Vitamin B_{12} in Psoriasis

SIR,—The recent article in the *Journal* by Dr. H. Baker and Dr. J. S. Comaish (December 29, p. 1729) has stimulated correspondence on the possible value of vitamin B_{12} in psoriasis.

In the course of a current investigation on psoriasis, triamcinolone, vitamin B_{12}, and normal saline have been injected into psoriatic lesions with a spring-loaded gun giving a concentration in the epidermis and penetration into the superficial and middle dermis. As was to be expected triamcinolone caused rapid regression of the lesion. Normal saline was without apparent effect. Vitamin B_{12} in eight cases showed regression of the lesion in six and no change in two. The vitamin B_{12} was injected into one lesion only in each patient, and no change was noted in other lesions present. Where regression took place, a smooth, slightly pink skin resulted.

It is hoped to publish the findings of this investigation in due course, but, in view of the recent correspondence, we wish to add our present experience with intralesional injection of vitamin B_{12}, which may indicate a specific action, to the evidence so far published on the value of this therapy.—We are, etc.,

Victoria Infirmary, Glasgow S.2. R. WORKMAN CARSLAW. J. NEILL.

Rheumatoid Pericarditis

SIR,—The letter from Dr. J. H. Glyn and Dr. J. H. Pratt-Johnson (January 26, p. 262) prompts us to record a further case of rheumatoid arthritis and constrictive pericarditis.

The patient, a 49-year-old male, was first referred to hospital in May, 1957, on account of cough, dyspnoea, and pain in his chest of several weeks' duration. Radiological examination revealed a massive pleural effusion on the right. Opacities and a small cavity were present at the apex of the right lung. A diagnosis of tuberculosis was made on clinical grounds and chemotherapy was begun. The effusion was repeatedly aspirated and streptomycin instilled into the pleural cavity. On no occasion were tubercle bacilli demonstrated in the sputum or pleural fluid.

The patient gave a history of transient pain and swelling of his joints in 1948, but at the onset of his pulmonary symptoms there was no evidence of arthritis. In March, 1958, he developed polyarthritis of the rheumatoid type, with nodules over the elbows and wrists. Radiological examination showed erosions of the metatarsal heads and bilateral pleural effusions. He was admitted to the Rheumatic Diseases Unit, Northern General Hospital, Edinburgh. Effusions were repeatedly aspirated. Chemotherapy was continued until September, 1959, when it was discontinued on account of its failure to control the effusions and the absence of any evidence of a tuberculous infection. Prednisolone in varying dosage was given between 1960 and 1962, without much effect on the pleural effusions.

At the end of 1962 he was readmitted to hospital on account of a marked deterioration in his condition. There was generalized oedema, marked dyspnoea, and cyanosis. The liver and spleen were enlarged, ascites was present, along with bilateral pleural effusions. A pericardial rub was noted. Jugular venous pressure was markedly elevated. In view of this and the presence of pulsus paradoxus, the pericardial space was tapped and 500 ml. sanguineous fluid was aspirated. Jugular pressure did not fall and pulsus paradoxus persisted in spite of repeated tapping of the pericardial space. The introduction of 200 ml. of air showed loculated fluid and a considerable increase in the thickness of the pericardium. Pericardiectomy was performed in January, 1963.

At operation the pericardium was found to be grossly thickened. Histological examination showed a non-specific chronic inflammatory condition. There was fibrous thickening of the pericardium and pleura, fibrinous exudate, patchy infiltration of lymphocytes and plasma cells with prominent perivascular infiltrates. There were no areas of fibrinoid necrosis or evidence of necrotizing arteritis.

During this recent illness the results of a variety of investigations were as follows: Haemoglobin 82%, E.S.R. 5 mm./1 hr., W.B.C. 7,000 to 11,000 per cu. mm., the sensitized sheep cell test was positive on a number of occasions, the L.E. factor and anti-nuclear factor were never demonstrated, smear and culture of the sputum and pleural and pericardial fluids were consistently negative for tubercle bacilli.

The association of constrictive pericarditis and rheumatoid arthritis has been reported on only a few occasions. Gimlette[1] in a survey of 62 cases of constrictive pericarditis found five patients with rheumatoid arthritis. In one, acute pericarditis had preceded the onset of arthritis by three months. It is of interest to note that in our own case and in those described by Keith[2] and McMurray *et al.*[3] the arthritis was of a comparatively mild type and had been present for a comparatively short time.

We are grateful to Dr. Michael Matthews for his advice and for allowing us access to case records made whilst the patient was under his care.

—We are, etc.,

Rheumatic Diseases Unit, Northern General Hospital, Edinburgh 5. R. E. H. PARTRIDGE J. J. R. DUTHIE.

REFERENCES

[1] Gimlette, T. M. D., *Brit. Heart J.*, 1959, **21**, 9.
[2] Keith, T. A., *Circulation*, 1962, **25**, 477.
[3] McMurray, C. M., Cayer, D., and Cornatzer, W. E., *Gastroenterology*, 1951, **17**, 294.

Side-effect of Dichloralphenazone

SIR,—I would like to draw attention to a very disturbing experience I had a few minutes after administering two tablets of dichloralphenazone ("welldorm") (10 gr. (0.65 g.) each) to a healthy adult. An urticarial rash appeared within a few minutes and rapidly covered her entire body. She was violently sick and started perspiring heavily. She complained of difficulty in breathing and her pulse became rapid and feeble. A few minutes later she developed severe cramp in the abdomen. I gave her 50 mg. "phenergan" (promethazine) by mouth, which did not have any appreciable effect. The entire episode lasted about five hours.

This product is also marketed as a paediatric preparation. I am quite sure the outcome in a feeble subject or an infant could prove to be very serious indeed if it evokes a similar allergic reaction. The manufacturers suggest that it has comparable action with chloral hydrate and it is presented as a safe hypnotic and sedative.—I am, etc.,

Burton-on-Trent, Staffs. M. GHOSH.

Local Corticosteroids and the Eye

SIR,—You were kind enough to print last year a letter from me (June 9, 1962, p. 1628) stressing the dangers of the use of local corticosteroids in relation to ocular infections. It appeared from the response to this letter that at least a number of ophthalmologists concurred in these views.