

rently 75 per cent of the sputum smear positive tuberculosis patients, 69 per cent of smear negative patients and 89 per cent of the eighty or so patients presenting each year with tuberculous pericardial effusion are HIV antibody positive (Harries AD, Maher D, Kumwenda J, personal communication). The latter group also receive high dose steroids to reduce the frequency of pericardial constriction and tamponade, both of which I saw as lethal complications. After returning to the UK I noted a South African research paper drawing attention to the benefits of a short course of steroids in very high dose in tuberculous pericardial effusion, 120 mg prednisolone daily for one week, higher doses being needed because of the enzyme inducing effects of concomitant rifampicin.⁹ High rates of HIV seropositivity are also being identified in tuberculous pleural effusion of which I also saw many during my short stay. Tuberculosis is more infectious in HIV seropositive patients and more likely to give rise to clinically apparent disease. The need for strict control of this HIV-associated tuberculosis epidemic is absolutely crucial to avoid the multiplication of resistant forms arising in Africa from where it could easily spread to other parts of the world. An incidental but minor problem of the overcrowded conditions with many HIV positive patients was scabies.

CONCLUSIONS

Malawi is a beautiful country with warm friendly people and rightly deserves the title proclaimed by its tourist board: *The warm heart of Africa*. QECH is struggling to fulfil its role as the first teaching hospital in Malawi. Some departments are swamped by HIV related illness and the hospital has progressed only part of the way toward changing its culture from that of regional hospital to one appropriate to a teaching hospital. Currently, support by governmental aid agencies, e.g. the UK Overseas Development Administration, is inexplicably being withdrawn rather than increased, thus threatening the viability of the whole project. Nelson recently observed that 'development aid is more about politics and money than about equity and caring'.¹⁰ Unless agencies concerned for the long term needs of such nations take a strong lead the future for the College of Medicine and QECH as its main teaching institution seems bleak.

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GETTING THE BIRD

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Avian comparisons are commonplace in the etymology of clinical medicine. Thus we have the swan-neck deformity of rheumatoid arthritis, pectus carinatum, winging of the scapula, a waddling gait, and (a) pterygium of the eye.¹ From our experience of acute medical admissions in an elderly population we now draw a further avian simile which we term the 'Owl sign'.

The sign does not refer to the unparalleled wisdom of senior physicians with whom we have had the pleasure of working but rather to similarities in the acoustic profile of Owls and a certain type of patient. When approached by a doctor the patient emits a "woowooo" noise not dissimilar to the call of the Owl, and this is associated in many cases with an acute confusional state most commonly caused by infection.

We have distilled the clinical features from case histories found in association with an Owl sign. The patient is usually female, more than seventy years of age, has a degree of visual impairment, and lives alone. Having previously managed a fairly independent existence she has become unwell over about 24 hours, and her General Practitioner has been asked to see her by her home help, a neighbour or a district nurse. She is assessed in the late afternoon and the referral letter often includes the phrases 'off her legs' and 'can't cope at home'. The patient eventually reaches the ward in the late evening when the other patients are being settled for the night and the main lights are off. It is at this stage that an Owl sign can most easily be observed. On approaching the patient there comes a low 'woo-ing' which may increase in intensity as the doctor starts to speak with her. It is difficult to elicit a history as the patient is disorientated in time and place. Examination always requires the assistance of a nurse and obtaining a midstream specimen of urine is well nigh impossible. The patient is pyrexial within 12 hours of admission, but with appropriate antibiotic treatment there is usually a rapid recovery, return to a normal state of mind, and discharge home at an early stage after some convalescence.

The sign is heard on approaching the patient in conditions of subdued lighting when her senses alert her that someone or something is close by. It is to be distinguished from the cries of anguish associated with the examination of painful parts. The Owl sign may also be elicited on the ward round the morning after admission, but its persistence to this stage suggests the wrong choice of antibiotic or a degree of chronic mental impairment.

Although the Owl sign and the call of the Owl are both heard at night, and may represent a form of communication when visual cues are less available, it is interesting to note that owls are famed for their good eyesight, whereas the Owl sign is usually observed in association with a degree of visual impairment. It is perhaps significant that the sign is often present in spinsters. Perhaps an adaptation

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to previous experience, in that in early life they may not have had the wit to woo.

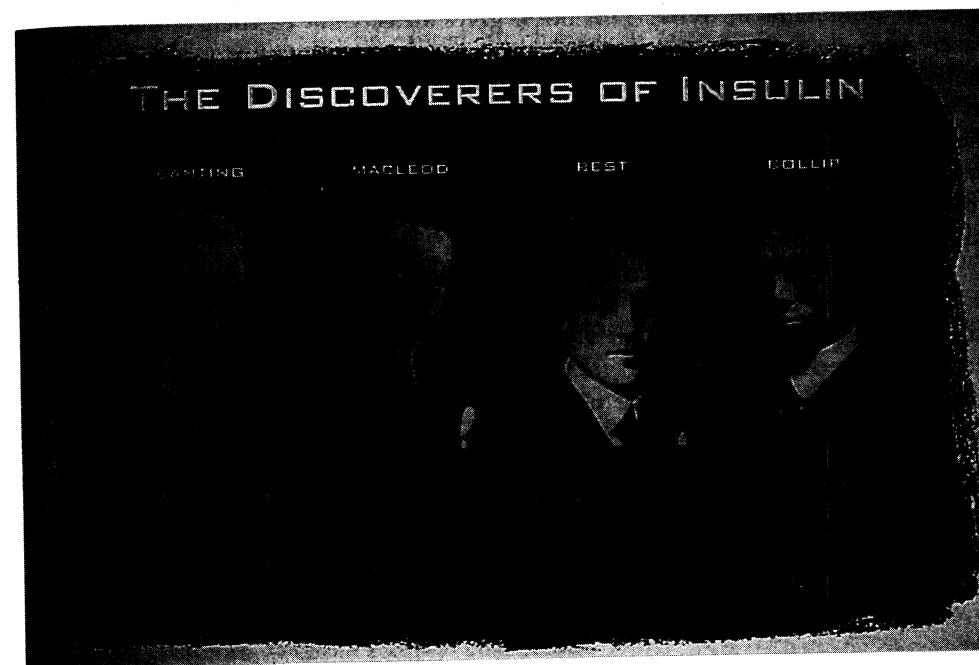
We believe the Owl sign to be associated with a good prognosis at least in the short term but a prospective trial would be required to confirm this. The good prognosis may reflect a strong constitution; it certainly does not reflect the benefits of prompt medical assessment and treatment as they do not usually receive either. This may be because we all tend to give them a low priority, not judging them to be 'interesting' patients. We hope the Owl sign may go some way to changing this. There is much basic epidemiological work which could be done to establish whether our perceived associations are valid, such as documenting the incidence of the sign, its effect on prognosis and its association with other predictors of outcome. The results of this activity will be letters, papers, conferences and several successful careers established. This may lead in the future to suspected cases being rushed to hospital by blue-light ambulance to a dedicated unit (perhaps to be known as the 'Parliamentary Unit'). Papers may even be published on the genetics of the Owl sign!

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MISCELLANEA MEDICA

Readers of the *Proceedings* supplement *J. J. R. Macleod: the co-discoverer of insulin* (July, 1993) will applaud the printing of this poster commemorating the discoverers of insulin and which recognises the contributions of all four scientists by equal representation. This has been devised by Kenneth Carroll, the director of the Centre for Human Nutrition at the University of Western Ontario. The poster is 35 cm × 53 cm and is available for \$14 (Canadian), postage included, from the Canadian Diabetes Association, Banting Museum and Education Centre, 442 Adelaide Street North, London, Ontario N6B 3H8.



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The three Royal Colleges of Physicians have produced a 64-page guide to the MRCP (UK) examination. Written by F. B. Gibberd, it is designed to inform candidates of the process of the examination. It explains in detail the requirements for entry and application, the way in which to deal with the written papers and the method by which the papers are assessed. It then describes the clinical examination with case examples and a wealth of detail about procedure is given which should go a long way to removing apprehension from first time candidates. This is a valuable contribution to making the examination candidate-friendly. It is available by direct application to any of the three Colleges at a price of £5.00 in the UK and £8.00 for overseas.

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