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## LEADING ARTICLES



## PAPERS AND ORIGINALS



## MEDICAL PRACTICE



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# CORRESPONDENCE

*Correspondents are asked to be brief*



## Future of Postgraduate Medical Centres

SIR,—The National Association of Clinical Tutors recently held a most successful regional meeting at Plymouth. During a discussion on the work of the clinical tutor, considerable concern was expressed about the future policy of the Department of Health and Social Security on hospital education centres. The intention of the Department appears to be to include areas for multidisciplinary education in all new hospitals and, although it has been conceded that certain accommodation will be for the exclusive use of the medical staff, the plans which have been seen do not provide accommodation on anything like the scale available in even modest purpose-built postgraduate medical centres.

The meeting of the National Association of Clinical Tutors was unanimous in its view that adequate accommodation must be available primarily for medical staff and under local medical control. Many tutors emphasized the value of independent catering facilities in postgraduate medical centres and regretted the absence of such facilities in the Department of Health and Social Security plans. Difficulties have already arisen when centres are used for multidisciplinary purposes and when they are being organized by a multidisciplinary committee.

The postgraduate medical centre movement developed as a spontaneous expression of a need at the periphery. The yield in terms of improved relations between general practitioners and hospital staff and improved patient care has been quite out of proportion both to the capital and running costs of such purpose-built centres. We believe it is essential to maintain the present character of these centres and to ensure that appropriate facilities are provided in all district general hospitals. We have expressed these views to the Department of Health and Social Security, through the Council for Postgraduate Medical Education, and we should welcome any comments from clinical tutors or postgraduate deans on this problem.—We are, etc.,

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## Epidemic Ataxia in Western Nigeria

SIR,—I have read with interest Dr. H. B. Coakham's letter on rapid irregular movements of eyes and limbs (1 April, p. 45). Although his description of the disease he referred to as "encephalitis tremens" is correct, some important features are not mentioned, and there are a few inaccuracies. For example, it is not in fact a "flu-like" illness. The symptoms usually appear a few hours after a meal, usually of yam; pyrexia is absent in most of the patients, and when present the temperature rarely exceeds 99-100°F (37-37·8°C). It is not as he wrote restricted to around Ilesha, although it was first described from Ilesha.[1] In the 1971 epidemic hundreds of cases were seen in almost every part of the western and north-western parts of Southern Nigeria, where yam forms the staple diet and yam crops are harvested mainly in the period September to November, when the epidemics usually occur. At Ibadan, 75 miles (120 km) from Ilesha, we have seen several cases between September and November every year for the past 10 or more years.

The disease is self-limiting and symptoms are of short duration. I investigated 50 cases in Ibadan and in Ilesha in the 1971 epidemic. The age distribution has a wide scatter, except that it was uncommon in the first decade. Symptoms appear half to 3 hours after a yam meal, but not all consumers of the same meal developed symptoms, and approximately about one in four of participants in the meal were affected. Nausea and vomiting were the earliest symptoms and preceded other symptoms by interval of one to 12 hours. The most characteristic symptom was the tremor, which was coarse, and Parkinsonian in character, but with some cerebellar features, and was usually widespread. Impaired consciousness was present in 40% of the patients and ranged from confusion and agitated rowdiness to coma. Excessive sweating, which was generalized, perseveration, echolalia, negativity, pin-point pupils, blepharoclonus, widespread myoclonic jerks, excessive salivation, greasiness of face, borborygmi, abdominal pain, diarrhoea, urinary retention (not helped by carbachol), demonstrable glabella sign, and cogwheel rigidity were other features present in many of the patients. Patients appeared to benefit considerably from atropine-like drugs and chlorpromazine.

I have found no evidence of a viral infection as an aetiological factor. Biochemical investigation have excluded intoxication by cyanate, cyanide, and significant vitamin deficiencies. The epidemiological data suggest that it is a form of intoxication probably due to intense cholinergic stimulation by a substance derived from yam, and that there is a genetically determined susceptibility. I am at the moment investigating the possibility that deficiency of an enzyme such as serum pseudocholinesterase may be an aetiological factor.—I am, etc.,

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Ibadan, Nigeria

1 Wright, J., and Morley, D. C., *Lancet*, 1958, 1, 871.

## Value of Thermography

SIR,—It is a pity that at a time when thermography is still under evaluation at several centres, Dr. B. E. Nathan and others (6 May,