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CURRENT SERIAL RECORDS

SATURDAY 9 JUNE 1973

LEADING ARTICLES

- Looking at Violence page 565 Carcinoma of the Prostate page 566 Safety in Flying
page 567 Aids to Diagnosis in Closed Abdominal Trauma page 567 Syndrome of
Gilles de la Tourette page 568 Better Aids for the Deaf page 569 What Future for
Computers? page 570

PAPERS AND ORIGINALS

- Virus Cross-infection in Paediatric Wards**
P. S. GARDNER, S. D. M. COURT, J. T. BROCKLEBANK, M. A. P. S. DOWNHAM, D. WEIGHTMAN 571
- Excretion Urography in Acute Renal Failure** W. R. CATTELL, C. S. MCINTOSH, I. F. MOSELEY, I. KELSEY FRY 575
- Euglycaemic Diabetic Ketoacidosis** J. F. MUNRO, I. W. CAMPBELL, A. C. MCCUISH, L. J. P. DUNCAN 578
- Hand Carriage of Gram-negative Bacilli and Staphylococcus aureus** JOHAN N. BRUUN, CLAUS O. SOLBERG 580
- Oral Glucose Tolerance and Hormonal Response in Heroin-dependent Males** J. L. REED, A. H. GHODSE 582
- Hereditary Giant Platelet Syndrome: A Disorder of a New Aspect of Platelet Function**
MARGARET A. HOWARD, R. A. HUTTON, R. M. HARDISTY 586
- Formylation of Folate as Step in Physiological Folate Absorption** JANET PERRY, I. CHANARIN 588
- Spastic Quadriplegia due to Electric Shock** S. C. SO, M. L. K. LEE 590
- Haemolytic-Uraemic Syndrome in an Adult with Pericarditis and Pleurisy** J. A. UTTING, D. R. SHREEVE 591
- Acute Abdomen in Rheumatoid Arthritis due to Necrotizing Arteritis**
M. K. LINDSAY, H. B. TAVADIA, A. S. WHYTE, P. LEE, J. WEBB 592

MEDICAL PRACTICE

- New Horizons in Medical Ethics: Changing the Patient's Personality**
L. H. FIELD, HENRY ROLLIN, C. A. H. WATTS 594
- The Problem Orientated Medical Record** NEIL MCINTYRE 598
- James Parkinson 1755-1824** MICHAEL JEFFERSON 601
- Reorganization—1974 or 1984? Where the Nurses will Stand** 603
- Appointment of Preregistration House Officers** J. ALEXANDER-WILLIAMS, IVOR G. STEPHENSON 605
- Any Questions?** 607
- Personal View** MARGARET FARQUHARSON 609

CORRESPONDENCE—List of Contents 610

BOOK REVIEWS 619

NEWS AND NOTES

- Medical Birthday Honours 620
- Parliament—Deputizing Services 621
- Medical News 621

OBITUARY NOTICES 617

SUPPLEMENT

- National Conference of Hospital Medical Staffs 79
- Special Meeting of Council 84
- Public Health Committee 84
- General Medical Services Committee 85
- General Medical Council 86
- Association Notices 88

CORRESPONDENCE

Correspondents are asked to be brief

Splenectomy and Leucopheresis in Chronic Granulocytic Leukaemia
A. S. D. Spiers, PH.D., M.R.A.C.P., and others. 610

Latent Morbidity after Abortion
K. J. Dennis, F.R.C.O.G., and others;
Margaret M. O'Meara, M.B. 611

Herpes-simplex Virus type 2 in Acute Aseptic Meningitis
B. Sköldenberg, and others. 611

Malaria Risk to Travellers
G. A. Myers, F.R.C.S. 611

Prevention of Pulmonary Embolism
F. S. A. Doran, F.R.C.S.; J. G. Sharnoff, M.D.;
C. A. Wells, F.R.C.S. 612

Advertising of Antibiotics
J. D. Williams, M.D., and A. M. Geddes,
F.R.C.P.ED. 613

Risks of the Good Samaritan
P. H. Addison, M.R.C.S. 613

Redesign of Medical Records in General Practice
J. J. C. Cormack, M.D.; S. R. Burne, M.B. 613

Ampicillin for Sore Throat
A. A. Robertson, M.R.C.G.P. 614

Antibiotic Sensitivity of Klebsiella
T. D. M. Martin, F.R.C.PATH. 614

Thrombocytopenic Purpura and Haemolytic Anaemia after Influenza Vaccination
W. St. C. Symmers, SEN., M.D. 614

Is Your Pain Really Necessary?
Dorothea M. Kerslake, F.R.C.O.G.; Prunella
E. Newton, M.B. 614

A New I.U.C.D. for Nulliparous Patients
D. G. Bluett, F.A.C.S. 615

Diabetes Mellitus and Refined Carbohydrate
A. C. B. Wicks, M.R.C.P., and J. J. Jones,
PH.D., M.B. 615

Incidence of Postoperative Deep Vein Thrombosis in the Tropics
K. B. Orr, F.R.C.S. 615

Serum Antitrypsin Levels in Acute Hepatic Necrosis
J. Campa, M.D., and others. 616

Odds on Getting a Coronary
W. E. Snell, F.R.C.P. 616

Management Arrangements for the N.H.S.
H. P. Ferrer, M.F.C.M. 616

Representation of Hospital Doctors
A. P. Grant, F.R.C.P. 616

National Conference of Hospital Medical Staff
C. Cohen, F.R.C.P., ED. 616

Splenectomy and Leucopheresis in Chronic Granulocytic Leukaemia

SIR,—We read with great interest the report of Dr. L. Schwarzenberg, Professor G. Mathé, and their colleagues at Villejuif (24 March, p. 700) describing their experience of elective splenectomy in patients with chronic granulocytic leukaemia and the use of these patients as donors of leucocytes for the treatment of other patients with neutropenia and septicaemia. However, several points in their valuable report seem worthy of comment.

Although it is unfortunate that three of their 18 patients who underwent splenectomy died of postoperative sepsis, the mortality scarcely justifies the authors' conclusion that in future patients should be operated on and nursed for one month in an aseptic environment. Acceptance of this recommendation would confine the operation of splenectomy in chronic granulocytic leukaemia to a very few special centres possessing the necessary isolation facilities. Patients with chronic granulocytic leukaemia appear to have no special liability to infection: they do not suffer from immune paresis and are seldom neutropenic—particularly not in the period immediately after splenectomy. During the past three years 17 of our patients with chronic granulocytic leukaemia have undergone elective splenectomy; all were nursed in ordinary surgical wards and no postoperative sepsis was observed.

Our preliminary results of elective splenectomy, like those of the Villejuif workers, suggest that survival time in chronic granulocytic leukaemia may be increased, but the matter can be resolved only by a controlled clinical trial.¹ A multicentre trial now being carried out by the Medical Research Council's Working Party on Leukaemia in Adults was designed to determine the effects of early

splenectomy on the duration and quality of survival in patients with chronic granulocytic leukaemia. We agree with the authors' view that previous splenectomy increases survival after the occurrence of acute transformation. One of our splenectomized patients lived 14 months after the onset of acute transformation; constitutional symptoms, anaemia, and thrombocytopenia were notably less troublesome, and transfusion requirements were smaller than is usual at this stage of the disease in nonsplenectomized patients.

Dr. Schwarzenberg and his colleagues claim that leucocyte transfusions from patients with chronic granulocytic leukaemia are of "immense value" in treating septicaemia complicating neutropenia. This may well be true, but their results—a 52% cure rate for infections—are not superior to those obtained with antibiotic therapy alone (see table).

Since the results of antibiotic therapy still leave much to be desired, it can be hoped

that the combination of leucocyte transfusion with an optimal antimicrobial regimen may bring about further improvements in survival.—We are, etc.,

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Treatment of Infections in Neutropenic Patients with Haematological Malignancy or Cancer

Source	No. of Infections	Antibiotics Used	Survival (%)
Graw <i>et al.</i> ²	37	"appropriate"	30
Graw <i>et al.</i> ²	39	"appropriate" (+ leucocytes)	46
Klastersky <i>et al.</i> ³	13	carbenicillin + polymyxin	46
Rodriguez <i>et al.</i> ⁴	15	carbenicillin + gentamicin	47
Schimpff <i>et al.</i> ⁵	48	carbenicillin + gentamicin	52
Tattersall <i>et al.</i> ⁶	15	carbenicillin + gentamicin + cephalothin + clindamycin + methicillin	53
Tattersall <i>et al.</i> ⁷	22	carbenicillin + gentamicin + cephalothin + clindamycin	54

(All patients were treated between 1969 and 1973)