BIO-MEDICAL RESEARCH
DOCUMENT DESCRIPTION FORM

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year as-1961-	File number [Right justify [Numeric only]	Sub-Index Code

R&S 109921

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requiring assisted ventilation and eventually tracheostomy. Two other PLS patients, however, were able to tolerate up to 75 mg/day in divided doses, with improvement of spasticity and speech (spastic dysarthria). There was no single instance in the cases in which the drug failed when the patient was able to tolerate 75 mg/longer than five days.

The reason for this low tolerance to dantrolene in patients with ALS is not clear, but this fact should be considered when treating spasticity in patients with associated motor neuron dysfunction.

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1. Monster AW, Herman R, Meeks S, et al: Cooperative study for assessing the effects of a pharmacological agent on spasticity. *Am J Phys Med* 52:165-168, 1973.
2. Gelenberg AV, Poskanzer DC: The effect of dantrolene sodium on spasticity in multiple sclerosis. *Neurology* 23:1313-1315, 1973.
3. Chyatte SB, Basmajian JV: Dantrolene sodium: Long-term effects in severe spasticity. *Arch Phys Med Rehabil* 54:311-315, 1973.

Reporting of Anticonvulsant Blood Levels

To the Editor.—The article by McDanal and Bolman (231:1063, 1975) presents a psychotic reaction to phenytoin (formerly diphenylhydantoin) that they conclude was an idiosyncratic reaction because blood levels of phenytoin were low. Unfortunately, there is as yet no generally agreed standard way of reporting anticonvulsant blood levels. Most laboratories report the levels as indicated by McDanal and Bolman in μg/mg, but others, including our own, continue to report the levels in mg/100 ml. This can lead to obvious confusion both on the part of the reporter as well as on the part of the reader. For example, the therapeutic range of phenytoin is indicated by the authors to be 10μg to 15μg/ml, which is the same as 1 to 1.5 mg/100 ml.

Confusion in making this transposition led to erroneous statements, for example, in the 1969 *Physician's Desk Reference*, concerning therapeutic and toxic levels of phenytoin, in which a wide latitude between these two was indicated. All epileptologists now agree this is simply not so, and that the upper end of the therapeutic range merges with the lower end of the toxic range and sometimes overlaps.

This prompts me to ask the authors of the article in question: "Are we sure that no similar mistake in transposition was made by either the laboratory or the physicians in the case of the patient reported?" The case would not be unique if the blood level in their case were actually 3.2 mg/100 ml.

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In Reply.—Laboratories do report anticonvulsant blood levels differently, and this can be confusing to physicians. We recognized this point and reported the correct values in our article. Our reported values of 3.2μg and 2.2μg/ml correspond to 0.32 and 0.22 mg/100 ml, respectively.

Dr. Karnes' point is an important one and should be made to all clinicians.

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Vietnamese Refugees

To the Editor.—There has been increasing concern and discussion about possible health hazards that might be brought to this country by the large number of Vietnamese refugees currently being processed in various centers in the United States. I wish to call attention to a different type of health hazard, one faced by the refugees themselves rather than their hosts.

Approximately 18,000 of the Vietnamese are awaiting relocation at Camp Pendleton in southern California. This base has for many years been known as an area of fairly high incidence for coccidioidomycosis. The late spring is one of the highest incidence periods of the year. All of us have seen pictures of the refugees being housed in open areas in tents, with children playing in the bare dirt outside. It is this intermingling of susceptible hosts in an endemic natural habitat that produces a considerable amount of disease among the Marine recruits who normally inhabit that area.

The incubation period for coccidioidomycosis is between 10 and 21 days. It is therefore quite possible that some individuals who have acquired their disease while at Camp Pendleton will report to medical facilities elsewhere in the country with a lower respiratory tract infection and probably lesions on x-ray examination. It is further not only conceivable but likely that most physicians in areas outside the coccidioidal endemic area, seeing a Vietnamese refugee with a pulmonary lesion, will call this tuberculosis, or melioidosis, or perhaps even pneumocystis pneumonia, particularly in the children.

Furthermore, in view of the well-known fact that Asiatics have a considerably higher incidence of dissemination following primary coccidioidal infection than have certain other racial groups, it becomes imperative to call the attention to physicians throughout the country to the possibility of coccidioidal infection in the Vietnamese refugees.

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Hemangiosarcoma

To the Editor.—A recent report (231:914, 1975) indicated that in a case involving primary hemangiosarcoma, liver tissue gave a strong positive reaction for acid mucopolysaccharide. Prompted by this report, we have examined for this property, specimens from our files. In three cases of hemangiosarcoma we stained sections of liver with alcian blue, pH 2.5 (nuclear-fast red-counterstain).[1] Adequate amounts of both tumorous and normal surrounding tissue were present on the slides. However, in contrast to Drs Barr and Bonnin, we were unable to detect either tumor cell staining properties or matrix that might distinguish them from those of adjacent liver tissue. Our results suggest that this particular approach is probably *not* useful as a marker for primary hemangiosarcoma of the liver.

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1. Luna LG (ed): *Manual of Histologic Staining Methods of the Armed Forces Institute of Pathology*, ed 3. New York, McGraw-Hill Book Co Inc, 1968, p 58.

Still More on Catfish Stings

To the Editor.—Previous letters on this subject (231:176, 1975; 232:248, 1975) have failed to mention anything about prevention.

My father was an inveterate catfish catcher and always included in his kit two pieces of equipment: a pair of canvas gloves and pliers. Having landed a catfish, he used the gloves to prevent its slipping as he held it. Then the pliers were used to pull out the stings—a simple technique to prevent a troublesome problem.

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