Campylobacter infections

To the editor: Campylobacter infections are now well recognized. However, one feature of infection with campylobacter enteritis that is not well emphasized is the presence of an inflammatory cellular exudate in the stools. We report a case in which this was a predominant feature.

Case report

A 22-year-old steelworker and his brother had eaten chicken at a local Chinese restaurant. The next day fever and chills developed in the steelworker and were followed by diffuse cramp-like abdominal pain associated with the passage of six loose bloody stools. Two days later he was admitted to hospital.

The results of physical examination were normal, apart from a temperature of 39.5°C. The hemoglobin concentration was 15.3 g/dl and the leukocyte count 17.9 × 10^9/l. The patient was treated with intravenously administered saline and acetaminophen. By the next day he had improved and the bloody diarrhea was less frequent.

Gram staining of stool samples showed large numbers of pus cells. *Campylobacter jejuni* was isolated on Skirrow's medium. No ova or parasites were found, and blood cultures gave negative results.

The patient made a full recovery without antibiotic therapy.

Although he lived in a rooming house where the cooking facilities were shared, he was the only person so affected.

Discussion

In his original description of campylobacter enteritis Skirrow[1] stated that he found a polymorphonuclear exudate in only 18 of 57 samples; however, he did not state how many samples were examined by smear. Several subsequent accounts have described abdominal pain and diarrhea as the two outstanding features of campylobacter enteritis.[2,3] The presence of pus cells in a significant proportion of cases implies an invasive component to the pathogenesis of campylobacter enteritis; however, the mechanism of the diarrhea has yet to be fully elucidated. The diagnosis of campylobacter infection has to be entertained in any patient with an acute diarrheal illness associated with pus cells.

We thank the bacteriology laboratory of Toronto East General and Orthopaedic Hospital Inc. for its technical assistance.

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The use of propranolol in treating tardive dyskinesia

To the editor: Beta-adrenergic blocking agents are being used more and more for a variety of conditions, including ischemic heart disease, hypertension and cardiac dysrhythmias. They have also been found useful in the treatment of essential tremor, as the following case illustrates.

Case report

In 1977 a 55-year-old woman with neurotic depression and excessive drinking was admitted to a psychiatric facility. She was treated with clomipramine hydrochloride tablets. At the time of discharge clomipramine was discontinued because of the development of tardive dyskinesia — specifically, mouth movements. Psychiatric consultations continued for over a year. Unfortunately, the patient was unable to carry on with her daily activities without such medications as tricyclic antidepressants or a phenothiazine derivative. The tardive dyskinesia persisted and became a great problem for her.

In October 1979 I thought it might be worth trying propranolol to modify the annoying mouth movements. Initially, I prescribed

10 mg to be taken four times a day; I soon increased the dose to 40 mg to be taken twice a day. Over approximately 6 weeks the mouth movements decreased; propranolol was continued at 80 mg/d.

I last saw the patient 1 week before the time of writing, when she stated that she had run out of the propranolol and had not bothered to renew the prescription. She found that the mouth movements returned quite rapidly; therefore, she immediately began taking propranolol again, 40 mg twice a day.

Comment

I hope this report stimulates interest in and investigation into the use of propranolol or other β-adrenergic blocking agents in the treatment of tardive dyskinesia.

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Legal abortions among teenagers, 1974–78

To the editor: It was difficult to read the article by S. Wadhera and C. Nair (*Can Med Assoc J* 122: 1386, 1980) without being overwhelmed by the sheer numbers of abortions currently being performed world-wide. Certainly the death of one person affects us more deeply than the deaths of many, mainly because we cannot fully appreciate the significance or the impact of a major disaster. Nevertheless, there has to be some revulsion, no matter how we try to suppress it, at the thought of 30 to 55 million abortions being performed annually throughout the world. If this is too much to comprehend realistically, then it is no less alarming to look closer to home and perceive that 62 290 abortions were performed in 1978 in Canada alone, which constitutes a rate of 11.3/1000 women aged 15 to 44 years. This rate, however, is misleading; the true enormity of the problem is more accurately depicted if we look at the abortion problem in terms of the percentage of pregnancies terminated.

Wadhera and Nair give all the relevant figures only for 1976, when there were 360 000 live births and 54 478 abortions in Canada. This signifies a mortality of approximately 15% for all fetuses, excluding those miscarried. The law states that an abortion should be performed only if in the opinion of a therapeutic abortion committee the continuation of the pregnancy would or would be likely to endanger the mother's life or health.[1] It is very difficult to believe that as many as 15% of pregnancies are so dangerous. Certainly if we accept the ludicrous definition of health as proposed by the World Health Organization,[2] then many pregnancies are dangerous to the health; indeed, we might be excused for believing that pregnancy is a pathologic condition and that we could conceivably terminate all pregnancies with the blessing of the World Health Organization.

The situation is untenable; we can no longer be considered true professionals, but rather mere technicians responding to the demands of the public.

Whether or not we regard the fetus as human (if we do, we calmly committed 62 000 murders in Canada in 1978) we must at least acknowledge that the fetus is potentially one of our human brethren. In that case, any society that has such little regard for its young is degenerate. Have the floodgates of irrationality opened too wide or is there still time for us to restore the founding principle of our profession — a deep reverence for life?

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To the editor: I disagree with Wadhera and Nair's simplistic conclusion that improved education on birth control will decrease the horrendous number of abortions among teenagers in Canada. They have aptly isolated the statistics for teenagers and have done an excellent survey of abortions; however, they have neither medical degrees nor the medical expertise to inform physicians as to how abortions among teenagers may be curtailed. It would have been more fitting for Dr. Christopher Tietze, who guided their work, to make the conclusions and draw any criticism or opprobrium that he could have defended with his expertise on abortion and population control.

The conclusion that education on birth control should be improved indicates that perhaps the teenagers had abortions because of poor birth control or none at all. Yet, Wadhera and Nair glibly quote the Criminal Law Amendment Act, which categorically states that an abortion can only be performed if the life or health of the mother is in danger.[1] Therefore, there is a deep suspicion that these teenagers had abortions because they did not want the pregnancy to continue. This indeed is improved birth control; it is virtually abortion on demand.

Wadhera and Nair state that the proportion of therapeutic abortions in teenagers with previous induced abortions increased slightly in terms of percentages of the total number of abortions in all teenagers. In fact, the actual number nearly doubled between 1974 and 1978. Therefore, in a supposedly well informed and motivated group there is a serious ignorance of birth control, which cannot be rectified no matter how persuasive the educative technique.

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2. World Health Organization: Text of the Constitution of the World Health Organization. *Off Rec WHO* no 2: 100, 1948

"Diagnosis of Diseases of the Chest' [correction]

Dr. Anthony S. Rebuck has informed us that, in his review of this book (*Can Med Assoc J* 123: 399, 1980), his address was incorrectly given as McMaster University, Hamilton. Dr. Rebuck is, in fact, at the Toronto General Hospital. We apologize for this oversight. — Ed.