Diarrhoea at the Olympics

SIR,—As one of the medical officers to the British athletes in Mexico City, I read with interest your leading article on "Diarrhoea at the Olympics" (12 October, p. 69). At the Rome, Tokio, and here at the Mexico Olympics we have given the British athletes prophylactically one tablet of Streptotriad twice daily, starting two days before arrival. The number of cases of diarrhoea has been negligible. This is very gratifying, particularly in Mexico City, where "travellers' diarrhoea" is so prevalent.—I am, etc.,

J. L. BLONSTEIN,
Senior Medical Officer,
Amateur Boxing Association,
President, Medical Commission,
Amateur International Boxing Association.
Mexico City,
Mexico.

SIR,—It was gratifying to read your reminder (12 October, p. 69) that there is no evidence to support antibacterial action of iodochlorhydroxyquinoline (Entero-Vioform). This compound is taken widely to combat "travellers' diarrhoea" in its various geographic guises, although, except in regions where amoebiasis is prevalent, no significant benefit can be expected.

A point which is seldom appreciated is that the organic iodine of this compound is only slowly excreted, and will vitiate both radioactive iodine studies of thyroid function and the chemical estimation of protein-bound iodine for many months after ingestion.[1] In spite of direct questioning many appear unable to recall having taken Entero-Vioform, and the high serum iodine level may become evident only after both tests have been performed and incompatible readings obtained. While other tests of thyroid function which are not affected by exogenous iodine are available it is often advisable to have confirmatory tests if abnormal readings are obtained, and the time may not be far off when those who require such studies will have to wait at least six months before the tests can give a reliable result.

Anti-diarrhoea remedies are, of course, readily available without prescription, but may we ask through your columns that when medical advice is sought as to the most suitable compound those containing iodine should not be prescribed unless there are definite indications for their use?—We are, etc.,

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REFERENCE

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When is a Placebo?

SIR,—A placebo in one clinical situation may not be a placebo in another. In your leading article (12 October, p. 69) "Diarrhoea at the Olympics," the writer quotes a clinical trial on the treatment of travellers' diarrhoea in which the placebo (lactose) was associated with a higher incidence of diarrhoea than either of the treatment groups.

Lactose may be a valid placebo in a trial of analgesics but not in a situation involving alimentary symptomatology. Acute alimentary infections are associated with disturbance in small bowel structure and function. Lactase, the enzyme necessary for the digestion of lactose, is the disaccharidase most susceptible to impairment in activity. Impaired digestion of lactose is itself a cause of diarrhoea. Therefore, in the paper quoted, the administration of lactose, far from being placebo therapy, could actually have augmented the symptomatology of the control group, leading to erroneous therapeutic conclusions.

May I suggest that you invite someone to write a paper or give a lecture on the title "The Science and Psychology of Placebos." One man's placebo may occasionally be another man's poison.—I am, etc.,

W. C. WATSON.
Royal Infirmary,
Glasgow C.4.

Prognosis in Tetraplegia

SIR,—I hope many of your readers beside myself will see the manifold merits of the paper by Dr. J. R. Silver and Mr. N. O. K. Gibbon (12 October, p. 79). They rightly stress the need for immediate admission of traumatic tetraplegics to a spinal centre; the need for equipment for intensive care in such a centre; systematic all round rehabilitation from day one to discharge; the startling range of possibilities for independence and work opened up by R. Maling's invention of Possum, a control-system making use of the minimal residual power of the most severely disabled; and the shameful lack of permanent accommodation for those of the—often young—tetraplegics who can work and enjoy life in a properly equipped and conducted hostel, as at Stoke Mandeville, but quickly deteriorate and die when discharged to an unsuitable home or institution. Administrators, please note. Pressure of space, no doubt, prevented the authors from differentiating among the incompletely paralysed between those who on discharge had subtotal, medium, or only slight neurological deficits.

The one really important point not made in their paper concerns the impact of bowel-function on prognosis. Even if reliably trained and dealt with while in a centre, bowel function is often neglected at home and in institutions. Too few people, relatives, general practitioners, and consultants not in this field, realize that the overloaded "neurogenic" bowel, not unlike the bladder, is responsible for much respiratory distress through pressure on the diaphragm, for urinary complications from retention via reflux and hydronephrosis to stone-formation, or even for volvulus of the sigmoid. That constipation is second only to contractures in reflexly aggravating spasticity is the simple truth, too simple for the sophisticated, but true all the same, as those who have looked after a few thousand "neurogenic" bowels know only too well.

A neurologically trained physician and a neuro-urologically experienced surgeon have given us an example of teamwork at its best.—I am, etc.,

L. S. MICHAELIS.
Dinton,
Near Aylesbury, Bucks.

Suppressing Rh-immunization

SIR,—Your otherwise excellent leading article (19 October, p. 135) is misleading in one respect—namely, that routine use of anti-D immunoglobulin in the "United Kingdom" is determined by the finding of foetal red cells in maternal blood. In Scotland Rh-negative primiparae who give birth to an Rh-positive, ABO compatible infant are given anti-D immunoglobulin irrespective of the number of foetal red cells in maternal blood. The 200-μg. dose is injected even when no foetal cells are detectable. In practice most laboratories engaged in this work in Scotland do not perform acid-elution tests for foetal cells. Only the essential blood grouping tests are done.—I am, etc.,

JOHN WALLACE,
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Blood Transfusion Service
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Inhibition of Lactation with Quinestrol

SIR,—Quinestrol, the cyclopentyl enol ether of ethinyloestradiol, has been shown to effectively inhibit lactation.[1-3] Its particular advantage over other oestrogen-like preparations is that "one tablet" therapy orally is all that is necessary. Each mother in a random series was prescribed one 4.0-mg. tablet of quinestrol (Estrovis) within 24 hours of her delivery. Twenty-three of the 26 (88%) so treated required no further treatment. None of the patients suffered any more than mild breast engorgement, which always occurred on the fifth or sixth day of the puerperium. It is possible that two further patients, each of whom left hospital 24 hours after delivery, might have achieved equally successful lactation suppression on the one tablet, but unfortunately their family doctors gave them stilboestrol at the first sign of breast discomfort, which appeared on the fifth day in each case. Only with one patient was quinestrol treatment considered to be completely unsuccessful.

Eighteen of these patients were multipara, and it is interesting that 11 of them had previously breast-fed their babies. Yet every one of these 11 had lactation successfully inhibited with the one tablet of quinestrol. Of the other seven, two had previously had lactation suppressed, and one, who had been delivered of a stillborn baby, had been treated similarly. In the notes of the remaining four no history as to the method of feeding was given.

Experience of this trial has convinced the medical and nursing staff of the efficacy of this treatment. They have found it quite unnecessary to be alarmed if a patient's breasts become slightly uncomfortable on the fifth or sixth day post partum. Certainly in the majority of cases the discomfort has subsided rapidly, without the need to give either a further quinestrol tablet or any other oestrogen therapy. Only very exceptionally will a patient's breast become excessively uncomfortable and leak milk from the nipple, and for such a patient it is suggested that a further 4.0-mg. quinestrol tablet should be taken at about the fifth or sixth day—and it might even be necessary to give yet a third 4.0-mg. tablet another 48 hours later. The very success of this preliminary quinestrol trial has determined the staff's decision to

adopt this approach to lactation inhibition and suppression routinely in the department.

We wish to thank Dr. John M. McGilchrist, medical director, of Messrs. William R. Warner and Company Ltd., not only for his encouragement and help in this survey, but also for supplying the Estrovis tablets ; and we also wish to thank the midwives of the department for their most willing co-operation.

—We are, etc.,

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MYRA SNELL.

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Treatment of Vitiligo

SIR,—In most cases of vitiligo the aetiological factor is not known. Treatment in the majority of cases is without effect. In a very limited number of patients there is a spontaneous recovery ; in other patients the depigmented areas do not increase. It is well known that melanin-stimulating hormone and A.C.T.H. can influence the melanocytes even in man, although A.C.T.H. has a much weaker effect than melanin-stimulating hormone (see hyperpigmentations in Addison's disease).[1] Owing to a close relationship between A.C.T.H. and alpha-melanin-stimulating hormone (they have an identical 13 amino-acid sequence) it is possible that they can be produced and released in certain circumstances simultaneously—for example, during a highly increased A.C.T.H. production.

We tried using metyrapone (Metopirone) to increase both the A.C.T.H. production and probably melanin-stimulating hormone as well, through the change in the feedback mechanism (blocking of cortisol production). We used it with the above possibility in mind in the treatment of vitiligo in 10 patients, as an attempt to cause repigmentation of the depigmented, vitiliginous areas. We have not found any reference in the literature to this possible use of metyrapone. All our patients had been treated previously and without benefit by dermatologists.

The treatment of most patients started in hospital, with metyrapone administered to adults intravenously 2 g. every other day in 5% glucose, the infusions taking six hours. In children (their weight was 25–35 kg.) the infusions contained 1 g. of metyrapone. As outpatients, our patients received metyrapone in capsules, the usual dosage being six 250-mg. capsules every other day for two to three weeks with a subsequent one to two weeks' pause. We did not encounter any side-effects, except for a transient feeling of fatigue in a boy, probably as a consequence of depressed cortisol production. All patients were instructed about this possibility, and were regularly checked at one-week intervals. Abstention from major physical activities was suggested for them during the treatment.

The best results were obtained in rapidly progressing cases with a not-too-extensive skin involvement. In such cases we observed not only an early cessation of vitiligo spreading, but repigmentation as well. Sometimes the vitiliginous areas of a few square centimetres were repigmented during a few days. The effect of treatment also depended on the total dosage used. In patients with very extensive involvement the areas affected did not disappear, but many of them became darker and more pigmented. Their sensitivity to insolation definitely decreased and there was no further spread of vitiligo. Some patients have been followed for more than a year. The largest single dose in a patient was 27 g. of metyrapone over a period of three months. —I am, etc.,

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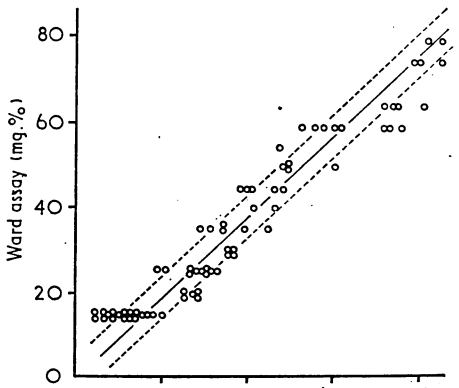
REFERENCE

1 Williams, R. H., *Textbook of Endocrinology*, 1968, 4th ed. Philadelphia.

Salicylate Estimation in the Side-room

SIR,—The value of estimating plasma salicylate levels in the ward side-room has been pointed out.[1] Although this assay was effected with a photoelectric colorimeter, as in the laboratory method, it was suggested that clinically useful results might be obtained with a simple visual comparator. Standard solutions of ferric salicylate may be used for this purpose, but the colours fade, particularly on exposure to light. This problem is overcome by adapting the analysis to use with a set of permanent glass standards, in a Lovibond comparator disc, covering the range 0–110 mg./100 ml. in nine steps. The results of a series of 72 such estimations on patients admitted to this centre have been compared with the corresponding values obtained by photometric assay in the laboratory. Good correlation was found, as shown in the figure ; the standard error is indicated by dashed lines.



We conclude that the comparator method offers a speedy and reliable means of estimating levels of plasma salicylate in the ward side-room. This is an important criterion for instituting forced diuresis[2] in severe salicylate poisoning, and the comparator is now in routine use here.

The comparator disc (No. 5/41) is available from Tintometer Ltd., of Salisbury, Wiltshire ; we are grateful to Mr. G. J. Chamberlin of this firm for arranging its manufacture.

—We are, etc.,

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A. C. A. SMITH.

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Surgery for Perforated Duodenal Ulcer

SIR,—Mr. M. G. Machayya (19 October, p. 155) must be congratulated on his report describing the emergency treatment by vagotomy and pyloroplasty of unselected patients suffering from perforated duodenal ulcer. His patients have been exposed to the double risk of perforation and an elective operation *simultaneously*. The results eloquently testify to his skilful care of the patients. I sincerely hope that inexperienced surgical enthusiasts do not take up this treatment.

Mr. Machayya quotes Mr. J. A. Shepherd (9 March, p. 625) as saying that only 25% of patients remain symptom-free following simple suture of a perforation. He continues "most of the remaining 75% will have further surgery." What Mr. Shepherd's admirable article stated was "75% have persistent or recurrent trouble, and of these at least a third come to elective or to further emergency surgery within five years."

If I had a perforated duodenal ulcer I should be chagrined to have an irrevocable operation performed which carries its own immediate and long-term complications. I might belong to the 25% who have no further symptoms following simple suture, or the 50% who, despite getting further symptoms, do not qualify for surgery during the next five years. A fit young man already eligible for an elective operation, who perforates his duodenal ulcer, arrives quickly at hospital, and is treated by an experienced surgeon supported by his full team, may be a candidate for curative surgery at the time of dealing with the perforation, after careful assessment before and during the operation.

I deprecate operations upon unselected patients in case of a future eventuality. To perform vagotomy and pyloroplasty on every patient with a perforated duodenal ulcer in order to protect 25% of them from another operation within five years is illogical. To carry out such an operation as an emergency procedure seems to court disaster.—I am, etc.,

London W.1. R. M. KIRK.

Winter Epidemics

SIR,—It seems likely that an epidemic of influenza will reach this country during the coming winter. The King Edward's Hospital Fund will shortly issue a study of the influenza epidemic as it affected London hospitals last winter. A number of practical suggestions are put forward for consideration by hospitals in this report, which will be circulated to London hospitals early in November. These include the need for early discussions with the matron, the hospital administrator, and the geriatric services.

It is very desirable that medical committees should review their arrangements for such an epidemic and consider the recommendations in this report.—I am, etc.,

London S.E.1. F. AVERY JONES.

'Flu Inoculation

SIR,—In the winter of 1957–8, when Asian 'flu was pandemic, my partners and I inoculated each other against it in the hope of avoiding simultaneous partner morbidity such as we had previously experienced. We are now coming again under pressure from