

mechanism defined by Cooke and Van der Veer in 1916;² and Storm van Leeuwen described reactions to mites in 1922.³ By 1928 Dekker was recommending house-dust mite-control measures to treat allergic disease.⁴ Voorhorst and colleagues in Holland in the 1950s and 1960s identified the faeces of the mite *Dermatophagoides pteronyssinus* as the major dust allergen⁵ (elegantly confirmed with monoclonal-antibody techniques by Tovey himself in 1981).⁶

Encasing the mattress was an allergen-control procedure routinely recommended from at least the 1940s. Contrary to the impression given by Tovey, there have been many controlled trials of their effectiveness.⁷⁻¹¹ Tovey and colleagues suggest the cost of allergen-barrier bed covers is prohibitive and quote the prices of one particular range. In fact, comparable products are available by mail order at a fraction of that cost from several specialist UK companies (adult mattress covers about £28). There are three reasons why environmental measures came to be virtually ignored: the change of emphasis since the introduction of corticosteroids and beta-agonists; commercial interests of pharmaceutical companies; and, most importantly, the refusal to accept allergy as a medical specialty in its own right in the English-speaking world outside North America. It would seem that each generation of UK doctors treating allergic diseases will be condemned to reinvent the wheel so long as the subject is excluded from undergraduate and postgraduate curricula.

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Haemorrhagic fever with renal syndrome

SIR—Kulzer and colleagues (July 31, p 313) report a substantial rise in the incidence of nephropathia epidemica in Germany during the first half of 1993. In 1989 we reported the increased recognition of hantavirus infection in the Netherlands.¹ Each year a few sporadic cases have been diagnosed, mostly in the eastern part of the country. In our hospital this amounted to 14 patients from 1974 to 1992. In 1993, 8 cases of hantavirus-induced acute renal failure have been treated in our hospital, 7 since June.

In this area, near the German border, an abundance of bank voles (*Clethrionomys glareolus*) has been noted since the spring of this year. Scandinavian experience has shown a relation

between the incidence of nephropathia epidemica and the cyclic variation in bank-vole prevalence.² We agree with Kulzer et al that the diagnosis of this disease can be easily overlooked and that subclinical cases almost certainly occur. The suggestion of an unrecognised pandemic needs serious attention, because not every case of nephropathia epidemica runs a benign course.³

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Haemorrhagic colitis epidemic in Africa

SIR—Isaacson et al¹ reported an outbreak of haemorrhagic colitis in Swaziland in southern Africa, and their results corroborate our own findings and impressions. In our paediatric unit in Angola, Luanda, we have been confronted for the past 12 months by patients with dysentery in whom we could not identify the common pathogens (shigella, *Entamoeba histolytica*). However, by March we noticed a gradual increase in the frequency of cases, which coincided with the rise of cholera (these were probably both exacerbated by the season and the concentration of war refugees), and from April 20 to May 31 we treated 248 children aged 0-8 years.

The clinical presentation was similar to that of the South African workers: intense colicky abdominal pains and colonic stool pattern (not very fluid with mucus and blood leading sometimes to the need for transfusion). Many cases were severe and a substantial number died (for example, in 1 child, whose mother and 2 siblings had died with the same clinical picture, we found numerous deep ulcers in the sigmoid and ascending colon, and the patient died despite our attempts). In most of our cases the outstanding finding was an unmixed and profuse growth of *Escherichia coli*, which we could not type because we did not have specific sera, and which was sensitive to cotrimoxazole, tetracycline, and chloramphenicol, and resistant to ampicillin-amoxycillin. Enterohaemorrhagic *E coli* was suspected. This finding was questioned because shigella was implicated in an outbreak last year in a southern province outside government control and which has ties with South Africa. Furthermore medical practitioners in the city were treating patients as if the cause of the outbreak was *E histolytica* (the price of one tablet of metronidazole on the black market rose to 1/100 to 1/50 of the minimum wage).

We had 1864 admissions in our unit in April and May and found different features from those of the coincident cholera epidemic. The better-housed families (living in the centre of the city and usually spared from cholera) were also affected, and there were more intra-family cases. Both epidemics spared most breastfed babies and declined in June.

By contrast with the South African workers, chemotherapeutic agents were not useful in the advanced cases admitted to hospital (probably with widespread severe colonic pathology, and demanding a great deal of general support); however, the use of cotrimoxazole/tetracycline in the early ambulatory cases was associated with a good recovery in most patients.

A task force created by the Ministry of Health with the support of UNICEF and other agencies is acting to reduce this