between the teeth on either side of the jaw, a characteristic cracking sensation is detected in the region of the medial pterygoid muscle as the impediment to movement is overcome. Following this action normal mouth opening is restored. The patient does not experience any postoperative pain and there is no tendency to recurrence. Care must of course be taken not to exert excessive force when opening the mouth in this manner, and a wide-bladed instrument, such as a Featherstone gag, should be used in order to avoid damage to the crowns of teeth or the accidental displacement of an upper second premolar into the maxillary sinus.

The cases examined appear to have had no common aetiological factor in so far as the injection technique and the nature of the analgesic solution is concerned. The most likely cause appears to be that with the modern, thin, sharp hypodermic needle there is a greater risk of penetrating a small artery. Rupture of the vessel would then cause haematoma formation with subsequent organization of a band of fibrous tissue in the vicinity of the medial pterygoid muscle. This would explain the gradual onset of the trismus and the mechanical locking effect achieved, and also account for the recent increase in the condition.—We are, etc.,

H. C. KILLEY.
L. W. KAY.

Eastman Dental Hospital,
London W.C.1.

Guanoxan

SIR,—We were interested to read the paper by Dr. V. Vejlsgaard and his colleagues (3 June, p. 598) in which they reported a double-blind trial of four hypotensive drugs. One of these drugs, guanoxan, we have used in an extensive clinical trial for more than two years, and the results of this trial are soon to be reported in detail elsewhere.[1] In our series we also found that severe lassitude is an important side-effect in some patients on guanoxan.

Vejlsgaard remarks that they found no evidence of a hepatotoxic effect of guanoxan. We would suggest that this was partly because in their trial the number of patients was small and they were observed for a short period of time (40 patients observed for from two to six months). In our trial we had 96 patients observed for periods from 2 to 27 months; 54 of these patients were observed for over one year. In our series 26 patients (27%) had some derangement of liver-function tests at some time and 10 patients (10%) had severe abnormalities of their liver-function tests—that is, very high serum transaminases with raised serum alkaline phosphatase. Four of these 10 patients developed frank jaundice and one of the four died with acute on chronic hepatic necrosis. Further details of these cases will be published.[1]

Since our trial was officially closed further cases of liver-function-test abnormalities have occurred among the patients who remain on the drug. One of these patients had severe derangement of his liver-function tests. We do not claim that the incidence of abnormalities in liver-function tests that occurred in our trial is necessarily the true overall incidence, but we do think that it represents a fairer picture than that of Dr. Vejlsgaard's trial, as the occurrence of liver-function-test abnormalities from patients on guanoxan in other centres has been at roughly the same level as in our trial, as reported in your correspondence columns (14 January, p. 111).

Finally, we would also like to draw attention to the fact that a systemic lupus erythematosus syndrome has also been observed in patients on guanoxan. One such patient was reported in the letter referred to above and a further case is reported in our paper.—We are, etc.,

SUSAN G. COTTON.
E. MONTUSCHI.

Whittington Hospital,
St. Mary's Wing,
London N.19.

REFERENCE

[1] Cotton, Susan G., Lovel, T. W. I., and Montuschi, E., *J. clin. Trials (Lond.)*, 1967. In press.

Lead Absorption in Children

SIR,—We have read with interest the paper by Dr. N. Gordon and colleagues (20 May, p. 480) on lead absorption in children, with particular reference to its association to mental retardation. In that paper it is stated that we claimed that "lead was a greater factor in producing mental retardation than previously thought" and that a "raised blood lead level is a common finding among mentally retarded children and that this is of aetiological significance." It is true to say that in comparison with our own control group, in which the upper limit of normal for blood lead was 36 μg./100 ml., 55% of the mentally retarded children did have elevated blood lead values, but it was never at any time claimed that this was of primary aetiological significance so far as the mental retardation was concerned, and thus Gordon and his collaborators are quite mistaken in their assertions. What was claimed, and this was the whole point of the paper, was that mentally retarded children with pica (to which many are prone) are clearly more liable to lead poisoning if there is lead in the environment, and in such circumstances the neurotoxic effect of lead could further impair their functioning.

The authors also assert that we claimed improvement with treatment of a child with a blood lead of 48 μg./100 ml. on clinical grounds alone. Again, this is a misrepresentation of our statement. The improvement was assessed clinically and also by formal psychometric assessment as detailed in the paper.

During childhood, the detection of lead poisoning before clinical toxicity is apparent still remains a difficult problem. It is not unreasonable to assume that lead can interfere with intermediary metabolism long before the classical clinical symptoms are produced. The choice of normal subjects is always difficult in clinical medicine, particularly in paediatrics. It is surprising that Gordon's controls included children that, by any standards, had significantly elevated blood lead values and that these children showed no signs at all of toxicity. It is also surprising that the authors found such variability in levels of repeated examinations.

Our original plea was not that lead poisoning caused much more retardation than was generally thought, but that mentally retarded children who have pica and who ingest lead could possibly deteriorate even further. It remains our considered view that the clinicians should do their best to detect and treat lead poisoning before the onset of severe symptoms. It is important that the parents should be aware of the dangers of pica, especially chewing paint in old houses. It may be that we will never know at what level lead becomes actively toxic until we have an accurate test of a biochemical nature to assess this.—We are, etc.,

A. A. MONCRIEFF.
B. E. CLAYTON.
G. E. ROBERTS.

Hospital for Sick Children,
London W.C.1.

The Scabies Epidemic

SIR,—As Service dermatologists abroad we see a small but constant number of cases of scabies, but certainly not the epidemic proportions described in your pages as occurring in Great Britain (18 March, p. 669).

I was impressed on returning to Britain after two years abroad by the vast increase in the number of youths wearing long hair, to which syndrome is usually added a failure to wash. The present-day soldier, whether he likes it or not, is obliged to wash regularly and keep himself smart, which I believe is one reason why the scabies epidemic has not affected the Services in my own experience.

Lack of precise instructions on the use of benzyl benzoate is no doubt another cause of failed treatment. All patients with scabies attending our clinics are given a simple but detailed typed proforma on treatment, which they are made to read before taking it home with them. Attention to the patient's environment and activity during the treatment period is important. It is unlikely, for example, that an old-age pensioner living on his own will be able to apply lotion "everywhere below the neck."

Here in the tropics, where all Europeans sweat, even at rest, it is impossible to keep an application on the skin for more than a few hours before sweat washes it off. For this reason we frequently admit our patients to air-conditioned rooms during treatment. While this procedure is obviously unnecessary in the United Kingdom, one can visualize that manual workers, miners, blast-furnace operators, athletes, etc., are unlikely to be able to carry out treatment successfully while remaining at work, and unless all aspects of the patient's environment are considered at the consultation treatment is less likely to be effective.—I am, etc.,

T. C. HINDSON.

Dermatology Department,
British Military Hospital,
Singapore.

SIR,—I have read the recent articles and correspondence on the subject of scabies, and it seems that our experience of this problem may be of interest to others.

Our work involves child health in remote villages in central Tanganyika. Scabies is a serious problem, and in some villages almost 100% of children over 6 months old are affected. In some cases the lesions are so extensive and the secondary infection so severe that it is a factor contributing to the very high child mortality in this area.

I have found benzyl benzoate effective in hospital use but quite useless in the village setting. The patients treated in hospital are promptly reinfected on returning home. The result was that after nine months' work in