

Correspondence

Correspondents are asked to be brief.

Smallpox Vaccination M. F. Dixon, M.B.	539	Crohn's Disease and its Consequences J. W. Paulley, F.R.C.P.	542	Self-examination of the Breast M. Donaldson, F.R.C.O.G.	544
Safe Hypnotics A. D. Clift, M.B.	539	Haemoglobinopathies and Anaesthesia L. R. Davis, M.D., F.R.C.PATH.	542	The Eternal Triangle N. Capener, F.R.C.S.	544
Campbell de Morgan Spots H. P. Ferrer	539	Haemophilus aphrophilus Endocarditis K. Zinneman, F.R.C.PATH.	542	Propranolol in Hypertension F. J. Zacharias, F.R.C.P., and K. J. Cowen, M.B.	544
Adjuvants to L-Dopa Therapy for Parkinsonism J. Braham, M.D.	540	Nifuratel (Magmilor) in the Treatment of Trichomoniasis A. G. S. Grimble, F.R.C.P., and D. J. Wright, M.B.	542	The Community Physician E. A. Smith, M.R.C.P. Glasg., and D. H. Vaughan, D.P.H.	544
Prophylaxis of Venous Thrombosis V. V. Kakkar, F.R.C.S., and others	540	Cardiac Catheterization S. A. Copeland and N. H. Brooks; D. E. Jewitt, M.R.C.P., and others	542	Appointments in Libya D. E. C. Mekie, F.R.C.P. Ed.	544
Use of Broad-spectrum Antibiotics M. Patricia Jevons, M.D.	540	Cost of Treatment A. P. J. Ross, F.R.C.S.	543	Contracts for Hospital Doctors Sir Hedley Atkins, K.B.E., F.R.C.S.	545
Phage Treatment of Severe Burns B. R. Sandiford, M.D., F.R.C.PATH.	541	Free Thyroxine Index F. Clark, M.R.C.P., and Hazel J. Brown	543	Profession—or Trade? D. C. Clark, F.F.A.R.C.S.; Mabel L. Haigh, M.B.	545
Evaluation of Simpson W. B. Gough, M.B.	541	Teething Troubles C. Josephs, M.D.	543	Photographs of F.R.C.P.s. C. Newman, F.R.C.P.	545
Pregnancy and Crohn's Disease P. F. Boreham, F.R.C.S., and D. H. K. Soltau, F.R.C.O.G.	541				

Smallpox Vaccination

SIR,—Your leading article "For and against Smallpox Vaccination" (9 May, p. 311) highlights the present controversy regarding routine vaccination. Of particular concern is the finding that the incidence of serious complications of vaccination greatly outnumbered the incidence of smallpox itself in Western countries.

The potentially fatal complications of vaccination could be avoided by using an inactivated vaccine. Unfortunately the development of an effective heat-killed vaccine has met with only partial success. In the absence of such a vaccine, serious complications can be minimized by constant regard to the established contraindications to vaccination. Some specific contraindications such as pregnancy, eczema, and septic skin conditions are well known, but more recently other important categories have been recognized. I refer to leukaemias, malignant lymphoreticular neoplasms (reticulososes), and patients on immunosuppressive therapy.

I have recently reported a case of progressive vaccinia (vaccinia necrosum) occurring in a patient with lymphosarcoma.¹ The patient, a man aged 67, was vaccinated by his general practitioner prior to a trip abroad. Lymphosarcoma had been diagnosed five years earlier, and he had received several courses of irradiation. Subsequent to vaccination he was treated with corticosteroids for an episode of haemolytic anaemia. Progressive extension of the inoculation site and the appearance of satellite and metastatic lesions followed, and he died with a vaccinal pneumonia 27 days after vaccination.

A review of the literature revealed 40 adult cases of progressive vaccinia. In 36 of these cases the disease was associated with a leukaemia or a reticulosis. This consistent association is not a new finding, however, and most current medical textbooks include leukaemias and reticulososes among the contraindications to anti-smallpox vaccination. Nevertheless, the continued occurrence of progressive vaccinia in such patients suggests that the information has not yet reached all concerned with vaccination. Fur-

thermore, the use of immunosuppressive therapy, including corticosteroids and irradiation, is on the increase.

Unless all doctors involved with vaccination are made aware of these important contraindications, and patients receiving such treatment are warned of the dangers of vaccination, more unnecessary deaths are inevitable.—I am, etc.,

M. F. DIXON.

Department of Pathology,
University of Edinburgh.

REFERENCE

- ¹ Dixon, M. F., *Journal of Pathology*, 1970, **100**, 53.

Safe Hypnotics

SIR,—Drs. I. Haiden and I. Oswald, (9 May, p. 318), have shown clearly the development of rapidly acquired drug tolerance and dependence.

Today, I saw a 61-year-old lady who had been admitted to hospital three days ago after an overdose (quantity unknown) of butobarbitone. She recovered consciousness in 24 hours and was discharged the next day. That night, she claims, she did not sleep at all despite nitrazepam 10 mg. and diazepam 5 mg. t.d.s. When I saw her she was agitated, depressed, and felt desperately in need of sleep.

It is noteworthy that this patient had not been on hypnotics regularly and had in fact stored her butobarbitone from two years ago; she took the overdose in a mood of depression on hearing she needed a mastectomy. This patient also serves to underline the inherent dangers of using barbiturates as hypnotics when adequate alternatives are now available.¹ It would seem that unless nitrazepam is much more likely to produce dependence than the barbiturates it is now the drug of choice for insomnia.

It is salutary to recall that at least 1.3% of patients in general practice are hypnotic-dependent.² Surely it is desirable that the

huge quantity of drugs represented by this should be comparatively harmless if taken in excess.—I am, etc.,

ANTHONY CLIFT.

Manchester.

REFERENCES

- ¹ Anderson, T., and Lingjaerde, O., *British Journal of Psychiatry*, 1969, **115**, 1393.
² Johnson, J., and Clift, A. D. *British Medical Journal*, 1968 **4**, 613.

Campbell de Morgan Spots

SIR,—The hypothesis that the Lancaster outbreak of the above lesion was of food-borne origin was based on the comparative scarcity of community cases. Drs. R. H. Seville and G. Birchall mention in their letter (9 May, p.364) the fact that they saw several cases in the hospital outpatients. However, what was remarkable was that despite notices being sent to general practitioners, health visitors, and district nurses in the area there were so few cases reported in the community in comparison with the very large number observed in institutions in the area.

It would be remarkable if a food-borne outbreak of any kind followed the same pattern in different areas, and before discarding the food-borne hypothesis I think that much more evidence is needed. As I suggested in my original letter (7 March, p. 628), the food-borne agent may well have been one factor in the outbreaks that we observed. Although it is arguable that ambient temperatures in institutions are higher than those affecting patients in the community, of the nine homes for the elderly which were under my care at that time two only were affected by the outbreak, although the conditions in each were very similar.

I would submit, therefore, that the original hypothesis cannot be so easily dismissed, and I hope that in any future outbreaks the possibility of a food-borne agent may be considered, as on