

# BRITISH MEDICAL JOURNAL

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## LEADING ARTICLES

Management of multiple casualties with burns	RICHARD W GRIFFITHS	917
The Debendox saga	ML'E ORME	918
Families who care	MARTIN G LIVINGSTON	919
Vibration white finger: a newly prescribed disease	WILLIAM TAYLOR	921
Helping the sick doctor: a new service	K RAWNSLEY	922

## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Bronchoalveolar mast cells in extrinsic asthma: a mechanism for the initiation of antigen specific bronchoconstriction	KEVIN C FLINT, K B PETER LEUNG, BARRY N HUDSPITH, JONATHON BROSTOFF, FREDERICK L PEARCE, NORMAN MCI JOHNSON	923
Passive exposure to tobacco smoke: saliva cotinine concentrations in a representative population sample of non-smoking schoolchildren	M J JARVIS, M A H RUSSELL, C FEYERABEND, J R EISER, M MORGAN, P GAMMAGE, E M GRAY	927
Extrapyramidal reactions with metoclopramide	D N BATEMAN, M D RAWLINS, JUDY M SIMPSON	930
Egg and cows' milk hypersensitivity in exclusively breast fed infants with eczema, and detection of egg protein in breast milk	ANDREW CANT, R A MARSDEN, P J KILSHAW	932
Does stopping smoking delay onset of angina after infarction?	LESLIE E DALY, IAN M GRAHAM, NOEL HICKEY, RISTEARD MULCAHY	935
Severe hypocalcaemia and increased serum creatine kinase activity	P TIMMS, A M BOLD, P ROTHE, E LAU	937
Acute hypersensitivity reactions to paracetamol	B H CH STRICKER, R H B MEYBOOM, M LINDQUIST	938
Photosensitivity during treatment with azapropazone	STEN OLSSON, CECILIA BIRIELL, GUNNAR BOMAN	939
Unreviewed Reports—Orchitis and hepatitis B infection (MOLITOR and WARRENS), Cutaneous vasculitis and amiodarone (STARKE and BARBATIS), Metastatic resistance in multiple primary neoplasms? (LEES and TAYLOR), Nephrotic syndrome and malignant peritoneal mesothelioma (HUBBARD and HOLMBERG), Terfenadine causing hair loss (JONES and MORLEY), Sympathomimetic abuse and coronary artery spasm (KEOGH and BARON)		940
Common childhood problems: variation in management	DAVID JEWELL, JOHN BAIN	941

## MEDICAL PRACTICE

Treatment of burns casualties after fire at Bradford City football ground	D T SHARPE, A H N ROBERTS, T L BARCLAY, W A DICKSON, J A D SETTLE, D J CROCKETT, M G MOSSAD	945
Epidemic of prosthetic valve endocarditis caused by Staphylococcus epidermidis	P J VAN DEN BROEK, A S LAMPE, G A M BERBÉE, J THOMPSON, R P MOUTON	949
ABC of Nutrition: Food sensitivity	A STEWART TRUSWELL	951
Lesson of the Week: Prolonged hypoparathyroidism presenting eventually as second trimester abortion	R EASTELL, C J EDMONDS, R C S DE CHAYAL, I R MCFADYEN	955
Personal Paper: Costs of health care: experience of one department of rheumatology	A K THOULD	957
Medicolegal: Doctors and blood tests	BY OUR LEGAL CORRESPONDENT	959
USSR Letter: Aspects of Soviet surgery	MICHAEL RYAN	960
CSM Update: How CSM data can be used by doctors		962
Any Questions?		950, 961
Materia Non Medica—Contributions from JAMES W RAE, BASIL MILES		956
Medicine and Books		963
Words—B J FREEDMAN		956
Personal View	MARY DUNLOP	965

CORRESPONDENCE—List of Contents	966
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OBITUARY	979
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## NEWS AND NOTES

Views	975
Medical News	976
BMA Notices	978

## SUPPLEMENT

The Week	981
Clinical freedom and management accountability	
MAX RENDALL	982
Medical manpower: a district model	
J N TODD, ANN-MARIE COYNE	984
Clinical academic staff salaries: Sir Keith Joseph to meet vice chancellors	986
"Towards quality in general practice": GMSC discusses RCGP's paper	987
Correction: GMSC Defence Fund Limited	988

# CORRESPONDENCE

<b>HTLV-III infection in spouses of haemophiliacs</b> P F Unsworth, MRCPATH . . . . .	966	<b>Factors that influence patients in Sri Lanka in their choice between Ayurvedic and Western medicine</b> I Wolffers, MD . . . . .	970	<b>Economics of coronary artery bypass grafting</b> R J Jarrett, FFCM . . . . .	972
<b>Absorption of 1.5% glycine after percutaneous ultrasonic lithotripsy for renal stone disease</b> N M Goble, FRCS, and others; R A Miller, FRCS, and H N Whitfield, FRCS . . . . .	966	<b>Aminoglutethimide induced agranulocytosis in breast cancer</b> G Caldwell, MRCP, and others . . . . .	970	<b>Manpower problems in general surgery</b> N G Rothnie, FRCS . . . . .	973
<b>Is the incidence of ectopic pregnancy rising?</b> M Burke, FRCS, and P Dale . . . . .	967	<b>Relation between recurrence of cancer and blood transfusion</b> L E F Moffat, FRCS, and G T Sunderland, FRCS . . . . .	971	<b>Consultants' contractual commitments</b> D H Vaughan, FFCM . . . . .	973
<b>Over the counter sale of topical corticosteroids</b> S Shuster, FRCP . . . . .	967	<b>Do locum duties help or hinder acquisition of clinical knowledge by final year medical students?</b> B A Ruparelia, MRCP . . . . .	971	<b>Trident versus health</b> J H Humphrey, FRCP, FRS, and others . . . . .	973
<b>Deaths from peptic ulceration</b> K G Wormsley, FRCP; R M Watkins, FRCS, and J Collin, FRCS . . . . .	968	<b>Do sex hormones affect colorectal cancer?</b> A M Walker, MD, and H Jick, MD . . . . .	971	<b>Points</b> Brain ischaemia (K Easton); General practitioners' advice on smoking to patients referred for barium meals (M Goldman); Persistent priapism (E N S Fry); Artificial insemination by donor (Bridgett A Mason and Susan Smith; J Slome); Ear wax and otitis media in children (C B Freer and Anne Fairley); Is the Dalkon shield more dangerous than other IUCDs? (J S Templeton); Female circumcision (S A Bhatti); Student audit of clinical teaching (G Houghton); Snoring as a risk factor for disease (W Liskiewicz) . . . . .	974
<b>Antihypertensive treatment in pregnancy</b> P Hogston, FRCS; E D M Gallery, FRACP, and others; L W Doyle, FRACP, and M A Quinn, FRACOG . . . . .	968	<b>Smoking, sugar, and inflammatory bowel disease</b> G B Porro, MD, and E Panza, MD . . . . .	971	<b>Correction</b> Intranasal calcitonin (Pontioli) . . . . .	974
<b>Raised plasma glutathione S-transferase values in hyperthyroidism and in hypothyroid patients receiving thyroxine replacement</b> R J Mardell, BSC, and T R Gamlen, MRCP . . . . .	969	<b>MRC trial of treatment of mild hypertension</b> Hendrika J Waal-Manning, MD, and others . . . . .	972		
<b>Thyroxine replacement treatment: clinical judgment or biochemical control</b> Vicky Rippere, PHD . . . . .	970	<b>Increase of oleic acid in erythrocytes associated with malignancies</b> N A Habib, FRCS, and others . . . . .	972		

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

## HTLV-III infection in spouses of haemophiliacs

SIR,—Dr Peter Jones and colleagues (14 September, p 695) rightly emphasise the urgency of finding the real (versus perceived) risk to wives of male haemophiliacs with human T cell lymphotropic virus type III infection.

May I suggest that we need to study how many female partners who contract infection have practiced anal intercourse? It is known that receptive (but not insertive) anal intercourse is a main risk factor for HTLV-III infection in male homosexuals.<sup>1</sup> Only limited reports have been made of spread to female sexual contacts of patients with the acquired immune deficiency syndrome and of persons in high risk groups; and in the USA the proportion of women affected has remained constant at about 6% of the total.<sup>2</sup> If it were shown that vaginal intercourse was much safer than anal

intercourse in the partners of male haemophiliacs, this would greatly relieve anxiety and enable prevention of an important risk factor.

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1 Goedert JJ, Sarngadharan MG, Biggar RJ, *et al.* Determinants of retrovirus (HTLV-III) antibody and immunodeficiency conditions in homosexual men. *Lancet* 1984;ii:711-6. Quoted in *Acquired immune deficiency syndrome: General Information for Doctors*. London: DHSS, 1985:13.

2 Department of Health and Social Security. *Acquired immune deficiency syndrome: general information for doctors*. London: DHSS, 1985.

## Absorption of 1.5% glycine after percutaneous ultrasonic lithotripsy for renal stone disease

SIR,—Because our urology department is actively concerned in the further investigation of the water intoxication syndrome (associated with both transurethral prostatectomies and percutaneous stone surgery) it was interesting to read the paper by Dr John F Sinclair and colleagues (14 September, p 691). There are, however, certain incongruities in the case they report.

Firstly, the use of the term transurethral resection reaction to describe the sequence of symptoms and signs in this case is probably a little misleading. The cause of water intoxication during percutaneous surgery is related to irrigant extravasation rather than the intravenous absorption occurring through the prostatic plexus (although

extravasation can occur to an appreciable extent during transurethral prostatectomies). The intravenous form of absorption is much more dangerous from the point of view of the rapidity with which it can occur, although extravasation into the peritoneal cavity may in itself lead to vascular collapse.<sup>1</sup>

Secondly, the report refers to hyperkalaemia being a cardinal feature of the transurethral resection reaction. We, however, have not found this to be the case and as far as we are aware there is only one other report of 1.5% glycine absorption being associated with hyperkalaemia (5.5 mmol).<sup>2</sup> Indeed, hypokalaemia during the ensuing diuresis is the more common feature. Furthermore, to

explain the hyperkalaemia on the basis of intravascular haemolysis is certainly contentious: 1.5% glycine is hypotonic, but Nesbit in his original work used 1% glycine in 200 cases with no evidence of haemolysis,<sup>3</sup> nor has this phenomenon been documented elsewhere to our knowledge.

Thirdly, the routine, use of hypertonic saline for the treatment of water intoxication is potentially hazardous due to the risk of precipitating fatal pulmonary oedema.<sup>4</sup> This is normally therefore reserved for combating the serious effects of water intoxication on the central nervous system and the hypervolaemia corrected using loop diuretics, or even allowing the natural diuresis to ensue.<sup>5</sup> There has in fact been only one recent trial on the efficacy of loop diuretics in the transurethral resection reaction, when no difference was found between the treated and untreated groups after 24 hours.<sup>6</sup> Therefore it is difficult to define an appropriate treatment for water intoxication.

Lastly, the paper suggests the use of saline for irrigation during lithotripsy. This proposal must be qualified to exclude electrohydraulic lithotripsy, where use of an electrolytic irrigant is absolutely contraindicated. Since this is becoming the more accepted means of stone disintegration during percutaneous surgery it would appear that the early recognition of irrigant absorption-extravasation and the abandonment of the procedure is the best recourse.

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