Deaths from Tuberculosis

SIR,—I have recently conducted an analysis of 71 new cases of tuberculosis diagnosed in a large general hospital over a six-year period. The results confirm some of the comments in your leading article on this subject (22 May, p. 419). In 17 (24%) there was undue delay in making the correct diagnosis. In 15 an interval of more than three weeks elapsed between hospital admission and diagnosis, and in two tuberculosis was not discovered until necropsy. In these two cases and in seven others, failure to consider tuberculosis in the initial differential diagnosis was a major factor in causing this delay. Three of these nine patients had recognized predisposing factors (one was an alcoholic and two were receiving corticosteroid drugs), and four had extrathoracic tuberculosis. None were immigrants.

The necessity of considering tuberculosis in the elderly is confirmed by the case of an 80-year-old woman who presented with weakness, anorexia, abdominal discomfort, and weight loss. Though there was a diffuse bilateral abnormality on chest radiograph, a diagnosis of intra-abdominal malignant disease was made. At necropsy, disseminated miliary tuberculosis was found.

These findings and the report of the Research Committee of the British Thoracic and Tuberculosis Association[1] stress the importance of communicating to medical students and postgraduates the continuing need to consider tuberculosis in the differential diagnosis of any unexplained illness, particularly where this occurs in the elderly, in immigrants, and in patients with recognized predisposing factors such as diabetes, alcoholism, and corticosteroid therapy.—I am, etc.,

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1 British Thoracic and Tuberculosis Association, *Tubercle*, 1971, **52**, 1.

Paracetamol Overdose

SIR,—Paracetamol is widely regarded as a safe drug. Figures supplied by the Committee on Safety of Drugs record 11,781,000 prescriptions on E.C.10 in 1968 and 12,594,000 in 1969. Its reputation for safety could lead to its being overlooked as a cause of a serious toxic reaction. We wish to record a case in point.

A spinster aged 38, who was a perennial victim of dysmenorrhoea, had been in the habit of taking analgesics for many years. Her normal dose was 6 (up to 10) tablets of Panadol (paracetamol) during the two days of menstrual pain. For a severe attack she would resort to Panadeine (paracetamol plus codeine phosphate) or occasionally Edrisal (acetylsalicylic acid, phenacetin, and amphetamine). In July 1970, on account of a particularly severe attack, she took 30 tablets of Panadol over two days. Twelve days later she developed arthralgia, fever, and a toxic erythema followed by an extremely severe headache. She treated her headache with Panadeine tablets, and a physician prescribed Anthisan (mepyramine) tablets for the rash.

She was admitted to hospital under the care of Professor Stuart Douglas for investigation on suspicion of having some serious disease such as systemic lupus erythematosus. In the event no abnormality was discovered except a moderately raised E.S.R., but since a drug reaction was considered possible all medication was forbidden from the start (which involved turning a deaf ear to her importunate demands for relief from headache). During the next three days all her symptoms disappeared, and the E.S.R. eventually returned to normal. Since then she has remained well. She has not taken any analgesics, her dysmenorrhoea being relieved by endocrine therapy.

A careful history of drug ingestion cast the strongest suspicion upon paracetamol, with codeine, amphetamine, aspirin, and phenacetin as remote possibilities. At first one of us (A.L.) was reluctant to accept paracetamol as the cause, particularly as the makers (Winthrop Laboratories—Dr. J. B. Spooner) had no record of any similar case. However, the patient's serum, examined by the second of us (S.A.) for lymphocyte transformation and macrocyte migration inhibition, gave strongly positive tests for paracetamol and negative ones for the other drugs.

It is therefore extremely likely that her illness was induced by paracetamol, albeit in a rather excessive dose, and we are interested to know whether your readers have encountered similar reactions.—We are, etc.,

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Angina Pectoris

SIR,—Dr. M. Ahmed (15 May, p. 404) requested the opinion of readers regarding the treatment of angina pectoris with adrenergic beta-receptor blocking drugs, particularly oxprenolol, and particularly with regard to the precipitation of congestive cardiac failure in these patients.

We have recently examined some of the haemodynamic effects of oxprenolol in angina pectoris.[1 2] Our experience has been that the drug is an extremely useful agent in angina pectoris. We have treated 90 patients during the past two years with oxprenolol with complete or nearly complete relief of symptoms in more than half. We have not witnessed congestive cardiac failure in any patient following the use of this drug. On the contrary, investigative studies of the acute intravenous effects and long-term oral treatment with doses of oxprenolol up to 480 mg daily have not shown any clinical or haemodynamic deterioration in left ventricular function. However, it must be emphasized that the angina patients under study in our unit are selected on the basis that they have *uncomplicated* angina—that is, normal electrocardiogram at rest, no radiological cardiac enlargement, and normal left ventricular function (normal left ventricular end diastolic pressure and normal cardiac output and stroke volume) at rest. We specifically exclude from treatment patients with enlarged left ventricles in association with angina, as in our experience this is invariably associated with evidence of significant left ventricular dysfunction even at rest, and such can reasonably be expected to be aggravated by any withdrawal of cardiac sympathetic support. In conclusion, therefore, we think it is important to exclude from treatment with beta-blocking drugs alone any patient with evidence of left ventricular insufficiency *at rest*, though as we and others have shown, all patients with severe anginal pain demonstrate considerable impairment of left ventricular function *during exercise*.[3]

Other studies from our laboratory have also demonstrated conclusively the improvement in left ventricular haemodynamic function during exercise that follows digitalization.[4] Though tests of the combined effectiveness of digitalization prior to beta-blockade in patients with angina associated with congestive cardiac failure have not been undertaken, there is perhaps some reasonable evidence to suppose that if beta-blockers are to be used in these circumstances then prior support of the left ventricle by digitalis glycosides is mandatory.—I am, etc.,

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1 Sharma, B., Majid P. A., Galvin, M. C., and Taylor, S. H., *Postgraduate Medical Journal*, 1970, **46**, November Supplement, 72.
2 Sharma, B., Meeran, M. K., Galvin M. C., Tulpule, A. T., and Taylor, S. H., *British Medical Journal*, in press.
3 Sharma, B., and Taylor, S. H., *Lancet*, 1970, **2**, 902.
4 Sharma, B., Majid, P. A., Meeran, M. K., and Taylor, S. H., *British Heart Journal*, in press.

Community Physicians

SIR,—As some of the few doctors presently undertaking formal training orientated to the management of a unified Health Service, we would like to comment on the uncertainty surrounding the role of the community physician in the proposed reorganization of the Health Service as outlined in the Consultative Document.[1]

We had hoped that the Consultative Document would define the role of that mythical figure, the community physician, who so far has been all things to all men. Perhaps the promised White Paper will be more precise. Are the medical officers of the regional health authorities and the area health authorities to belong to one speciality or two? The proposals for the faculty of community physicians suggest that there will be one, as the incumbent members of both groups are to be accommodated. Yet at present they constitute two quite separate groups with different interests, training, and experience. Are they now to have a common career structure and a common training?

The medical staff of the area health authorities may well present difficulties as two completely different types of doctor will be candidates for the appointments. Doctors already employed in the Public Health Service in most cases have training and considerable experience in one aspect of the Health Service. New trainees in community medicine have a greater breadth of formal training covering all aspects of Health Service management but for the most part have a limited practical experience. It is easy to see how professional stress in this situation could arise.

The introduction of an integrated career structure for community medicine with training grades and conditions of service akin to present hospital junior staff and the vocational training schemes for general practice and a satisfactory goal to aim for at the end of training should be regarded as a first priority. The "able young doctors of the future" must be shown a clearly defined career pattern if they are to be attracted to