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LEADING ARTICLES

Doubtful epilepsy in childhood.....	1	Extracranial-intracranial anastomoses in cerebrovascular ischaemia.....	2
Units for cardiac surgery.....	2		
Community medicine.....	3	Infective endocarditis.....	4

PAPERS AND ORIGINALS

Anaerobic axillary abscess R D LEACH, SUSANNAH J EYKYN, IAN PHILLIPS, BRYAN CORRIN, ELIZABETH A TAYLOR.....	5
Hospital outbreak of trimethoprim resistance in pathogenic coliform bacteria R N GRÜNEBERG, M J BENDALL.....	7
Asthma due to industrial use of chloramine M S BOURNE, M L H FLINDT, J MILES WALKER.....	10
Long-term parenteral exposure to mercury in patients with hypogammaglobulinaemia M R HAENEY, G F CARTER, W B YEOMAN, R A THOMPSON.....	12
Relation between medicines sweetened with sucrose and dental disease I F ROBERTS, G J ROBERTS.....	14
Comparison of sulglycotide with cimetidine in short-term treatment of duodenal ulcer: double-blind controlled trial G BIANCHI PORRO, G DOBRILLA, G VERME, M GALLO, M PETRILLO, M VALENTINI.....	17
Synovial rupture of rheumatoid elbow causing radial nerve compression L FERNANDES, C J GOODWILL, S R SRIVATSA.....	17
Extracranial to intracranial microvascularisation for the treatment of completed ischaemic stroke R M GREENHALGH, R D ILLINGWORTH, J MCFIE, S P MILLS, G D PERKIN, F CLIFFORD ROSE.....	18
How quickly can haemoglobin A ₁ increase? R D G LESLIE, D A PYKE, P N JOHN, J M WHITE.....	19
Upper airways obstruction after Dettol ingestion L N J ARCHER.....	19
Contact allergy to methoxsalen E M SAIHAN.....	20
Corrections: Blood-pressure screening and supervision in general practice BARBER.....	20
Oral metronidazole in Clostridium difficile colitis PASHBY.....	20

MEDICAL PRACTICE

Costs of unnecessary tests GERALD SANDLER.....	21
Addison's disease G I M SWYER.....	25
Inhibition of mourning by pregnancy: psychopathology and management EMANUEL LEWIS.....	27
Sexual dysfunction ERIC TRIMMER.....	28
Letter from Chicago: Generic acrimony GEORGE DUNEA.....	31
Medical History: The "Radcliffe" hospitals, Oxford MALCOLM H GOUGH.....	33
Other people's lives P J TOGHILL.....	35
Any Questions?.....	24, 26, 32, 41
Materia Non Medica—Contributions from PETER KONSTAM, KEITH NORCROSS, NEVILLE OSWALD.....	30
Medicine and Books.....	37
Personal View H W FLADEE.....	42

CORRESPONDENCE—List of Contents.....	46
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OBITUARY.....	43
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NEWS AND NOTES

Views.....	55
Medical News.....	56
BMA Notices.....	57
Instructions to authors.....	57

SUPPLEMENT

The Week in Liverpool.....	58
From the ARM	
Review Body 67 Ethics 69 Senior hospital staff 72	
Medical manpower 74 Debates in brief 77 Some resolutions 78	
Council meeting: new chairman elected.....	75
Armed Forces doctors' pay review.....	76
Consultants and Review Body: minister's letter.....	80
GMC election.....	80

CORRESPONDENCE

Muslims, Ramadan, and diabetes mellitus S G Barber, MRCP, and others..... 46	Prophylaxis of tetanus J F Stent, MB..... 50	Heatstroke in a "run for fun" T D Noakes, MB, and L H Opie, MRCP..... 52
Analgesia in terminal malignant disease F R Gusterson, FFARCS, and others; I M C Clarke, FFARCS, and S M Tempest, BPHARM... 47	Antibiotic-induced interstitial nephritis? Squadron Leader D Saltissi, MRCP, and others 50	NHS security beds R W K Reeves, MRCPsych..... 52
The why and how of hypnotic drugs K L Thompson, RPH..... 47	Collaborating with the pharmaceutical industry P Jacobs, MD..... 50	Falciparum malaria despite chemoprophylaxis D J Bradley, DM..... 53
Colour coding of insulins H Keen, FRCP, and others..... 47	Proteinuria at high altitude A Pines, FRCPED..... 50	Multiple-puncture tuberculin testing P K Wilson, MB..... 53
Photocoagulation and diabetic retinopathy G P Walsh, MB..... 48	Renal enzyme and protein excretion after induction of a diuresis G Guarnieri, MD, and others..... 50	Contaminated hospital water supplies J D Ross, MRCS..... 53
X-ray examination of acute ankle injuries W H Rutherford, FRCSed; R W Wilkinson, FRCS..... 48	Vaginal microbial flora in normal young women E W Walton, FRCPATH..... 51	Review Body report A R Rogers, MRCP..... 53
Injuries to boys who scramble M Place, MB..... 48	Uterine rupture after intra-amniotic injection of prostaglandin E₂ S J Emery, MB, and others..... 51	Pay and contracts W R Russell, FRCP..... 53
MRC treatment trial for mild hypertension W S Peart, FRCP, and W E Miall, FRCP..... 48	An open-access morbid pathology facility for GPs? A J Ferris, BM, and A P Glanville, MRCP..... 51	Domesticated doctors C Angela Scott, MRCPATH..... 53
Depot neuroleptics in a community mental health service B Blake, MRCPsych..... 48	Enterotoxigenic Escherichia coli and travellers' diarrhoea Sujatha Panikker, MB, and Anne Davies, LBIOL..... 51	The general practitioners' work load M S Hall, FRCP..... 53
Psychiatric symptoms and hallucinogenic compounds D Jacobs, MB..... 49	Pituitary suppression in chronic airways disease? D A G Newton, MRCP, and others..... 52	Points Cigarette smoking and health (J D Egdell); Matters of life and death (D B Carron); What is to be done with the XYY fetus? (P D Child); How to use an overhead projector (B A Nettlefold); Racial discrimination? (J Whewell and D S Strachan); Pellet or dropping? (R A Davis); Keeping up to date (J A C Wilson); History and humour preferred (J Sluggitt); Merit awards (D I Walker); Re-organisation of the NHS (R D Brittain); NHS certificates for hospital patients (R Lancer)..... 54
The dilated upper urinary tract K E Britton, FRCP, and others..... 49	A luxury drug? P D Trevor-Roper, FRCS..... 52	
Treatment of tetanus R K M Sanders, MD..... 49		

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Muslims, Ramadan, and diabetes mellitus

SIR,—Dietary regulation plays an important role in the management of diabetes mellitus. Several of the world's great religions recommend a period of fasting and abstinence, and of these perhaps the Islamic fast of *Rosa* during the month of Ramadan is the most strictly observed. This proscribes all food, drink, tablets, and injections between sunrise and sunset. Medical conditions such as diabetes mellitus merit exemption at the patient's own discretion.

Since the month is calculated on the lunar cycle, it may occur at any period in the year. In temperate regions subjects may be without food and drink for up to 18 hours daily; *Rosa* this year will start on 27 July, when it will last approximately 17 hours. After sunset

there may be a meal containing far more carbohydrate than usual. In order to see if this presents a problem we have interviewed 30 unselected Muslims attending our clinic at around the time of the 1978 fast. The distribution of the treatment groups, compliance, and alteration of carbohydrate intake and diabetic control are shown in the accompanying table. Half claimed exemption on medical grounds; insulin therapy did not appear an obvious cause for this. All who fasted claimed total observance without even occasional lapses. Only three patients noticed any alteration in their diabetic control, though few tested urine samples regularly. One on oral hypoglycaemics reported increased glycosuria and had also increased dietary carbohydrate,

from 150 to 180 g daily. Another on tablets noticed "less thirst." The insulin-treated patient noticed less glycosuria. Six patients altered the overall quantity of carbohydrate consumed daily: four (two on tablets, two on insulin) increased the amount by 20-110 g/day, whilst two (one on tablets, one on insulin) reduced it by 20-50 g/day.

The six patients on insulin who chose to adhere altered their regimens variously: one, on twice-daily insulin, simply omitted the morning dose altogether, while another (similar) patient omitted the evening dose. Of the four on once-daily insulin, one had it at night instead of in the morning; another continued with morning injections, taking ampicillin when "unwell" but denying hypoglycaemic symptoms; the third simply stopped his insulin altogether; and the fourth seemed, after close questioning, to be having random doses of insulin anyway.

Thus, although Ramadan imposes a severe restriction on Muslim diabetics, there appears to be little radical change in the patient's apparent control. Since only a small proportion of patients attended the clinic during Ramadan itself, sufficient blood sugar levels are not available for comparison. It seems unlikely that a fast lasting approximately 18 hours will have no effect on diabetic control and it may be that the small numbers involved may mask serious consequences. Those who elected exemption may have experienced difficulties in the past but this did not appear to be the reason in those interviewed. Moreover, we have failed to notice any particular increase in the incidence of admissions to hospital for un-

Muslim diabetics in Ramadan

Treatment	No interviewed	No observing the fast	No who noticed alteration in their diabetic control	No who altered their daily carbohydrate intake		
				Reduced	Increased	No change
Diet	3	1	—	—	—	1
Diet and oral hypoglycaemic agents	16	8	2	2	1	5
Diet and insulin	11	6	1	1	2	3
Total	30	15	3	3	3	9