Janet Lock and Dawn Gallagher are surprised that we mentioned the use of cardioselective β blockers. We did not wish to imply that patients with clear cut active asthma would be given β blockers but rather wished to point out that many patients with little or no disease at all could be considered for treatment. Many patients are labelled as having asthma but do not in fact have the condition, and we considered our audience to be sufficiently sophisticated to take our point. With regard to methysergide, we mentioned retroperitoneal fibrosis to highlight a reasonably well appreciated clinical problem. With regard to sumatriptan and the manufacturer's recommendations, it is a matter of fact that data from clinical trials do not point to a difference between doses of 50 mg and 100 mg. This leads to the conclusion that the recommendation to start treatment at 100 mg would result in many patients taking an excessive dose without any scientific rationale. Our recommendation remains that treatment should begin at the lowest possible effective dose, which is 50 mg in Britain and 25 mg in the United States.

The use of low dose aspirin as preventive treatment is attractive in some clinical settings but could usefully be investigated in a larger study, as Catherine Nelson-Piercy and Michael de Swiet imply. Migraine may improve in as many as 70% of patients in the normal course of pregnancy, and so the results of uncontrolled studies must be interpreted with caution.

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Problems with the penis and prepuce in children

Lichen sclerosus should be treated with corticosteroids to reduce need for surgery

EDITOR,—We wish to make several comments about Mark Davenport's article on problems with the penis and prepuce in children.[1] We would argue that the term balanitis xerotica obliterans should be avoided and lichen sclerosus used instead. This is because the disease can be localised to different parts of the body—for example, on the genitals of both sexes.[2] The cause of lichen sclerosus is unknown, and there is no good evidence of an infectious aetiology.

Lichen sclerosus can be treated with potent corticosteroids locally, with good results in both men and women.[3] Phimosis in boys can be treated with a potent topical steroid, which thus reduces the need for surgery.[4] Surgery on the prepuce may be indicated in some boys with lichen sclerosus, but even in these cases it may be wise to use a potent topical steroid after surgery to prevent recurrence and to treat any lesions on the glans penis and in the urethral orifice. Opinions vary on the value of preputial stretching since it may worsen the phimosis.[5]

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Author's reply

EDITOR,—Esben Techau Jørgensen and Åke Svensson raise two unrelated points, concerning terminology and treatment. Balanitis xerotica obliterans is probably the male genital variant of lichen sclerosus, and the authors are right to relate the two conditions. Balanitis xerotica obliterans, however, is a descriptive term that virtually all paediatric surgeons and urologists use,[1] and I fail to see the advantages of substituting one long Greek name for another purely descriptive Greek name. It adds nothing to the comprehensibility of the condition itself, as the underlying aetiology of both conditions is not known. It is also interesting that in their contribution to this literature the authors have used the unwieldy term lichen sclerosis et atrophicus.[2]

The authors' other point is valid, and more research needs to be done on the use of steroids in this common condition. Nevertheless, the evidence for benefit is not overwhelming. The authors' study, in which they gave topical clobetasol to 54 boys, was small and uncontrolled. They made no attempt at placebo comparison, which is surprising in view of the condition's natural course and an admitted failure rate of 30%. The response of balanitis xerotica obliterans to steroid is even more contentious, and the authors fail to quote a much larger Australian trial of topical steroid in childhood phimosis, which among its conclusions states that phimosis due to balanitis xerotica obliterans does not respond to topical steroid treatment and does require circumcision.[3]

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Hyperkalaemic cardiac arrest

Use of suxamethonium should be avoided

EDITOR,—M A Jackson and colleagues report their successful management of a prolonged asystolic cardiac arrest occurring as a result of hyperkalaemia that was attributed to the use of suxamethonium during routine anaesthesia.[1] We are disappointed that they make little mention of the risks and benefits of using suxamethonium to facilitate tracheal intubation.

Suxamethonium, a depolarising neuromuscular blocking drug, has been extensively used by anaesthetists since its introduction in 1951. It undoubtedly provides the fastest onset of neuromuscular blockade and facilitates early tracheal intubation, but its usefulness is marred by a number of both unpleasant and serious side effects, which include unpredictable hyperkalaemia in patients with spinal cord injury, burns, neuromuscular conditions, and severe sepsis; bradycardias; anaphylactic reactions; severe muscle pains, particularly in young, ambulatory patients; and a prolonged action in patients with cholinesterase deficiency.

There are no absolute indications for the use of suxamethonium, although many anaesthetists insist on using it for "rapid sequence" or "crash" induction. It should be avoided in patients who are to be mobilised rapidly after surgery because it results in muscle pains. Such pains may be severe enough to keep patients bedbound for several days, which would preclude its use in an ever increasing proportion of patients in today's health service.

The hyperkalaemic response to suxamethonium is unpredictable, and, as in the case reported by Jackson and colleagues, there is often no reliable way of identifying patients at risk. The only way to avoid such severe reactions is to avoid using the drug whenever possible. In our practice we find that airway care in anaesthesia and intensive care can be satisfactorily managed without the use of suxamethonium except in very occasional cases. This issue was highlighted in North America recently when one of the main suppliers of suxamethonium (Burroughs Wellcome) changed the wording on its drug insert to indicate that the drug was contraindicated in children and adolescents except when used for emergency tracheal intubation or when the airway had to be secured immediately.[2 3]

We believe that the widespread use of suxamethonium could be greatly reduced without detriment to patients, and we doubt that the drug would be granted a product licence if it underwent clinical trials today.

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Patient may have had a muscular dystrophy or Andersen's syndrome

EDITOR,—M A Jackson and colleagues report their lifesaving treatment of hyperkalaemia and asystole in a 16 year old boy with exercise induced muscle pain and abnormal muscle histology.[1] Their final diagnosis of muscular dystrophy with hyperkalaemia induced by suxamethonium may be correct, although the absence of any detectable skeletal muscle weakness would be unusual.

Two muscle disorders that should have been considered in the differential diagnosis are hyperkalaemic periodic paralysis and Andersen's syndrome. Andersen's syndrome is a dominantly inherited form of potassium sensitive periodic paralysis associated with cardiac arrhythmias, facial dysmorphology, and clinodactyly.[2] Examination in family members should include a search for myotonia (especially lingual) and the relevant dysmorphic features. Microtubules may be present in skeletal muscle on electron microscopy. A diagnosis of hyperkalaemic periodic paralysis is confirmed by the detection of a mutation in the α subunit of the adult skeletal muscle sodium channel gene on chromosome 17q, although cardiac arrhythmias are said to be rare in hyperkalaemic periodic paralysis. The recent dramatic advances in muscle immunohistochemistry would help to characterise any muscular dystrophy.

Making a precise diagnosis is important for three reasons. Firstly, this boy may be at risk of