worse, was advised to omit—his insulin, because he was not eating a normal diet, or was vomiting. Omission of insulin in the insulin dependent diabetic will inevitably lead to ketoacidosis and its prompt treatment is therefore essential if these disasters are to be avoided.

A period of thirst, polyuria and weight loss usually precedes vomiting, over-breathing and drowsiness by a matter of days or weeks in the previously undiagnosed diabetic; but for the diabetic already on insulin, omission of one dose of insulin can lead to diabetic coma within a matter of hours; vomiting under these circumstances is particularly ominous.

The diabetic must be taught how to manage his diabetes in the presence of intercurrent illness or infection. The normal carbohydrate allowance can frequently be tolerated even if solids cannot. One tablespoonful of 'Ribena', four tablespoonsful of 'Lucozade', or two teaspoonsful of sugar dissolved in water flavoured with diabetic squash, are each equivalent to ten grams of carbohydrate and can be used in place of solids.

The urine must be tested twice daily and if 1–2 per cent glycosuria develops in the presence of infection the insulin should be increased. For adult diabetics on twice daily soluble insulin an increase of about one-third of each dose until the urine shows less than one per cent glucose, is usually adequate. If this does not rapidly restore control an extra dose of about eight units of soluble insulin may be given before the midday meal, as long as the urine at that time shows 1–2 per cent glucose.

For diabetics on a single injection of soluble plus a long acting insulin, if the urine before the injection and before the evening meal shows 1–2 per cent glucose, the soluble insulin should be increased by about one third of the total dose in the morning, and an additional dose of about eight units of soluble insulin should be added before the evening meal. These doses may need further daily increases until there is less than one per cent glycosuria.

Increasing the dose of a daily injection of lente or isophane insulin is often not very effective in overcoming a rapid increase in insulin requirement, and if control is not rapidly restored by so doing it is wise to switch temporarily to twice daily soluble insulin.

Finally, if diabetes is not rapidly controlled at home in the presence of intercurrent infection and particularly if there is continued vomiting, the patient should be admitted to hospital. Hospital doctors should always be ready to admit such patients as a little trouble spent in prophylaxis can avert a major medical emergency.

D. PYKE
J. SHELDON
F. E. HIGGINS
P. E. DIPPLE
T. D. R. HOCKADAY
S. OLEESKY
J. W. FARQUHAR
K. J. GURLING
J. A. G. WATSON
C. HARDWICK
T. D. KELLOCK
Members of the medical advisory committee of the British Diabetic Association.

British Diabetic Association,
3–6 Alfred Place,
London, WC1 7EE.

MANAGEMENT OF INCONTINENCE IN THE HOME

Sir,

The King Edward Hospital Fund has made a grant to the Disabled Living Foundation for a 12 month study of the problems facing the incontinent in their own homes, looking particularly at the local authority provisions to see how adequate they are.

The study is to take account of incontinence in anyone over 18 years and whether or not it is associated with other disabilities. I am aiming to interview about 120 incontinent people in the North-west Metropolitan Hospital Board area and if any of your readers in this area knows of people who would be willing to help in the project I would be very pleased to hear from them.

P. DOBSON
S.R.N., H.V.

Disabled Living Foundation,
346 Kensington High Street,
London W14 8NS.

INFECTIOUS MONONUCLEOSIS

Sir,

I reply to Dr R. K. McElderry's comments (May *Journal*) of my article about the treatment of infectious mononucleosis (February *Journal*).

Patients were only allowed to enter the trial if they were known to be tolerant to penicillin and in fact I had no cases of sensitivity reaction.

As far as ampicillin is concerned, a number of authors have commented on the incidence of rashes when this is given to patients with infectious mononucleosis.

I would say that the percentage of rashes found in these cases was much higher than the 50 per cent suggested by Dr McElderry, being in the experience of several authors in the region of 90–100 per cent.

This does not seem to be a true and permanent ampicillin sensitivity as the drug has been given six or more months later to the same patients with no allergic response.

K. J. BOLDEN

94 Sidwell Street,
Exeter.