pregnancy was probably not caused by incest or rape.

Even though the rate of late abortion was lower than the national average (4% *v* 6% in 1986), in one third of our patients there was a delay of two weeks or more between referral by the general practitioner and the operation. The underfinancing of the NHS has led to bed shortages and closure of the outpatient clinic over holiday periods. In two thirds of the women there was a discrepancy of more than two weeks between the woman's dates and gestation shown by ultrasound, a quarter had continued to menstruate for one or two months while taking the pill, and three women had irregular periods and did not realise they were pregnant until late.

Ignorance about the system, cultural change, poverty, homelessness, drug addiction, mental illness, violence from the male partner, youth and inexperience, and failed contraception in older women are associated with late presentation. These women would not be helped by any restrictive changes in the 1967 Abortion Act, which while not ideal, has helped many women, reduced the death toll and morbidity from illegal abortion, and allowed women and their doctors to discuss openly what was secret and hidden and thus deal with the problem safely.

MANFREDO SIMEONI
FRAN READER
WENDY SAVAGE

Department of Obstetrics and Gynaecology,
The London Hospital,
London E1

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Strongyloidiasis

SIR,—Dr J A Hill (12 March, p 753) discusses the screening programme for *Strongyloides stercoralis* infection in ex-Far East prisoners of war. These patients are known to be at increased risk,[1] but *S stercoralis* is endemic in several parts of the world.[2-6] I present three cases of hyperinfestation occurring in patients of West Indian origin.

A 64 year old Jamaican man presented with a four year history of abdominal pain and weight loss. Stool parasitology had never been done. His eosinophil count was normal. Gastroscopy and colonoscopy showed lesions suggestive of Crohn's disease, and he was started on oral prednisolone. The biopsy reports, however, confirmed the presence of *S stercoralis*. The steroids were stopped and he was started on thiabendazole. Twelve hours later he developed an *Escherichia coli* septicaemia and meningitis. He developed a cough, and live worms were isolated from his sputum. His treatment was changed to mebendazole and chloramphenicol, and he made a slow but uneventful recovery.

An 18 year old girl was admitted for investigation of weight loss and a low serum concentration of albumin. She developed clinical evidence of septicaemia and died. A postmortem examination showed hyperinfestation with *S stercoralis*, and filariform larvae were found in the brain.

A 50 year old man was treated with thiabendazole after the organism was isolated from his stool. Within 12 hours he developed the clinical features of septicaemic shock and died.

S stercoralis may be endemic among patients in Britain who have previously lived in the West Indies, and they are at risk of hyperinfestation. Other cases of hyperinfestation have been reported in Britain. Smallman and others reported two fatal cases in patients from the West Indies.[7] A 29 year old Jamaican woman was successfully treated,[8] and two other fatal cases have been reported from the West Indies. These patients were all previously fit and three of them had not been back to the West Indies for more than 10 years.

J DACRE

Department of Rheumatology,
St Bartholomew's Hospital,
London EC1A 7BE

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Sulphonylureas and hypoglycaemia

SIR,—The leading article by Drs R E Femer and H A W Neil (2 April, p 949) omitted one aspect of hypoglycaemia developing with sulphylureas—namely, this complication occurring with high dose sulphonamides, which are chemically related to the sulphylureas.[1] This has been observed in the last four cases of pneumocystis pneumonia we have treated by such therapy; we present here our most florid case. The other cases were less severe, but the patients did not have renal failure.

A 64 year old man was admitted with a five month history of general debility. Investigation showed renal failure (sodium 131 mmol/l, potassium 5·4 mmol/l, total carbon dioxide 12 mmol/l, urea 45 mmol/l, creatinine 837 μmol/l, creatinine clearance 3 ml/min). Biopsy showed active focal segmental glomerulonephritis. He was treated with cyclophosphamide 150 mg and prednisolone 60 mg orally per day. His condition deteriorated and he required haemodialysis and blood transfusion.

His chest radiograph showed progressive confluent shadowing of the left upper lobe. Suspected *Pneumocystis carinii* pneumonia was confirmed from bronchial washings. Treatment with co-trimoxazole 1920 mg intravenously four times a day was started, as recommended by Winston *et al*.[2] After initial improvement he relapsed and suffered an unexpected cardiac arrest, from which he was resuscitated.

At this time he developed hypoglycaemia and for the subsequent 48 hours his blood glucose concentration remained at 2-4 mmol/l despite an infusion of 10 g of dextrose per hour, repeated 20 g dextrose boluses, and on one occasion 100 g of dextrose in two hours. He recovered consciousness, but the response to treatment was not sustained and he died 48 hours later. The patient had received prednisolone 30 g, propranolol 120 mg, indomethacin 75 mg, flucloxacillin 2 g, calcium carbonate (Titralac 6 tablets), and danthron (Dorbanex 60 ml) daily. There was no evidence of liver or adrenal failure.

Necropsy showed an organising pneumonia, a quiescent glomerulonephritis, renal scarring, and patchy pancreatic necrosis. There was no evidence of an insulinoma.

We believe that accumulation of the sulphamethoxazole contained in the co-trimoxazole caused the hypoglycaemia. Hypoglycaemia has been recorded in cases of renal failure after much more modest doses of co-trimoxazole.[3,4] This is clearly a rare complication but it is important to be aware of such a possibility in the increasing cohort of immunocompromised patients developing problems such as pneumocystis infection and requiring high dose sulphonamide treatment.

D W RYAN
J OYSTON

Intensive Therapy Unit,
Freeman Hospital,
Newcastle upon Tyne NE7 7DN

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Drug addicts and the GP

SIR,—The report from the Advisory Council on the Misuse of Drugs discussed by Dr Tessa Richards (16 April, p 1082) recognises the rapid spread of human immunodeficiency virus (HIV) among drug misusers which has overwhelmed the present arrangements for coping with them.

Among the proposals to contain misuse and combat the spread of AIDS are ones which affect the whole of general prctice. For example, one proposal says: "We conclude that the advent of HIV makes it essential that all GPs should provide care and advice for drug misusing patients to help move them away from behaviour which may result in them acquiring and spreading the virus. Health authorities should ensure that appropriate support is available and that GPs are made aware of it."

As a result of this report considerable pressure will be put on all general practitioners to participate in combating drug misuse. Many, however, are reluctant to do so, although their response is based on practical reasons rather than the prejudice implied by Dr Richards. Their reluctance will be founded on lack of training; the expectation of lack of support, based on past experience of dealing with dependent groups; concern about demands on their time; and worries about their staff being exposed to patients who will bring manipulation and violence into the waiting room, where there is greater danger to staff than in hospital.

If any progress is to be made it will not come from rhetoric, reports, or the simple transfer of problems to general practice. Success can come only from a programme designed to train general practitioners and their staff to deal with this group and from effective support in the hospital and community.

JOHN G BALL

Bewdley,
Worcestershire DY12 2ES

Early detection of visual defects in infancy

SIR,—Drs D M B Hall and Susan M Hall (19 March, p 823) do not analyse which visual defects screening programmes are likely to uncover. No claim to detect severe visual defects in the first weeks of life has ever been made. Myopia and refractive errors, by far the most common