

## CORRESPONDENCE

Correspondents are asked to be brief

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### Holiday Cholera and Other Vibrios

SIR,—With the approach of the summer season, your warning (8 April, p. 62) to all concerned about the hazards of holiday cholera is timely. As you rightly indicate, the clinical picture may vary from acute gastroenteritis to mild diarrhoea, or even symptomless excretion of the organisms. *Vibrio cholerae* is not, however, the only vibrio which may cause such illness in travellers returning from abroad. The actual diagnosis depends on isolation of the causative organism, and other vibrios, particularly *V. parahaemolyticus*, should also be considered.

This halophilic marine vibrio was first identified in Japan, where it is associated with the consumption of raw fish and other sea-food products, and is now the commonest cause of food poisoning in summer.<sup>1</sup> It is almost certainly widely distributed throughout the world and is becoming more generally recognized as an important or potential pathogen. Its significance as an endemic cause of food poisoning in Britain is not yet known, although its presence in various marine products has been confirmed recently.<sup>2</sup> It may also be imported not only by travellers but also commercially in sea-foods. *V. parahaemolyticus*, like cholera and other enteric pathogens, should therefore be sought in all cases of gastroenteritis in persons who have recently returned from abroad, and also from anyone who has consumed sea-foods. The possibility of cross-contamination to other foods should not be forgotten. Indeed, for the first time in Britain, *V. parahaemolyticus* has just been identified as the cause of acute gastroenteritis among airline passengers who had eaten cooked crab-meat served as hors d'oeuvres during a flight from Bangkok to London.<sup>3</sup> Apart from the Far East, food poisoning caused by this organism has recently been reported also in Australia<sup>4</sup> and the U.S.A.<sup>5</sup>

As in cholera, *V. parahaemolyticus* is ex-

creted in large numbers during illness, but the vibrios diminish rapidly with clinical recovery. The role of possible carriers is not known, but direct transfer from one person to another does not seem to be important. Adequate clinical and epidemiological information is essential to ensure that suitable cultural techniques are used for appropriate specimens. Fortunately, *V. parahaemolyticus* can be isolated by the same media and methods used for cholera organisms, though salt-colistin or glucose-salt-teepol broth may also be employed for enrichment culture.<sup>1</sup> *V. parahaemolyticus* forms large characteristic green colonies on thiosulphate citrate bile-salt sucrose (TCBS) medium in contrast to the yellow sucrose-fermenting colonies of *V. cholerae*. Whatever media used, however, any Gram-negative organisms which are motile, oxidase- and catalase-positive, and sensitive to methylene blue<sup>6</sup> and vibriostatic agent 0/129 (2, 4-diamino-6, 7-di-isopropylpterdine phosphate)<sup>7</sup> should be regarded as vibrios and further identified. If this were done, infection with non-cholera vibrios, including *V. parahaemolyticus*, might be recognized more often.—I am, etc.,

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<sup>1</sup> Sakazaki, R., in *Foodborne Infections and Intoxications* (ed. H. Riemann), p. 115. New York, Academic Press, 1969.

<sup>2</sup> Barrow, G. I., and Miller, D. C., *Lancet*, 1972, **1**, 485.

<sup>3</sup> *British Medical Journal*, 1972, **1**, 701.

<sup>4</sup> Bartey, Y. M., Wallace, R. B., Allan, B. C., and Keeffe B. M., *Medical Journal of Australia*, 1970, **1**, 430.

<sup>5</sup> *Morbidity and Mortality*, 1971, **20**, 356.

<sup>6</sup> Yan, W. K., *Journal of Medical Laboratory Technology*, 1969, **26**, 90.

<sup>7</sup> Shewan, J. M., Hodgkiss, W., and Liston, J., *Nature*, 1954, **173**, 208.

### Digoxin Dosage

SIR,—The need for individual adjustment of digoxin dosage in elderly patients is now widely recognized. It is particularly impor-

tant to reduce maintenance dosage to a minimal effective level. Even the conventional dose of 0.25 mg daily may be excessive for certain patients, and it is here that one runs into practical problems. I can prescribe either a half tablet dose—that is, 0.125 mg—or a Paediatric-Geriatric ("P-G") tablet of 0.0625 mg strength. Such complex decimals and unwieldy numbers are inconvenient and faintly ludicrous, not to say potentially hazardous. Such awkward fractions may also lead to a reluctance to prescribe sufficiently small doses of digoxin whenever indicated.

Why can we not have digoxin tablets in two distinct, sensible, and easily-written strengths—0.2 mg and 0.1 mg? Tablets of 0.1 mg would be scored so as to be easily divided into doses of 0.05 mg. The drug would then be prescribed in three strengths for adults—0.2 mg, 0.1 mg, and 0.05 mg—instead of the present clumsy doses of 0.25 mg, 0.125 mg, and 0.0625 mg, respectively. The former doses are more succinct and more sensible; admittedly they are fractionally smaller than the present standard doses but probably the better for that.

Lastly, it must always be remembered that a long-accustomed dose of digoxin in an elderly person may at any time become excessive—for example, in the presence of potassium deficiency, or as may be caused by potent diuretics, or defective renal function. It used to be said, "once digitalis, always digitalis," but is prolonged maintenance treatment always really necessary? Very often it is, albeit sometimes in an infinitesimal dose.—I am, etc.,

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### Survival of Gonococci Outside the Body

SIR,—The possibility of acquiring gonorrhoea by non-venereal contact has been considered.<sup>1-4</sup> In order to shed further light on

this question, the following experiment was carried out.

Urethral discharge from male patients with positive direct smears and cultures was put on a clean glass slide or on a piece of towel. Each slide and towel with the small amount of exudate was placed in a Petri dish and kept on a bench in the laboratory at room temperature. At different intervals the air dried exudates were then washed off the slides with physiological saline and the towels were swabbed in the same solution. The washing fluids were transferred to haematin agar for culturing. Tests for surviving gonococci were made by conventional bacteriological techniques—namely, the presence of typical colonies, positive oxidase tests, and carbohydrate fermentation reactions.

Ten patients have been studied up to the present. For each patient the urethral discharge was tested at only one interval after its collection. The maximal period of gonococcal survival found hitherto has been 24 hours for discharge transferred to the towels and 17 hours for the slides (Table).

*Results of Tests for the Survival of Gonococci from Urethral Discharge Kept on a Glass Slide or a Dry Towel for Different Intervals Prior to Collection and Culture.*

	Time in hours after collection	Number of patients	
		Growth	No growth
Slide	2	1	2
	6	1	
	17	1	
	48		
Towel	3	1	2
	6	1	
	24	1	

—We are, etc.,

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- 1 Doyle, J. O., *British Medical Journal*, 1972, 1, 88.
- 2 Shore, W. B., and Winkelstein, J. A., *Journal of Pediatrics*, 1971, 79, 661.
- 3 King, A., and Nicol, C., *Venereal Diseases*, p. 142, London, Baillière, 1969.
- 4 Mark, A., and Starck, V., *Läkartidningen*, 1971, 68, 4265.

### Battered or Pigmented?

SIR,—Mongolian spots consist of grey-blue areas of pigmentation over the sacral area, buttocks, back, sometimes on the shoulders and legs, and occasionally in the buccal mucosa. They are commonly seen in coloured infants, but rarely in white babies. They disappear during the first three years and are of no clinical significance in themselves, though in cases for adoption their presence may lead to the suspicion that an apparently white baby has coloured ancestry, and they may also be mistaken for bruising and attributed to birth trauma (particularly with a breech delivery) or in older infants to battering.

We have seen two examples of the latter which seem worth reporting. One was an inpatient in a surgical paediatric ward and by the time one of us (Z.H.Z.) was called in the medical social worker and children's officer were already involved, and the police were about to be informed. The other, aged five months, was the illegitimate offspring of a coloured father and white mother. While the mother was confined in hospital with this baby the father murdered the mother's

legitimate daughter, which not surprisingly led to a severe nervous breakdown in the mother, and a long prison sentence for the father. The baby was taken into care. It was the foster mother who suspected battering on receiving the baby because of areas of pigmentation over both shoulders extending up to the neck and nearly down to the elbow, two circular patches on the back and one in each loin, an irregular area over the sacrum and right buttock, and encircling lesions around the ankles involving the dorsum of each foot. The family doctor referred the baby to hospital as a case of battering, but, in spite of the strong circumstantial evidence supporting the diagnosis and the remarkable extent of the lesions, doubt was felt because of the uniformity of the pigmentation. Subsequent observation revealed that the areas neither faded nor changed colour in the way that bruises normally do.—We are, etc.,

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### Presenile Dementia

SIR,—I read the paper by Drs. C. D. Marsden and M. J. G. Harrison on "The Outcome of Patients with Presenile Dementia" (29 April, p. 249) with interest, but regret the total lack of information about the ages of the patients they included in their study. They fail even to give an upper age limit for what they considered to be "presenile." Without this information, their paper gives little help to those wishing to know the value of neurological investigation at any given age in middle life. One might expect that the picture would be rather different in those in later middle age as compared to the younger subjects. This difficulty in assessing the value of neurological investigation is made the greater by the paucity of information as to outcome. Fifteen per cent. of patients in the whole series were said to have "conditions that were amenable to treatment." How many of these came from the 14% of the whole series who were not in fact demented? How many truly demented patients actually achieved a useful improvement and what were the diagnoses in this presumably small group?

Without further information on these points it is not easy to accept the authors' conclusion that their study re-affirms the value and necessity of neurological investigation of patients presenting as apparent dementia in the presenium. The presumably small gains from neurological investigations were no doubt cancelled out, at least in part, by the morbidity or even mortality of these procedures, although there is no comment on these points. The paper does appear to show that proper psychiatric evaluation is of far greater practical value in this group.—I am, etc.,

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### Asthma and a Lump in the Breast

SIR,—The article on 11 March in the series "Second Opinion, Please" (p. 681) contains several extraordinary remarks on various aspects of the management of asthma.

It is by no means unusual, as one of your contributors states, for asthma to develop in middle age. Extrinsic allergens cannot be demonstrated in many patients with late onset asthma and the statement that "there must be an allergic factor" is misleading. In fact, in the case under discussion the source of an important allergen (a budgerigar) seems to have been demonstrated—but surely removal of the source is a more logical approach to management in the first instance than any attempt at "specific desensitization"?

One possibility that was not discussed is that the patient's yellow sputum was due to eosinophilia rather than bacterial infection, a distinction which can be demonstrated by microscopy, but which, if neglected, can lead to repeated courses of unnecessary antibiotics. No attempt seems to have been made to assess objectively the patient's degree of airways obstruction by either spirometry or peak-flow measurements. One or other of these simple investigations should nowadays be regarded as essential in the management of asthma, particularly when the patient, as here, has been given a variety of bronchodilators, and is then subjected to treatment with corticosteroids. This latter course seems to have been embarked upon without a fair trial of other less potentially dangerous drugs such as disodium cromoglycate.

The main thesis of the article seems to be that the woman developed asthma to attract attention to the lump in her breast. This is purely speculative, and the evidence would suggest rather that her asthma was precipitated by sensitivity to the budgerigar.

In summary, we feel that this article is unrepresentative of current ideas in the management of asthma and its publication in a leading medical journal could be misleading.—We are, etc.,

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SIR,—In the Second Opinion article "Asthma and a Lump in the Breast" (11 March, p. 681) it was with concern that I read the surgeon's remark "I felt sufficiently sure of a malignant diagnosis to re-scrub and begin mastectomy and axillary clearance before confirmation of malignancy by frozen section reached me."

I should like to ask why he proceeded with the frozen section at all in these circumstances? What action would he have taken if the apparently unwanted report had been "Sclerosing adenosis; no evidence of malignancy"?—I am, etc.,

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### Alpha Receptors and Control of Blood Pressure

SIR,—Dr. I. R. Gray's article (1 April, p. 31) requires comment on two pharmacological points.

Firstly, it is stated that alpha receptors are responsible for sweating and thus may be blocked by alpha antagonists. It is, I think, a fairly well accepted fact that post-ganglionic sympathetic synapses at sweat