lication in writing. I think this is a matter which should be taken up by the B.M.A. without delay.—I am, etc.,

E. J. LACE.

The William Budd Health Centre,
Bristol 4.

Tinea Incognito

SIR,—Under this title Drs. F. A. Ive and R. Marks (20 July, p. 149) have drawn attention to a variety of skin lesions which are not what they seem, and which they believe are evoked by fungi in sites modified by local applications of corticosteroids. This may be true of many but not, I think, of all the 14 cases they describe.

For instance, in Cases 7 and 11 the kerionic lesions may well have arisen spontaneously without the help of corticosteroids. Kerion on hairy skin due to *T. rubrum* is not so very rare in subjects with established *T. rubrum* lesions elsewhere, a possibility known to dermatologists at least eight years ago. In 1960[1] we showed the first example seen by us which arose, without the intervention of corticosteroids, in the beard region of a man who for years had had scaly erythemata on the limbs due to *T. rubrum* infection. A scaly vesicular erythema provoked by *T. mentagrophytes* on a child's face may become heaped up and pustular in the scalp. I showed such a case to illustrate this point at the Royal Society of Medicine in 1943. Similar differences are well known when *Candida* invades the skin, the heaped-up granulomata occurring chiefly in hairy regions like the scalp.

Kerion-like granulomata with pus exuding from follicles may arise in other disorders such as drug eruptions, particularly from halogens, and also in Sweet's neutrophilic dermatosis. This type of reaction is partly determined by the site, and kerion is more likely where large follicles are involved.—I am, etc.,

C. HOWARD WHITTLE.

Addenbrooke's Hospital,
Cambridge.

REFERENCE

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Oral Fibrinolytic Agents

SIR,—In their paper on the fibrinolytic effect of onions Dr. I. S. Menon and others (10 August, p. 351) quote us as finding metformin to be the most effective and best-tolerated fibrinolytic drug of those we studied. This is incorrect. Both phenformin[1] and metformin[2] increased blood fibrinolytic activity, but partial resistance was later found to develop to the fibrinolytic effect of each after three to four months' treatment. In the paper to which Dr. Menon and his colleagues refer[3] we showed that a sustained increase of fibrinolytic activity could be obtained by combining either phenformin or metformin with the anabolic steroid ethyloestrenol. The combination of phenformin with ethyloestrenol was marginally superior to that of metformin with ethyloestrenol in respect of fibrinolysis, and there was no difference in tolerance between metformin and phenformin when the latter was given in the form of sustained-release capsules. More important perhaps, serum cholesterol levels were reduced by about 15% by the phenformin combination but rose during treatment with the metformin combination. Plasma fibrinogen was reduced by about 25% by the former and by about 12% by the latter, again an advantage of phenformin over metformin. Furthermore, phenformin plus ethyloestrenol was found to decrease platelet stickiness in vitro by about 50% in 15 of 20 arteriopathic patients treated.[4]

Recent studies in our laboratory have confirmed that these two combinations of fibrinolytic drugs have opposite effects on serum cholesterol, and have revealed the unexpected finding that platelet stickiness is actually increased by metformin plus ethyloestrenol in contrast to its reduction by phenformin plus ethyloestrenol (to be published). Metformin therefore seems unsuitable for arteriopathic patients, whereas phenformin when combined with ethyloestrenol favourably influences four factors related to thrombosis, that is, fibrinolysis, plasma fibrinogen, platelet stickiness, and serum cholesterol, effects which have been sustained in the great majority of our patients for as long as the drugs have been given—up to 2½ years at present. Hence, phenformin plus ethyloestrenol would seem to be suitable for trial as a long-term prophylactic measure in survivors of myocardial infarction (among whom there is an appreciable incidence of defective fibrinolysis[5]) and of other vascular accidents. Because of its adverse effects on cholesterol and platelet stickiness, metformin plus ethyloestrenol is clearly inappropriate for this purpose and we have abandoned its use.—We are, etc.,

G. R. FEARNLEY.
R. CHAKRABARTI.

Gloucestershire Royal Hospital,
Gloucester.

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Toxocara Skin Tests

SIR,—During the last three to four years several investigations have been made in the United Kingdom on the value of a skin test for the diagnosis of toxocariasis. Results from these preliminary studies indicate that the test is valuable, but it is considered that additional information could be obtained from its more widespread use. We should therefore like to make it known that this antigen is now available and may be obtained from the Standards Laboratory. It is suggested that it would be worth testing patients with otherwise unexplained eosinophilia, including that associated with lung pathology, choroidoretinitis and granulomatous lesions involving the optic fundus, epilepsy of undetermined origin, and patients proved or suspected of having toxoplasmosis.

Antigen for immediate use only and not for storage will be supplied. Those using the antigen will be asked to complete and return a card, giving information on the history of the case, the blood findings, and the result of the skin test obtained.—We are, etc.,

A. W. WOODRUFF.

London School of Hygiene
and Tropical Medicine,
London N.W.1.

C. M. P. BRADSTREET.

Standards Laboratory for
Serological Reagents,
Central Public Health Laboratory,
London N.W.9.

Pain in the Face

SIR,—I must take Dr. R. W. Barter (27 July, p. 251) to task on a point. In discussing atypical facial pain he states the condition improves without treatment if the case is cranial arteritis.

This may well be true for the facial pain, but blindness from ophthalmic artery occlusion in cranial arteritis is a striking complication and occurs in approximately 50% of cases. This does not improve without treatment. In fact high-dosage steroid treatment is indicated, if a clinical diagnosis is made (confirmed by high E.S.R. and temporal artery biopsy), in order to prevent ophthalmic artery involvement.—I am, etc.,

MARTIN JOYCE.

Wolverhampton and Midland
Counties Eye Infirmary,
Wolverhampton.

SIR,—May I comment on Professor H. Miller's article (8 June, p. 577)? No age is an "invariable feature" of tic douloureux; recorded ages at onset include 1⅓,[1] 7,[2] 8,[3] 10,[3] and 87[4] years. Nor does it "most characteristically affect . . . the sixties, seventies and eighties." Percentages of patients with onsets in relevant decades are: forties, 21%; fifties, 35%; sixties, 24%; seventies, 4%; eighties, 1%; more in the fifties, that is, than in Professor Miller's three most characteristic decades put together.[5] (Figures for prevalence, if available, would differ little from these, since few patients have the disease for ten years before cure.) In 3% of cases[6] the ophthalmic division is initially the only one affected, and to write, "the pain practically always first affects either the second or third division," is an exaggeration which may encourage wrong diagnosis of the 3%. Nor is the pain "always a reflex response to some form of sensory stimulation." All patients with tic douloureux have precipitated paroxysms, but most, perhaps all, have unprecipitated ones also. Nor is a "remittent history" (implying, in the context, weeks or months without pain) an "invariable feature." Professor Miller deprecates the word "never," but surely "always" and "invariable" are equally sweeping.

In his experience, he writes, multiple sclerosis "furnishes most of the few cases where trigeminal neuralgia is bilateral, affecting either side alternately." People have known for over 40 years[4] that disseminated sclerosis gives tic douloureux an increased tendency to bilaterality. Of all sufferers from tic douloureux, 5% to 6% have it bilaterally[5] and 2%[7] or 3%[8] have dis-

seminated sclerosis. If those with disseminated sclerosis were to "furnish most" of the bilateral cases, none of them could have unilateral tic douloureux; in fact they furnish only about one bilateral case in twelve.[5] Bilateral tic douloureux sometimes affects both sides together.

Alcohol injection of the trigeminal sensory root has not "lost its vogue," at least in southern England, where recently another neurosurgical centre was added to those which use it. Neither this nor adequate dosage of carbamazepine beforehand prevents me from still having to inject 50–100 patients a year. Given radiology, patience, and regular practice (not enthusiasm), injection is neither difficult nor "unpredictable." With over 500 patients injected in 1956–60, my five-year failure rate was 12%, failure being interpreted most strictly to include all those lost from follow-up, injected more than once, or radically treated by others. Used regardless of age or frailty, injection has, like carbamazepine,[9] a very small death rate, and it seldom calls for admission to hospital. These are substantial advantages over sensory rhizotomy, as many neurosurgeons will continue to recognize. No "diagnostic test" is needed for tic douloureux. If carbamazepine were thus used, patients obtaining no benefit from it (an appreciable minority) would be condemned to wrong diagnosis and unrelieved pain. It has improved but by no means "transformed" the therapeutic situation.

In this letter there has been space to deal only with the first section of the article. Much could and should be said about the later sections, and especially about heroin for "post-herpetic neuralgia."—I am, etc.,

London S.W.20. JOHN PENMAN.

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Hereditary Quivering of the Chin

SIR,—I was most interested to read your leading article on "Hereditary Quivering of the Chin" (20 July, p. 138) and the letter commenting on this (10 August, p. 377).

I have suffered from this condition all my life, but had not realized that it constituted a recognized, and rare, syndrome. The condition was first noticed when I was a baby, and attacks have continued intermittently since then, though they are now considerably less frequent. They appear to be precipitated by any emotion, although minor attacks may often have no precipitating factor. The attacks vary in severity: often I am quite unaware that my chin is quivering until someone brings it to my attention, while on other occasions they are so intense as to move my lower lip.

Unfortunately, I am unable to gain much information about my relatives. My father certainly suffers from the condition, and it seems probable that my grandfather did also. I have no information about my grandfather's brothers. The condition has never caused me any distress, and I have never sought advice about it.—I am, etc.,

East Kilbride, Glasgow. ALAN J. CAIRNS.

Smoking and Lung Cancer

SIR,—For many years I have taught that the triad of physical signs—an upper abdominal scar, brown clubbed fingers, and an abnormal shadow on *x*-ray of the chest—invariably leads to the diagnosis of carcinoma of the lung. The patient is always found to be a heavy smoker who has undergone gastrectomy or repair of a perforated peptic ulcer, and in spite of this has continued his smoking until carcinoma of the lung has supervened.

I still see a large number of patients presenting with this syndrome, and in practically every case they assure me that they were not advised to give up smoking by the surgeon who was responsible for their gastric surgery. They claim to be totally unaware that cigarette smoking played any part in the causation of their peptic ulcer. One must allow for the fact that patients will often ignore advice that they find distasteful and pretend they have not received it. Even so, there does seem to be a lack of awareness on the part of general surgeons of the opportunity that gastric surgery offers to demonstrate to the patient the dangers of his smoking habits. It is the object of this letter to draw attention to this opportunity.—I am, etc.,

LESLIE J. TEMPLE.
Liverpool Cardiothoracic Surgical Centre, Broadgreen Hospital, Liverpool 14.

Notice to Police Surgeons

SIR,—Dr. J. A. G. Clarke (10 August, p. 375) is, we believe, referring to the serum-coated swabs produced by this company.

It could be assumed from his letter that the serum component used in the pretreatment of our swabs is of human origin. This is not so, the serum coating material being made from foetal calf serum and a beef heart broth. This we have found allows delicate organisms, such as haemolytic streptococci, to remain viable on the swab tip for periods of up to six days. The serum-coated swabs have been designed specifically for bacteriological specimens. We also produce a completely plain swab which is suitable for forensic work, and where we have been asked for our views in this connexion we have recommended that a plain swab be used.

We are grateful to Dr. Clarke for raising this question. The correspondence which we have received as a result of his letter would indicate that there is a degree of confusion among a number of doctors regarding the identification of our three different types of swab. At present there is a coloured band on the labels of the individual swabs, that is, red=plain, yellow=serum coated, blue=charcoal coated, together with a fully descriptive end label on the box in which they are packed. It is now realized that this is not sufficient for swabs which are to be used outside of the hospital laboratory. New labels are at present being printed which will carry the word "plain," "serum," or "charcoal" in addition to the coloured band.—I am, etc.,

BRIAN COOK,
Sales Director, Exogen Ltd.
Glasgow W.3.

Requests for Abortion

SIR,—Professor W. I. C. Morris (10 August, p. 373) is faced with the Augean task of implementing compassionate legislation. An alternative method consists in the establishment of abortion clinics staffed by personnel adept at processing all cases referred.

Doctors who claim conscientious objection could be assigned compensatory work in the present infertility clinics.—I am, etc.,

Manchester 20. P. G. SEED.

SIR,—There is no doubt that the Abortion Act 1967 has increased the work-load of gynaecologists. Patients requesting abortions are taking up considerable outpatient time, sidestepping our long waiting-lists, and occupying valuable hospital beds—all these at the expense of the genuine gynaecological patients. Further, their complete assessment often includes the services of the psychiatrists and medical social workers. At a recent count, one in five of the patients in our wards are cases for termination of pregnancy. Their increasing numbers have been an embarrassment to many medical and nursing staff who have conscientious objections, especially those working in the operating-theatre.

Further to Professor W. I. C. Morris's palliative measures (10 August, p. 373) we would suggest special sessions for such patients. As prevention is better than cure, we firmly believe that contraception on social grounds should also be available under the National Health Service.—We are, etc.,

H. B. BAGSHAW.
T. T. LEE.
J. MCAULEY.
Victoria Hospital, Blackpool, Lancs.

Amputees Advisory Service

SIR,—I should like to draw the attention of your readers to a pilot scheme introduced in the South-east Metropolitan Regional Hospital Board area in March 1967 to test the value of the British Limbless Ex-Service Men's Association's Amputees Advisory Service. This service provides for the visiting of new amputees by a member of the association and is designed to help alleviate the deep concern for the future in the minds of primary amputees. The value of such visiting by someone who has himself had to face up to the same problems is immense, as has been shown in a comparable situation by the activities of the Ileostomy Association.

The introduction of this scheme to help the new amputee should be widely welcomed. I myself have made use of it wherever possible, and my patients have found the visits most helpful. I understand, however, that the