LETTERS TO THE EDITOR

ANTERIOR CRUCIATE LIGAMENT CONSTRUCTION USING THE GORE-TEX LIGAMENT
From: Major B R Singer, RAMC and Group Captain M W Ward, RAF

Sir, Captain Bowyer and Major Matthews (1) are to be congratulated for reminding us of the serious implications of anterior cruciate ligament (ACL) injuries to a soldier’s fitness and career. Their short follow-up (mean of 18 months) reflects the problems inherent in reviewing a mobile population of servicemen.

A patient who underwent a Gore-tex ligament reconstruction at Queen Elizabeth Military Hospital during the study period was recently admitted to the Princess Alexandra Hospital. He had obtained a good post-operative result and was returned to full military activities. Two weeks prior to admission he had reinjured his knee during military training. Examination revealed medial collateral ligament and ACL instability and the Gore-tex ligament was found to be completely ruptured at arthroscopy.

This case unfortunately demonstrates the already noted (2,3) deterioration in results of ACL reconstruction with time. The need for follow-up beyond 5 years in order to assess ligament reconstruction is reinforced.

We are etc
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REFERENCES:

DOCUMENTATION OF BLOOD FOR TRANSFUSION
From: W02 K A Smith, RAMC

Sir, with reference to Colonel Thomas’s reply to my earlier letter (J R Army Med Corps 1991; 137; 107-108), it is reassuring to see that Colonel Thomas agrees with the second paragraph of my letter in that the risk of raising an anti-C or anti-E in cde/cde patient transfused with a single unit of r" or r' blood is extremely low, and also that an MLSO would not be blamed for selecting such a labelled unit of blood.

Clearly we are duty bound to follow the policy of the National Directorate of the NBTS but, considering the points raised in favour of retaining the Rhesus genotype on the label, it is doubtful that such information would provide any significant technical advantage in the event of known or overt patient allo-sensitisation and this is poor justification for its presence on the unit of blood. The facts remain that correct pre-transfusion testing, including previous history, antibody screening and identification will identify patients of potential risk and any competent blood bank department will select antigen negative units serologically, before crossmatching. Although more than 90% of clinically significant red cell allo-antibodies routinely found are Rhesus, Kell or Duffy, many of them (and far more examples of anti-C and anti-E) are found in Rhesus (D) positive patients anyway making the argument irrelevant.

If the presence of a Rhesus genotype on the label is intended to provide important information then why is it only restricted to less than 1.7% of the UK donor population? Similarly if this is the intent then a more comprehensive blood group genotype should also be provided on all units including Kell, Duffy and Kidd. Clearly this would be ridiculous and expensive. It should also be noted that world leading blood banking authorities actively discourage and do not recommend the testing of blood for transfusion beyond ABO and D in routine circumstances (1,2,3).

Of course it is the responsibility of the clinician in charge of the transfusion to transfuse any given unit, but it is the pathology staff who select that unit for crossmatch and in whom that clinician must trust to provide him with clear unambiguous information from which to make his decision.

The presence of the r" or r' label on a few units can only confuse unnecessarily even though in reality its presence is of negligible consequence. If the risks are negligible and the information provided is insignificant then such a label is inappropriate. If it were not there then no-one involved in the transfusion could be blamed.

I am etc
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REFERENCES
3. PETZ D. In Clinical Practice of Transfusion Medicine, 2nd edn, Churchill Livingstone. 1989,248
THE ANTABUSE PROVOCATION TEST AND NEW MANAGEMENT STRATEGY
From Colonel (Retd) D E Bradford, LIRAMC and Major A C Thompson, RAMC

Sir, the patient was suitable, her husband was suitable and they were both agreeable to a treatment course of supervised Antabuse. She was duly started on therapy and in the course of events admitted for an antabuse/ethanol provocation test. But who would pay for the alcohol?

"Not I", said the dispenser. "Not I", said the medical supplies officer. "My alcohol is not for drinking", said the pathologist. "I have plenty of beverage alcohol", said the mess manager, "but not for treatment".

She responded well to three measures of her favourite tipple and a signed bar chit is now on its way to the budget holder in the hope that someone somewhere will have funds to pay for therapeutic alcohol.

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SIDE EFFECTS OF NERVE AGENT PRE-TREATMENT SYSTEM
From Captain J A N Slade, RAMC

Sir, I was very interested to read Major P Kennedy's personal anecdote, and explanation for chest pain associated with Nerve Agent Pre-Treatment Symptom Tablets (NAPS) during OP GRANBY (Letters, Vol 137 No 3 October 1991). I too suffered with this, and saw at least two more patients with the same. I wonder if sublingual GTN would be appropriate to relieve this in protracted cases?!

I am etc.

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From Colonel G O Cowan, LIRAMC

Sir, I don't really feel that the NAPS side-effect reported anecdotally by Major Kennedy and Captain Slade merits much attention. This did not come up in two large surveys of hospital staff in the Gulf. The solution is to swallow the NAPS with plenty of liquid. Local oesophageal spasm might certainly respond to a nitrate, nifedipine or a little atropine or hyoscine.

As to the meningitis charity and their letter, I suggest that this is a 'Prev Med' matter. Lt Col Lois Lodge has studied the subject but Brig Tony Harwood might offer guidance.

I am etc.

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SIDE EFFECTS OF DOXYCyclINE
From Captain M J Bennett, RAMC

Sir, The side effects of doxycycline are well recognised, but may often go unreported. Nausea, vomiting, photosensitivity and onycholysis are side effects of the group as a whole but there is a marked variation between specific drugs.

On a sailing holiday to Turkey during August 1991 the seven members of the crew took 100mg of doxycycline once per day as a prophylaxis against traveller's diarrhoea. Five of the group reported an unusual pattern of sunburn on their hands and forearms where they had not previously burned. This caused severe pruritus and stinging which had lasted for up to eight hours after sun exposure ceased and which would flare up after only a few minutes of sun exposure the following day. All but one member noticed discoloration of their nails three weeks after the fortnight's course had ended and in five of these cases this progressed to onycholysis involving between two and eight nails. The onycholysis was associated with severe pain as if the nails had been trapped in a door and which prevented simple tasks being performed. In one case the detached nail became secondarily infected although this did not require drainage.

Doxycycline has been shown in trials to be 79% protective against shigella (1) and similarly effective against Escherichia coli.

A study in 1983 conducted in Mexico in which 145 volunteers took doxycycline for only three days reported minimal side effects of nausea in 8% and nausea with vomiting in 4% (2).

Cell culture studies have shown that doxycycline is concentrated in mitochondria and damage occurs to both these organelles (3) after exposure to both UVA and UVB irradiation (4). Initially this damage is reversible, but with greater intensity and length of exposure cell necrosis occurs. Onycholysis appears to result as a consequence of the nail acting as a lens (5).

A patient who had been taking tetracycline-hydrochloride for several years with no adverse effects for Rosacea developed onycholysis after one month of exposure to high intensity sunlight while abroad on holiday (6).

A trial to compare the photosensitivity produced by doxycycline, desmethylchlortetracycline and lymecycline in subjects exposed to UVA and UVB showed that a similar degree of erythema was produced irrespective of which drug had been taken. However subjectively only those taking doxycycline experienced stinging, and this symptom was found in 50% (7).

The prophylactic effect of doxycycline in traveller's diarrhoea is well demonstrated. Similarly it is increasingly being shown to be a highly effective prophylaxis.
against falciparum malaria (8). The high rate of side effects, particularly when exposure to sunlight is intense, and when prophylaxis is required for more than a week makes its use highly questionable.

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REFERENCES

HONORARY CONSULTANTS TO THE ARMY

Dr P A Trot has been appointed Honorary Consultant in Cytopathology to the Army with effect from 22 August 1990.
Mr C A Van Hasselt has been appointed Honorary Consultant in Otorhinolaryngology to BMH Hong Kong with effect from 5 June 1990.
Mr A B MacGregor has been appointed Honorary Consultant in Surgery to the Army in Scotland with effect from 26 March 1990.
Mr D C Rule has been appointed Honorary Consultant in Dental Postgraduate Education to the Army with effect from 8 May 1990.

Professor G Slavin has been appointed Honorary Consultant in Histopathology to the Army with effect from 18 November 1991.
Dr P Hamilton has been appointed Honorary Consultant in Neonatology to the Army with effect from 1 November 1991.
Dr I Hopper has been appointed Honorary Consultant in Otorhinolaryngology to the Duchess of Kent's Military Hospital with effect from 18 November 1991.
Professor M J Farthing has been appointed Honorary Consultant in Gastroenterology to the Army with effect from 16 September 1991.