Secondly, delay in radiographic clearing after a fall of left atrial and thus pulmonary venous pressure—the "phase lag" phenomenon—was well known and certainly could account for the relatively low pulmonary artery end-diastolic pressures in their patients with delayed resorption of oedema fluid following diuresis, either frusemide induced or spontaneous. That low filling pressures indeed existed in their patients was indicated by the low or normal mean right atrial pressures reported in their article—zero or less in four and 3 mm Hg or less in seven.

Thirdly, the clinical implication of these findings needs re-emphasis. I wish to echo the authors' cautious advice that, while in most cases chest radiography gives a useful guide to diuretic requirement in the treatment of pulmonary oedema complicating acute myocardial infarction, in some the appearance may be misleading.

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Acetazolamide in prevention of acute mountain sickness

SIR,—Mr M K Greene and colleagues (26 September, p 811) should be congratulated not only on their paper but also on their ability to combine research and recreation. It remains to be seen if acetazolamide lives up to its promise, but perhaps I could make an entirely subjective, uncontrolled, and anecdotal observation.

I have always been troubled with mild symptoms of headache, weakness, and dyspnoea above 4000 m, which have frequently seemed much worse than in my companions with a similar degree of fitness. This year I took acetazolamide prophylaxis and ascended from sea level to around 4600 m (Monte Rosa) in 48 hours with surprisingly little incapacity. My breathing, clarity of thought, and general well-being were a revelation. Of course, this could well have been a placebo reaction; but I take heart from the findings of Mr Greene and his colleagues. In addition to its uses on trekking holidays and expeditions to the Greater Ranges, acetazolamide should perhaps be considered by those going to the higher Alpine summits, when the shortness of a holiday necessitates a rapid ascent.

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Treatment of acute mountain sickness

SIR,—Since your leading article on the treatment of acute mountain sickness (8 August, p 396), which emphasised the use of acetazolamide, Dr R Macdonald (12 September, p 732) has stressed that the most important treatment is descent to a lower altitude. There will, of course, be circumstances when descent is impossible—for example, because of weather conditions—or undesirable—for example, during high-altitude mountain rescues or military operations. At these times acetazolamide may prove invaluable.

The suggestion in the leading article that acetazolamide should be used as a prophylactic for acute mountain sickness is a separate matter and raises an important ethical issue. The most effective prophylactic is gradual ascent; and this accords with my personal experience as the medical officer on a 12-man climbing expedition to Mount Api (7130 m), Nepal, when by ensuring gradual acclimatisation only one mild case of acute mountain sickness occurred, which was rapidly cured by descent. In the past, slow ascent could invariably be achieved by those going to high altitude as time was not at a premium. Now, however, package holiday trips enable hundreds of thousands of people to go to high altitude to climb, trek, and ski. It is in the nature of these holidays that time is limited, and therefore time spent acclimatising is seen as wasted.

To what extent doctors should co-operate with these holidaymakers and prescribe prophylactic therapy—which, as Mr Peter McDonald (3 October, p 919) stated, may give a false sense of security—is questionable. Should the giving of "acetazolamide for altitude" be considered as the same as providing immunisations for holidaymakers travelling to exotic climes, or should doctors advise that high-altitude leisure activities voluntarily undertaken do not merit such active, and potentially hazardous, prevention, when all that is required is time?

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Ingrowing toenails: an evaluation of two treatments

SIR,—As one who has been responsible for the training of chiropodists for many years I read with interest Dr P F Cameron's article on the evaluation of treatment for ingrowing toenails (26 September, p 821). One is tempted to comment at some length on Dr Cameron's methods but I will be brief. My chiropodist colleagues certainly viewed the description of his "simple treatment procedure" as crude in the extreme and a method of treatment that we would be very reluctant to carry out without the use of a local anaesthetic. We were all agreed that we would not care to have it carried out on ourselves.

I would moreover make a more serious point, which is that we would teach students to remove the offending section of nail by cutting it, *not* tearing it, in a posteroanterior direction towards the free edge of the nail. Our experience has been that the procedure of nicking a nail and then tearing it is very often the way in which a true ingrowing nail (onychocryptosis) is produced. I am certainly surprised by the high success rate claimed by Dr Cameron and I wonder what his definition of an ingrowing toenail might be. Many chiropodists have over the years developed very skilful techniques for removing slivers of nail in cases of ingrowing toenail but these techniques, if they are to be painless, do call for a very high degree of skill indeed.

We have been training chiropodists for some years to use partial nail avulsion techniques similar to but not the same as those described by Dr Cameron, and I would make the comment that we would favour a digital nail block rather than a ring block when using this procedure. We find that this procedure is of particular value in the long-term treatment of problem nails which are likely to become ingrowing.

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SIR,—We were interested in the article by Dr P F Cameron concerning phenolisation in the management of ingrowing toenails (26 September, p 821). This technique, although not new,[1 2] deserves further publicity as it is superior to surgical ablation procedures, which we no longer use in our management protocol for ingrowing toenails.

The article describes the phenolisation technique in detail and presumably is intended not only as a report on the results of the procedure but also as a practical guide for those wishing to use it. We would like to amplify some points of surgical technique which we have found to be important for successful phenolisation. The use of 0·5% marcaine with 2% plain lignocaine (50: 50 mixture) significantly prolongs local analgesia and in many cases no postoperative oral analgesia is required. Exsanguination of the hallux is essential for phenolisation and to achieve this we use a ½-inch (1·25 cm) Esmach bandage rather than a simple tourniquet alone. Unwanted cauterisation of the skin over the edge of the nail bed can be minimised by elevating the fold with a skin hook. We have found that the application of phenol to the corner of the nail bed for three minutes is adequate for ablation, and at the end of that time we always neutralise the residual phenol with surgical spirit. A serous discharge from the nail bed, which may be mistaken for infection, is common after phenolisation[3–5] and both patients and nurses should be warned about this. This discharge subsides once the crusting has begun and is rarely an inconvenience to the patient.

Almost half of Dr Cameron's patients with an ingrowing toenail of over four weeks' duration eventually required nail bed ablation. Our own experience supports this finding and we now offer phenol ablation to all patients with an ingrowing toenail of more than four weeks' duration. Phenol ablation now allows us to cure ingrowing toenails quickly with minimal inconvenience to the patient.

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SIR,—I have read with interest the article (26 September, p 821) by Dr P F Cameron "Ingrowing toenails: an evaluation of two treatments."

Having carried out over 400 total and partial nail avulsions, with and without phenolisation of the nail matrix, I agree that a high success rate can be achieved (in my case over 99% with phenolisations over a three-year period). But a word of caution: great care must be taken when excising the sliver of nail. I do not agree with Dr Cameron that it can be easily torn. This will result in an angular tear at the base of the nail fold with more postoperative discomfort than necessary. A straight cut with

a pair of Thwaites nippers followed by a nail chisel will result in a perfect excision of the sliver of nail. This can either be packed and left to resolve or phenolised. Many patients have been referred by GPs who have had the popular Zadik operation with poor results, ranging from spike regrowth along the nail bed to regrowth of nail at right angles to the midline of the toe protruding through the skin. These spikes can be carefully dissected out and the base phenolised. Most patients can return to work (or school) the following day, unless they have an occupation which requires kneeling. With phenolisation the resolution varies from three to six weeks. The age range I have treated is 7-80 years.

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Vaginitis revisited

SIR,—I was very interested to read your splendid leading article "Vaginitis revisited" (19 September, p 745). As I have had an active research interest in *Gardnerella vaginalis* infection for the last seven years, perhaps I may be allowed to expand on the subject a little.

Vaginal discharge is a common symptom among women attending clinics dealing with sexually transmitted diseases. Treatment is prompt and effective when a clear diagnosis of gonorrhoea, trichomoniasis, or candidiasis is made. Those without such a microbiological diagnosis and with so-called non-specific infection have largely gone untreated and are presenting an ever-increasing problem. In such cases one is confronted with two alternatives—to treat empirically (and treatment before diagnosis is always unscientific) or to pat the woman on the back and say, "There is nothing wrong with you, my dear—it is all in your mind." *Gardnerella vaginalis* has gone a long way to remedy this sorry state of affairs. In "special clinics" about a quarter of all women (and this is a conservative estimate) suffer from this infection.[1] In many cases they do not complain about their condition but when cured they usually say that only since being cured have they known what normality was. As regards treatment, I get consistently good results in vivo with triple sulpha vaginal tablets in the dosage of one twice daily for 14 days. I am aware of the fact that in vitro studies usually show this organism to be insensitive to sulphonamides but, as we have stated elsewhere,[2] the concentration of sulphonamides in the discs is usually no higher than 500 μg/ml; and in two minimal inhibitory concentration studies[3 4] the highest concentration tested was only 500 μg/ml. It may be that the topical application of sulphonamides at high concentrations (as in triple sulpha vaginal tablets) is the reason why we found them to be so successful. In our study[2] we showed that lower concentrations of sulphonamides had no effect on this organism whereas higher concentrations gave a wide zone of inhibition on culture plates.

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New technique of drug promotion?

SIR,—I have read the letter from Dr J Iqbal (3 October, p 291) in which he criticises the activities of certain medical representatives.

Dr Iqbal states that representatives who have called on him have used personalised commendatory communications from members of the medical profession in order to promote a particular product. He inquires if the Association of the British Pharmaceutical Industry has a view on such techniques. Your readers will be aware that members of the ABPI have agreed to accept the provisions of a "code of practice for the pharmaceutical industry." I have written today to Dr Iqbal forwarding a copy of that code and asking him to submit further details so that I may initiate appropriate inquiries.

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SIR,—Dr J Iqbal (3 October, p 921) complains of two instances of pharmaceutical industry representatives using "testimonial" letters from doctors praising the virtues of a drug.

The code of practice of the Association of the British Pharmaceutical Industry specifically advises against the use of "Doctors' names . . . in a prominent manner in promotional material." In addition, all promotional material must be approved by a medical practitioner, and it would be of interest to establish that this procedure has been followed in these cases.

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Will doctors miss out again?

SIR,—I was very interested in the points raised by Dr M F H Bush (12 September, p 734) and Mr R C L Feneley (3 October, p 920). Mr Feneley's letter appeared under the heading "Will doctors miss out again?" I respectfully point out that the whole nation, and not only doctors, will miss out unless we improve our ability to evaluate health care services.

I am a neurologist working in a neurosciences department of a busy general hospital. For some years I have been interested in the problem of evaluating health care for patients who have suffered a stroke. I have been involved with three major projects—two of which are completed, and their results will shortly be published. The first concerns the advantages and disadvantages of handling patients in a specialised stroke unit. The second is concerned with the evaluation of speech therapy for dysphasic patients, and involves comparing the outcome in patients given conventional speech therapy with another group who are treated by volunteers only. The third study is concerned with the domiciliary management of stroke patients.

All the three studies mentioned above have important financial implications for the nation. For instance, it costs at least £3000 to keep the average stroke patient in hospital for six or seven weeks. It is possible that some such patients could be managed equally well at home—if the appropriate help for the relatives was available. Despite the fact that large sums of money are being spent on hospital care for stroke patients, there have been no published studies comparing the benefits of home versus hospital care.

Mr Feneley makes the point that community physicians, with their particular expertise in the field of epidemiology and evaluation of services, have a vital role to play in this type of research. I agree with this view. Certainly none of our studies would have been possible without the active involvement of a community physician with research experience and time to devote to this work. I suggest that each region should consider setting up a small health services research unit (which might have on its staff two or three community physicians) that would initiate appropriate research and assist clinicians in their own research.

If the State is to get good value for money, then research of the type mentioned above must be undertaken. Certainly no commercial enterprise in a similar situation could neglect doing so.

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What future for children in the developing world?

SIR,—I was surprised by the reference made by Mr J K Monro (26 September, p 859) to Malthus's "law" that human populations multiply to meet their food resources. The history of the Western world belies this and has also shown that given economic growth population growth decreases even without contraceptive information. Population pressures are important but the most significant factor in famine is poverty. There is enough food in the world today to feed everybody; the poor simply do not have the means to buy it. Hygienists may be an answer to population increase (I doubt it) but the only answer to the cruel and pressing problems of hunger is the transfer of resources, as advocated by the Brandt report.

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Investigation of the effects of torture

SIR,—We attended the World Medical Assembly held in Lisbon from 27 September to 3 October as associate members. We put forward the suggestion that the WMA should form a subcommittee involving psychiatrists to investigate the effects of torture and recommend methods of treatment. This was noted by the chairman of the Council of the WMA, and we intend to pursue this formally in the future.

In view of the evidence of the widespread and systematic practice of torture in many countries, we feel that this is an important issue. The BMA is an active member of the WMA, and we should like to draw the attention of BMA members to this issue and seek their support for the idea of a WMA initiative on this matter in the future.

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