1974. The incidence of postgonococcal urethritis in these years was 11·7% (20 cases), 12·6% (48), and 12·1% (22) respectively.

W FOWLER

VD Department,
General Hospital,
Birmingham

1 Wilcox, R R, *British Journal of Venereal Diseases*, 1970, **46**, 412.
2 Gray, R C F, Phillips, I, and Nicol, C S, *British Journal of Venereal Diseases*, 1970, **46**, 401.
3 Smithurst, B A, *British Journal of Venereal Diseases*, 1970, **46**, 398.

Teething myths

SIR,—I read your leading article "Teething myths" (13 December, p 604) and, while in no way questioning the time-honoured historical aspects of the subject, as a dentist I know that the teeth of an infant can and do cause local disturbances when erupting into the oral cavity. The results of a longitudinal study which I undertook recording 4480 episodes of tooth eruption in 224 children has helped to demonstrate this quite clearly.[1]

In a leading article in April 1970 you gave guidance on treatment.[2] Now, however, five years later treatment of the symptoms of this common problem has been omitted, presumably because teething has once again assumed the mantle of being a myth.

MARGARET SEWARD

British Postgraduate Medical Federation,
London WC1

1 Seward, M H, *British Dental Journal*, 1971, **130**, 72.
2 *British Medical Journal*, 1970, **2**, 67.

*** We did not suggest that the *local* disturbances that are undoubtedly associated with the eruption of the primary teeth are in any way mythical. The myth to which we wished to draw attention was the dangerous one that may lead to the symptoms of serious systemic disease being dismissed as due to "teething."—ED, *BMJ*.

Steroids and common skin diseases

SIR,—Drs P W M Copeman and S Selwyn (1 November, p 264) state that the indiscriminate use of corticosteroids in common skin diseases is dangerous. As a substitute, particularly in the treatment of stasis ulcers and varicose eczema, they advocate the use of Miol lotion and cream, with which they claim encouraging results.

Some doubts, however, must be raised about the method of their investigation. The authors state that "in the case of leg ulcers, however, limb elevation and bandaging or supportive hosiery were continued." It is not clear if these patients were treated in hospital or as outpatients. If they were admitted and treated with bed rest and limb elevation no conclusions may be drawn from the fact that the ulcers healed, since simple varicose ulcers will do so with bed rest even if nothing else is done. As no control series is reported nothing can be learnt from a possible difference in the rate of healing.

It is also remarkable that in this series "in all cases prolonged conventional treatment with corticosteroids—often with antibiotics—was unsuccessful." Since in several series of cases of varicose eczema treated by us with various corticosteroid creams and ointments the healing rate varied between 80 and 100% one might suspect that these patients had not been adequately treated before admission to Westminster Hospital. They could, for example, have been treated without effective compression bandages. It should be remembered that in the treatment of both varicose stasis ulcers and varicose eczema the physical treatment by compression and not the topical application of some cream or other is the most important. However, particularly in cases of severe itching, application of a corticosteroid cream is valuable and reduces healing time. Furthermore, with the exception of fluocinolone and fluclorolone, we have not seen any side effects in treating varicose eczema even with potent corticosteroids.

KNUT HAEGER

Slottsstaden Clinic,
Malmö, Sweden

Diagnosis of pericardial effusion by echocardiography

SIR,—Dr P Kramer and his colleagues (6 December, p 564), diagnosed pericardial effusion and tamponade in their patients on clinical and chest radiographic criteria alone. In patients with renal failure the cardiac dilatation and failure secondary to prolonged and often poorly controlled hypertension may cause this evidence to be misleading.

A more reliable diagnosis may be reached by either radioisotopic[1] or ultrasound techniques. The latter is the more sensitive[2] and may detect effusions as small as 20 ml. Approximate measurement of the effusion is possible by echocardiography, and pericardial tamponade may be diagnosed if there is posterior motion of the interventricular septum with decreased left ventricular dimension on inspiration.[3]

Pericardiocentesis, even with electrocardiographic and radiographic control, is not without hazard.[4] We feel that it should be performed without prior echocardiography or isotope scanning only in acute life-threatening situations. In less severely ill patients the presence of an effusion should be confirmed by these techniques and the fluid then aspirated if there is failure to respond to conservative therapy.

C G C MACARTHUR
A J REES

Department of Medicine,
Hammersmith Hospital,
London W12

1 Weiss, E R, *et al*, *American Journal of Cardiology*, 1972, **30**, 258.
2 Horowitz, M S, *et al*, *Circulation*, 1974, **50**, 239.
3 D'Cruz, I A, *et al*, *Circulation*, 1975, **52**, 460.
4 Stone, J R, and Martin, R H, *Annals of Internal Medicine*, 1972, **77**, 592.

Gastric ulcer—short-term healing and long-term response

SIR,—Your leading article on this subject (12 July, p 61) summarised well this complex problem. However, we wish to comment on several points which have been clarified in a study carried out in Australia and published since your article appeared.[1] Factors studied relevant to your discussion were initial healing rate, sex of patient, and smoking status. None of these were found to affect recurrence rate. Recurrence was more frequent with larger ulcers: 53·6% of ulcers greater than 51 mm^2 in area compared with 25% of ulcers less than 51 mm^2 recurred, regardless of whether the patient had been discharged from hospital with the ulcer healed or unhealed ($P=0·005$). On the other hand the rate of initial healing in hospital did not influence the ultimate recurrence rate—those patients whose ulcers healed rapidly during the period of initial hospital treatment did not necessarily have a longer remission. Complete initial healing with medical treatment produced a better long-term response than incomplete healing, as shown by others.[2] In view of this, and of the morbidity of ulcer disease demonstrated by Watkinson,[3] a plea is made for all doctors to insist on a period of treatment, preferably in hospital, and to achieve complete healing in all patients with chronic gastric ulcer. Our current practice is to recommend surgery if the ulcer recurs within a period of two years following initial healing or if other complications occur.[4] Using these criteria 77% of patients in a placebo-treated group came to surgery.[5] Hence it is seen that Australian findings support your conclusions regarding operation.

D W PIPER
M J GREIG
K D LANDECKER

Departments of Medicine and Gastroenterology,
Royal North Shore Hospital,
St Leonards, NSW,
Australia

1 Piper, D W, *et al*, *Gut*, 1975, **16**, 714.
2 Sun, D C H, and Stempien, S J, *Gastroenterology*, 1971, **61**, 576.
3 Watkinson, G, *Gut*, 1960, **1**, 14.
4 Piper, D W, Cumberland, V H, and Fevre, D I, *Drugs*, 1975, **10**, 56.
5 Baume, P E, Hunt, J H, and Piper, D W, *Gastroenterology*, 1972, **63**, 399.

Cooking the Christmas turkey

SIR,—I read with interest Dr Norman D Noah's (20 December, p 714) comprehensive list of instructions and warnings on the preparation and cooking of the Christmas bird. Having reviewed the information given with supermarket turkeys, presented in four well-known cookery books,[1-4] collected from the catering departments of the three general hospitals in Leicester, recalled from my bachelor cooking days, and supplied, last but not least, by my wife, I must disappoint him in that to judge from this small sample it is by no means "usual to allow . . . 204°C (400°F—regulo 6)" for roasting. Recommended oven temperatures range from 325 to 375°F (163 to 190°C) for a fairly constant allowance of 15-20 minutes per lb (35-45 min per kg) plus up to one-half hour at the end. All the above sources also suggest stuffing the bird *before* cooking. I wonder if these facts and those mentioned in Dr Noah's article are the cause of so much post-Christmas gastrointestinal upset rather than the assault by mere quantity of substances and alcohol consumed that is often blamed. Food for thought?

D L CARR-LOCKE

Department of Medicine,
University of Leicester

1 *The Robert Carrier Cookbook*. London, Sphere Books, 1970.
2 *Mrs Beaton's All About Cookery*. London, Ward Lock, 1970.
3 *The Constance Spry Cookery Book*. London, Pan Books, 1972.
4 *The Penguin Cookery Book*. Harmondsworth, Penguin Books, 1971.