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G ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Lyme disease

SIR,—Dr Derek C Macallan and colleagues describe yet another presentation of Lyme disease (25 April, p 1062). We describe two cases of Lyme disease whose presentation has important implications for general practitioners, particularly those in rural areas.

On 26 June 1985 a woman living near Chard, Somerset, went to a local wood to collect stripped bark for her garden; she noticed a pile of bark infested with ticks. By 1 July she had sore eyes, a slight fever, and aching neck and arms. She consulted her general practitioner, who diagnosed a viral infection. The pain in her neck and left arm became worse and by 6 July she had a unilateral facial palsy. Her general practitioner confirmed a Bell's palsy and photographed her face. Subsequently her arms and neck recovered but pain was evident in the distribution of both sciatic nerves. Her facial weakness began to recover by 10 July, and after profuse nose bleeds on 17 and 18 July she was fully recovered with all signs and symptoms quite resolved by 21 July. Her general practitioner confirmed her recovery and rephotographed her face.

The patient discussed her illness with a neighbour, who revealed that he, a fit 45 year old, had had a similar facial paralysis the year before. He gave the following story. In September 1983 he suffered intense back pain after going to remove fallen trees in the same wood. The pain and stiffness extended to the right wrist, elbow, and shoulder. In spite of rest the pain increased over the next two weeks sufficient to cause sleeplessness. He was treated with analgesics and osteopathy with little effect. His face became stiff and he developed a facial palsy which lasted for a week. It was not until six weeks after his original trip to the wood that he was fully recovered. The second patient had noticed numerous ticks in the wood, which is populated by deer, and he had been bitten many times. He had had minor rashes, which he attributed to contact with gorse.

Chard (population 11 000) provides a wealth of unusual cases and so the presence of Lyme disease was, perhaps, to be expected. Sera from both patients, when examined by Dr Wright at Charing Cross Hospital, produced a strongly positive result in the indirect immunofluorescence antibody tests to *Borrelia burgdorferi*.

Bell's palsy is not uncommon, with in our experience an incidence of one or two cases a year in a practice of 6000 patients. In these cases the general practitioner's interest was aroused by the patient's observation that a neighbour had had a similar illness and the suggestion that it might have a tick borne aetiology. In contrast to the patients with Lyme disease previously reported in Britain,[1-3] these patients had relatively trivial illnesses. Nevertheless, it is clear from the burgeoning reports that despite the minor nature of the initial infection the long term sequelae may be extremely unpleasant. In future Lyme disease should be considered in the differential diagnosis of facial palsy particularly in the presence of systemic symptoms—however mild.

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1 Williams D, Rolles CJ, White JE. Lyme disease in a Hampshire child—medical curiosity or beginning of an epidemic? *Br Med J* 1986;**292**:1560-1.
2 Bateman DE, White JE, Elrington G, Lawton NF. Three further cases of Lyme disease. *Br Med J* 1987;**294**:548-9.
3 Bendig JWA, Ogilvie D. Severe encephalopathy associated with Lyme disease. *Lancet* 1987;i:681-2.

Drug formularies in hospitals

SIR,—The coincidence of a leading article on drug formularies in hospitals (11 April, p 919) and a vigorous correspondence on propofol infusion for sedation in the intensive care unit (p 970) in the same issue prompts me to hoist a distress signal from the wastelands. It is particularly apt that the correspondence from University College Hospital considers the cost and suggests that there may be a case for "rationing this promising drug to those patients in whom rapid awakening is essential." The cost conscious author of the leading article would clearly approve.

Frankly, University College Hospital is lucky to have such freedom of choice. In this teaching hospital the committee that admits new drugs into the hospital formulary does not at present allow the use of propofol at all for long term sedation. Much as I and my colleagues might like to enter the clinical debate, we could hope to do so only if the makers of the drug were willing to subsidise the health authority by a not inconsiderable sum by providing free supplies. Otherwise, we can offer this treatment only when we can make a convincing case that it represents a real therapeutic advance—on evidence presumably obtained by those who have a more enlightened formulary committee (or