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LEADING ARTICLES

Which pill? JAMES DRIFE	1397
Biochemists nearer the patient? STUART E EVANS, BRENDAN M BUCKLEY	1399
Computing in child health: significant progress COLIN H M WALKER	1400
Can we still recommend meditation? PETER FENWICK	1401
Regular Review: Radioimmunoassay of cancer: problems and potential ELAINE M RANKIN, J GORDON McVIE	1402

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Calcium antagonists in hypertension: relation to abnormal sodium transport A M HEAGERTY, R F BING, H THURSTON, J D SWALES	1405
Changes in gastric mucosa after vagotomy and gastrojejunostomy for duodenal ulcer P C H WATT, J M SLOAN, T L KENNEDY	1407
Histology of the postoperative stomach before and after diversion of bile P C H WATT, J M SLOAN, ANNE SPENCER, T L KENNEDY	1410
Enalapril in the treatment of hypertension with renal artery stenosis G P HODSMAN, J J BROWN, A M M CUMMING, D L DAVIES, B W EAST, A F LEVER, J J MORTON, G D MURRAY, I ROBERTSON, J I S ROBERTSON	1413
Psychiatric morbidity in patients with alcoholic liver disease ISAAC EWUSI-MENSAH, J B SAUNDERS, A D WODAK, R M MURRAY, ROGER WILLIAMS	1417
Severity of alcohol dependence in patients with alcoholic liver disease A D WODAK, J B SAUNDERS, I EWUSI-MENSAH, M DAVIS, ROGER WILLIAMS	1420
Prospective study of post-transfusion hepatitis after cardiac surgery in a British centre J D COLLINS, M F BASSENDINE, A A CODD, A COLLINS, R E FERNER, O F W JAMES	1422
Chloramphenicol toxicity in neonates: its incidence and prevention ANNE MULHALL, JOHN DE LOUVOIS, ROSALINDE HURLEY	1424
Do some marathon runners bleed into the gut? ALAN M W PORTER	1427
Skin test wheal size and erythema not reduced by topical antihistamine C J GIBBS, I I COUTTS, S M JACKSON, R J WHITE	1427
An unusual cluster of babies with Down's syndrome born to former pupils of an Irish boarding school PATRICIA M E SHEEHAN, IRENE B HILLARY	1428
Relation between intake and plasma concentration of vitamin C in elderly women H M V NEWTON, D B MORGAN, C J SCHORAH, R P HULLIN	1429
Protracted survival in patients with Down's syndrome S J L HOWELL, K J FOSTER, J RECKLESS	1429
Myopotential inhibition of unipolar pacemakers DAVID R RAMSDALE, RICHARD G CHARLES	1430
Do patients who move to a new town consult their doctor more often? JOHN S COBB, DAVID P B MILES, ALEXANDER E LIMENTANI	1431
Estimating list inflation in a practice register JOHN S COBB, DAVID P B MILES	1434
Overlapping General Practice: Samaritans: amateur lifesavers	1436
Papers That Have Changed My Practice: More than one source of enlightenment PATRIA ASHER	1437

MEDICAL PRACTICE

General practice orthopaedic outpatient referrals in North Staffordshire ALISTAIR K ROSS, WILLIAM A DAVIS, GRAEME HORN, ROSEMARY WILLIAMS	1439
Migraine, headache, and survival in women W E WATERS, M J CAMPBELL, P C ELWOOD	1442
My Student Elective: Thursday Island—where and what? MICHAEL GRAY	1444
Bronchopulmonary infection due to <i>Branhamella catarrhalis</i> D T MCLEOD, F AHMAD, JOAN T POWER, MARGARET A CALDER, A SEATON	1446
Computers in Medicine: A simple system for references and reprints A S HENDERSON, R BOSLY-CRAFT	1448
Style Matters: Improving medical meetings: IV—Evaluate for the future D E RICHMOND, C J MERCER	1450
ABC of Sexually Transmitted Diseases: Urethral discharge: management MICHAEL W ADLER	1452
Malaria prophylaxis for long term visitors PUBLIC HEALTH LABORATORY SERVICE MALARIA REFERENCE LIBRARY	1454
Letter from Chicago: Below the diaphragm and above GEORGE DUNEA	1455
Lesson of the Week: Variable intrathoracic airways obstruction masquerading as asthma C G A MCGREGOR, M J HERRICK, I HARDY, TIM HIGENBOTTAM	1457
Any Questions	1447, 1449, 1451, 1456, 1458
Medicine and Books	1459
Medicine and the Media—Contributions from ANGELA BURR, GORDON MACPHERSON, TONY SMITH, JOHN FRANKLAND	1463
Personal View ANDREW R POTTER	1465
Correction: Control and prevention of tuberculosis BRITISH THORACIC SOCIETY	1445

CORRESPONDENCE—List of Contents	1466
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OBITUARY	1477
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NEWS AND NOTES

Views	1474
Medical News	1475
BMA Notices	1475
One Man's Burden MICHAEL O'DONNELL	1476

SUPPLEMENT

The Week	1481
"NHS belongs to the British people" says Kinnock WILLIAM RUSSELL	1482
Inpatient waiting: a discussion and policy proposal JOHN G CULLIS, PHILIP R JONES	1483
£9m to help primary care in inner cities	1486
GMC's proposals for basic specialist training	1487

CORRESPONDENCE

Falciparum malaria resistant to chloroquine: implications for prophylaxis P Francioli, MD, and others..... 1466	Legionella infection in Scotland 1981-2 R J Fallon, FRCPATH..... 1469	arteries or aneurysms and salmonella infection M Rahman, MRCPATH..... 1471
Stillbirth: a personal experience D H Horwell, FRCSed; D Morris, FRCP .. 1466	Whooping cough and pertussis vaccine G T Stewart, MD..... 1470	Inner cities: time for a cure J Cohen, FRCP..... 1472
Aetiology of human toxoplasmosis P M Hendy-Ibbs, MB..... 1467	Denmark—the elderly living in style J Jones, MB..... 1470	Measurement of digitalis like compound in plasma N C Henningsen, MD, and others..... 1472
A National Museum of Health? Julia Sheppard..... 1467	The controlled clinical trial and the advance of reliable knowledge D H Spodick, MD..... 1470	"I have been back from holiday for a week and still have diarrhoea" B Chattopadhyay, MRCPATH..... 1472
Changing pattern of poisoning in children D G Gill, FRCP; R H Jackson, FRCP, and others; A D Greig, MB..... 1468	Haemophilus influenzae type b resistant to ampicillin and chloramphenicol M A Cary and M V Vaz Pato..... 1471	Part time training in acute medical specialties Rosamond A K Jones, MRCP; Helen Lewis, DM..... 1473
Family and community factors associated with infant deaths that might be preventable D Southall, MD; Elizabeth M Taylor, MB, and J L Emery, MD..... 1469	Mean platelet volume in myocardial infarction J van der Lelie, MD, and J A C Brakenhoff, MD..... 1471	General management in the NHS J S Horner, FFCM..... 1473
	Rupture or leakage of atheromatous	Unsolicited mail M Kerr, MRCPG..... 1473

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 should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by *et al*; and the first and last page numbers of articles and chapters should be included.

Falciparum malaria resistant to chloroquine: implications for prophylaxis

SIR,—The report by Dr C Herzog and others (1 October, p 947) of resistant *Plasmodium falciparum* malaria from east Africa has prompted us to report that we have recently seen three such cases and to comment on recommendations for prophylaxis. R I and R II chloroquine resistant *P falciparum* (WHO classification) have been recognised in east Africa for several years, and there have been at least three recent reports of well documented R III chloroquine resistant *P falciparum* malaria acquired in that region.¹⁻³ This prompted the Centers for Disease Control in the United States to revise the recommendations for malaria chemoprophylaxis of travellers to east Africa, now advising the combination of chloroquine and Fansidar (pyrimethamine 25 mg and sulfadoxine 500 mg).⁴ In contrast, for several reasons, but mainly because of the scarcity of reports of high level chloroquine resistant *P falciparum* on the one hand and of the fear of development of Fansidar resistance on the other hand, the World Health Organisation (WHO) still recommends chloroquine as sole prophylactic agent for travellers in that region, advising, however, that, "persons under regular chloroquine prophylaxis should carry as a precaution a treatment dose of Fansidar, to be taken if fever occurs."⁵

Our three patients all had severe *P falciparum* malaria acquired in Kenya while they were taking chloroquine but not Fansidar prophylaxis. All gave a reliable history of meticulous daily chloroquine prophylaxis with a rather high total dose of 700 mg of chloroquine base per week. Adequate intake and absorption was also proved by the serum chloroquine concentrations (performed in Hoffmann la Roche Laboratory, Basle, by courtesy of Ms Renée Portmann), which were

within the therapeutic range of 31-310 nmol/l (10-100 µg/l) for sensitive strains,^{2,3} but were nevertheless insufficient to prevent a "break-through." Although the parasites could unfortunately not be cultivated and tested in vitro, the serum chloroquine concentrations at which these "breakthroughs" occurred are consistent with a high level of chloroquine resistance, similar to that of the recently isolated R III resistant strains.^{1,2}

Our three cases were observed over a short period of time at one hospital. They show that a high level of resistance is probably no longer a rarity in east Africa and, in view of the increasing frequency of similar reports, we believe that chloroquine can no longer be the sole prophylactic agent for non-immune travellers to that region, as still recommended by the WHO.⁵ As Fansidar resistance has also emerged in this part of the world, as described by Dr Herzog and his colleagues and by Eichenlaub *et al*,⁶ and as *P vivax* attacks might not be adequately prevented by Fansidar alone,⁷ the association of Fansidar and chloroquine appears to be the best regimen for the prophylaxis of malaria in travellers in this part of the world, unless specific contraindications are present.

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¹ Weniger BG, Blumberg RS, Campbell CC, *et al*. High level chloroquine resistance of *Plasmodium falciparum* malaria acquired in Kenya. *N Engl J Med* 1982;307:1560-2.

² Stuby K, Gorecka M, van Schulthess F, Reber-Liske R. Ein Fall von chloroquinresistenter Malaria tropica aus Ostafrika (Kenia). *Schweiz Med Wochenschr* 1983;113:258-60.

³ Chulay J, Spencer HC, Warshaw MM, *et al*. Chloroquine-resistant *falciparum* malaria. *N Engl J Med* 1983;308:781.

⁴ Centers for Disease Control. Revised recommendations for malaria chemoprophylaxis for travellers to East Africa. *MMWR* 1982;31:328-30.

⁵ World Health Organisation. Malaria chemoprophylaxis. *Weekly Epidemiological Record* 1982;57:381-4.

⁶ Eichenlaub D, Rogler G, Hoffmann HG, Weise HJ. *Falciparum* malaria despite pyrimethamine/sulfadoxine prophylaxis in five tourists to East Africa. *Lancet* 1982;ii:1041-2.

⁷ Leiliveld J. Problems with pyrimethamine/sulfadoxine malaria prophylaxis. *Lancet* 1982;ii:915.

Stillbirth: a personal experience

SIR,—Dr R J L Oglethorpe's personal paper (22 October, p 1197) emphasised the tragedy of stillbirth and the helplessness of women and their partners in the face of this totally unexpected event. Even when unavoidable, perinatal death challenges obstetricians, paediatricians, and midwives with their apparent failure to ensure the survival of a healthy child. It is therefore not surprising that the care of the parents is handled so poorly in many units.

One way in which this problem may be overcome is by familiarising medical and nursing staff of all grades with the correct and humane approach to the care of the parents and with all the procedures to be followed after stillbirth, including the awkward problems of certification and of arrangements for burial. These guidelines form one section of the protocol for the labour ward at this hospital, ensuring uniformity of approach by staff and avoidance of confusion for the parents and providing an opportunity for them to consider their options in advance, rather than having to take hurried decisions on matters such as whether or not to see the baby and where it should be buried.