Adult Fanconi Syndrome and Cirrhosis

SIR,—In 1947 we published a paper[1] entitled "Studies on the Mechanism of the Fanconi Syndrome." The subject of the study was a man aged 34, presenting in 1945 with gross osteomalacia. He was found to have the full renal-tubular abnormalities usually associated with the name "Fanconi syndrome"—namely, renal tubular reabsorptive defects of phosphate, glucose, and amino-acid, with renal-tubular acidosis. He was also found to have severe cirrhosis, from which he died in early 1946, his bone disease having been largely controlled by treatment. We thought then that cirrhosis was an occasional association of "Fanconi syndrome," indeed we then speculated that the cirrhosis might have resulted from amino-acid depletion in consequence of the amino-aciduria.[2] (We do not believe this any longer.)

Our subsequent clinical studies at University College Hospital have shown that cirrhosis is only consistently associated with a childhood form of the Fanconi syndrome, as in the case described by Baber.[3] One of us (C. E. D.) began to get worried about the original case in an adult man, since no further similar "idiopathic" cases have since been seen or heard of in this age group. The post-mortem material was no longer available, but a measured aliquot of the patient's 24-hour urine of 7 January 1946 has been traced in our cold room. It has been sent to Professor J. N. Cumings, who reports that it contained 45 μg./100 ml. of copper, or 594 μg. in the 24-hour specimen. He adds that this grossly excessive excretion is "undoubtedly diagnostic of Wilson's disease if it cannot be explained by contamination."

It would seem necessary to record now that the diagnosis of "idiopathic adult Fanconi syndrome with cirrhosis of the liver" probably no longer exists on the basis of present evidence. Any apparent case should therefore be carefully screened for causes of secondary renal tubular or of liver dysfunction such as myeloma, and heavy-metal poisoning—but especially for Wilson's disease, for which we now have excellent treatment.[4]

The existence of adult Fanconi syndrome without cirrhosis remains fully substantiated.—We are, etc.,

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Anaesthesia and Monoamine-oxidase Inhibitors

SIR,—The monoamine-oxidase inhibitors are widely used in the psychiatric treatment of depression. There is, therefore, an increasing number of patients who may require an operation whilst they are taking these drugs. It is known that very occasionally such patients show a profound reaction if they are given either an analgesic or a vasopressor drug.[1-4]

Recent reports on the anaesthetic management of patients on monoamine-oxidase inhibitors have suggested two possible courses.[5,6] First, that the therapy is discontinued and the surgery is postponed for at least two weeks: or secondly, that a local-analgesic technique without the addition of vasopressor drugs is used. Neither of these suggestions is ideal—to discontinue the monoamine-oxidase drug may lead to a recurrence of the depression: and to produce satisfactory local analgesia for certain operations may well be beyond the capabilities of many anaesthetists—besides the whole procedure being an ordeal for a patient deprived of the customary preoperative sedation. Furthermore, although general anaesthesia with modern techniques can be performed without preliminary sedation, powerful analgesic drugs are needed after all but the most trivial operations.

Since only a very small percentage of patients who are taking these drugs show a sensitivity reaction it would seem a more rational approach to this problem to try to test beforehand for any such sensitivity to either analgesic or vasopressor drug. The system is simple and has been satisfactorily used in eight patients receiving full doses of monoamine-oxidase inhibitors. The sensitivity test for analgesics is carried out in the following manner:

The patient's blood-pressure, pulse, and respiration are first measured and charted. The general state of awareness is also noted. Then either 5 mg. pethidine or 0.5 mg. morphine are injected intramuscularly. The vital signs, together with any change in the level of consciousness, are then observed and recorded at five-minute intervals for the next 20 minutes, after which they are noted and charted every 10 minutes for the remainder of the first hour. At the end of this period, if there has been no obvious change, then either 10 mg. of pethidine or 1 mg. of morphine is given and the whole process repeated for the second hour. Again, at the end of the second hour, if there has been no obvious change, a further dose of 20 mg. of pethidine or 2 mg. of morphine is given. After three hours, if no change has developed, then 40 mg. of pethidine or 4 mg. of morphine is given. It is unnecessary to carry the test beyond this stage, since any sensitivity response would have been apparent by the time this stage had been reached.

In one patient the injection of 5 mg. of pethidine produced a fall in systolic blood-pressure of 30 mm. Hg, a rise in the pulse rate of 20 beats per minute, and some slight drowsiness; whereas in the remaining seven patients there was no obvious change in the vital signs.

The advantage of using such a sensitivity test is that it can be carried out even if only a few hours are available before operation, and the injection at the third hour, with what remains from the previous injections, can be used as the premedication. Once it is known that the patient does not respond in an abnormal manner to these drugs then they can be used freely in the treatment of pain in the post-operative period. On this basis there is the minimum of disruption of the normal therapeutic procedure.—I am, etc.,

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Skin Conditions in Children

SIR,—I would like to thank Dr. Martin Beare for his excellent account of skin conditions in infancy and childhood (16 January, p. 171, and 23 January, p. 233) as it contains a great deal of helpful common sense.

I also congratulate him on being able to distinguish so clearly between the seborrhoeic pattern of eczema in infancy and childhood and that of "true" infantile eczema or atopic eczema. Many of us find this is very difficult, as mixtures of the two patterns seem to be so common and a child may have predominantly one pattern, only at a later stage to have a distribution more in keeping with the other. A family history of eczema, asthma, and hay-fever—or the development of these conditions—is commoner with the atopic pattern, but they are by no means uncommonly associated with distributions of eczema of the seborrhoeic pattern. Recently I have tried applying similar criteria to those mentioned by Dr. Beare in his differential diagnostic table, and whereas it is possible to say some patients have predominantly the seborrhoeic eczema pattern and some the atopic pattern the majority seem to have mixtures of the two.

I am worried about the bad prognosis which is given under the heading of atopic eczema, as the casual reader might get the impression that their patients, and indeed often their own children, are "doomed to a life of either eczema or asthma." Eczema, to a degree requiring medical attention at some time, occurs in about 1 in 30 normal children.[1] In minor grades it is even commoner than this. It is true that we see many patients who do continue to have eczema throughout childhood and in adult life, and in the very severe grades who have required admission to hospital some 50% develop asthma.[2] This type of case often has to be seen frequently by dermatologists and general practitioners, and this may give a wrong impression of the incidence of serious trouble compared with the vast number of children who have eczema at some time. Dr. Beare does indeed apply his bad prognosis to "the moderately severe or severe atopic." I personally would give a much happier prognosis and would say that the majority of children with this pattern of eczema clear up with age, as their skins become less easily eczematized; even many patients with severe eruptions will also clear. It would only be in the very severe cases which have persisted for a long period that I would qualify my optimism.

I am sure Dr. Beare is quite right in pointing out how readily monilia invades a pre-existing eruption in the napkin area. He may remember the work of Miss M. English, who found monilia in 9 out of 30 babies with simple and mild napkin rashes and none in a series of thirty controls.[3] For this reason I have taught that it is inadvisable in most cases to use antibiotics in this area, and was therefore surprised to see Dr. Beare advocating their use. For even severe napkin rashes I still use a simple routine which includes explanation and advice, the regular use of Past. Zinc. Co. and Ung. Emuls. Aquos. in equal parts, and the rinsing of the napkins, before dying, in boric acid (1 drachm to 1 pint (3.9 g. to 560 ml.) of boiling water). Very occasionally I may resort to the addition of vioform-(iodochlorhydroxyquinolin)-hydrocortisone ointment applied two or three times per day. The more powerful steroids are