged 52, an acetylene welder, was referred to the Skin Department of the Leeds General Infirmary by Professor S. J. Hartfall on January 20, 1958, with a rash on the forehead. He was being treated for osteoarthritis and had been on phenylbutazone, 200 mg. daily, for three weeks. Two weeks after beginning treatment, an irritable rash had appeared on the forehead near the hairline (see Fig.).

He was a stolid obese man who showed the typical excoriated papules and commencing varioliform scars of acne necrotica on the forehead. On stopping the phenylbutazone and using ung. sulphur. et acid. salicyl. 2%, the rash subsided. On resuming the drug the rash recurred. The drug was again stopped and no treatment was given;



the rash again disappeared and he remained clear for two months. He was then given one 200-mg. tablet of phenylbutazone daily. Previously he had taken two 100-mg. tablets. These tablets, being white and red respectively, are not readily identified by the patient as the same drug. When seen two weeks later there was no rash, but it recurred during the following week. On stopping the tablets it disappeared in another two weeks and has not recurred since.

This case is interesting in that acne necrotica is usually considered to be due to infection, psychological factors, or a combination of the two. I can find no reference in the literature to its occurrence as a drug eruption.

I wish to thank Dr. F. F. Hellier for his help in reporting this case.

—I am, etc.,

Adelaide, South Australia. G. A. HUNTER.

Hospital Sterilization

SIR,—As is noted in your leading article (*Journal*, December 27, p. 1582, para. 3) "Defects in Sterilization," hospital arrangements for treating soiled linen are often defective. Nurses may be expected to clean foul linen on the wards and dry it before dispatch to the laundry. Sometimes the linen is returned clean in the same basket as was used for sending it dirty to the laundry. In this hospital, on the suggestion of Dr. G. A. Lilly, of the Board of Control, in October, 1951, a satisfactory scheme was introduced, and the following instructions are issued to all wards:

LAUNDRY

Washing that is not foul, though it may be wet, is entered in the proper book, and sent to the laundry weekly.

Foul washing must be kept separately.

FOUL WASHING

Each article must be entered in the special book, when it is put in the proper bin.