Management of acute stroke

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transferred and not transferred? This would be of great value to many medical and geriatric services who do not have the facilities of a stroke unit and who regularly inducte in transferring stroke patients, albeit at times it seems in a wholly random fashion.

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* * We sent this letter to Dr W M Garraway and his colleagues, whose reply is printed below.—En, BMJ.

Sir,—The limitations inherent in conducting controlled trials of methods of providing health services, which we refer to in our paper, mean that we have no information on the criteria which were used to transfer a selected group of patients from medical units during the acute phase of rehabilitation. But we were able to examine the results of standard clinical tests which were designed to predict outcome following acute stroke, and which will form the subject of a future publication. No difference was found in the pattern of neurological impairment present in the transferred group compared with those patients remaining in medical units throughout. Therefore it may not be surprising that there was no difference in outcome between the two groups. Transferring stroke patients from medical units for further rehabilitation appears to be a common practice in Britain, and on the basis of our results these transfers should be arranged earlier rather than later if the full benefits of intensive therapy following stroke are to be a reality.

A solution to the problem may be the use of the Ridel-Walker technique for Salmonella typhi—instead of for teaching purposes or evaluating disinfectants for hospital use, where because of the readily availability of Salmonella cultures alternatives to Staphylococcus aureus may be inadvertently used. While we agree with the Howie Codew's recommendation that the use of exhaust protective cabinets (class 1) is necessary for most category B pathogens, which cause airborne infections, we do not agree that it is appropriate for organisms causing infection by the alimentary route such as Salmonella typhi. To cover this case the association had drawn up its own code of practice for the handling of Salmonella typhi NCTC 786 in members' laboratories.

R A COWEN
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Why has Swann failed?

Sir,—In your leading article (17 May, p 1195) you state that legislation enacted as a consequence of the Swann Report has failed to prevent the emergence of multiple drug resistance in Salmonella typhimurium in bovines in Britain despite the fact that it was precisely intended to do so. The legislation was not designed to do this. Its purpose was to stop the feeding of pigs and table chickens continuously on diets containing antibiotics which are used in veterinary medicine, because the practice had given rise to enormous populations of antibiotic-resistant bacteria in these animals. The feeding of such diets to bovines in Britain had never been permitted.

The Swann legislation, in essence, has now been adopted by many other countries and I think Britain can take some pleasure in having initiated it.

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Possible cancer hazard associated with 5-methoxypsoralen in suntan preparation

Sir,—With regard to the current discussion (3 November, p 1144; 1 March, p 648; 29 March, p 940) on the safety of cosmetics containing 5-methoxypsoralen (bergapten) I would like to add a number of points.

(1) Although the current controversy concerns the suntanning aids containing bergamot oil, they are not the only cosmetics involved. Of a total of 108 perfumes investigated, 57.4% contained bergapten in concentrations ranging from 0-0004 to 0-0108%.1 Perfumes are therefore likely to produce phototoxicity unless the psorals are removed or the content of 5-methoxypsoralen reduced to 0-001%.2 Subjects known to be sensitive to small concentrations of 5-methoxypsoralen and patients suffering the disease of urticaria due to sun caitvate should therefore be warned about all these preparations.

(2) The suntanning aids of current concern contain up to 0-003% (30 ppm) (Chfaro Proprieties Ltd, perfunctory). The amount of 5-methoxypsoralen necessary for the achievement of an enhanced tan has, however, been reported to exceed 1%.3

(3) Not only is there a possible risk of human carcinogenicity associated with the use of methoxypsoralens in combination with ultraviolet A light, but also there may be as yet unknown effects on the microbial ecology of human skin. Methoxypsoralens are known to induce photoactivations in various bacteria and fungi. Any genetic changes in skin organisms may be clinically important with regard, for example, to acquisition and transfer of antibiotic resistance.4

(4) Many substances are photosensitisers. They include several fluorescent dyes (erythrosin B), some metabolites (for example, bilirubin and porphyrins, and drugs like phenothiazines, tetracyclines, sulphonamides, thiourea, naldixic acid, frusemide, quinine, and anthracycline).5 The topical application therefore of preparations containing another phototoxic compound, 5-methoxypsoralen, could lead to an increased photosensitivity in any already sensitised skin.

(5) All tanning aids contain sunscreens, which are substances designed to prevent