I would like to thank Dr. M. G. FitzGerald, under whose care the propositus was admitted, for his help and advice, and Dr. H. Thompson for reviewing the histology.

—I am, etc.,

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Scabies in Negroes

SIR,—I was interested to read of the impression gained from Dr. F. A. Ive's experience in West Africa and that scabies was a rare disease in Africans (14 December, p. 706). It is certainly not rare among the urban Africans in Rhodesia and it has also been reported from Tanzania by Dr. R. W. Smith (15 July 1967, p. 174) that in Central Tanganyika scabies is a serious problem and in some villages almost 100% of children over 6 months old are affected.

In Salisbury we have found it necessary, as a public health department, to set up a scabies clinic in the Harari township, and the monthly total of patients treated at this clinic in the past three years has varied between 1,000 and 5,000. Bearing in mind that the total African population of the township is reputedly 236,000, this represents a fairly high endemic rate of scabies. Recurrences are frequent, particularly among single men and families in the older types of accommodation sharing ablution facilities.

While we do not examine every instance by scrapings, many of these have been confirmed microscopically and respond to the usual treatment (benzyl benzoate or monosulfiram). Some of our patients report that a similar type of skin condition has been occurring in their home reserves, so it is clear that scabies is not limited to Africans living in the township.—I am, etc.,

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SIR,—Dr. F. A. Ive (14 December, p. 706) has kindly invited comment on some inconsistent features of scabies as between negro and white patients. Clinical observation over 20 years in Pretoria has taught us that Dr. Ive's puzzles are not imaginary.

In the white population the regular reservoirs of scabies were for many years the country boarding schools, inferior boarding houses, and similar crowded residences. Importation of scabies into "nice" families would come from teenage children home for the holidays from these boarding schools, or from the vicissitudes of travel. When a baby or a toddler developed scabies it was never acquired from a Bantu nanny but usually from a young and helpful white friend or relative. Furthermore, scabies in whites has been extremely scarce for the last few years. Recovery of the acarus has been very easily accomplished in white patients at all times.

In the Bantu population we were wont to diagnose scabies uncritically in the early 1950s in about 5% to 6% of outpatients. After a few years we started to wonder if we had been dreaming. Follicular rashes there still were, but convincing scabies vanished. In the late 1950s the writer often challenged the registrars to produce an acarus from the negro skin, and none was forthcoming. An occasional Indian patient back from India, who had acquired scabies over there or on the boat, made us realize that a brown skin was no bar to finding the acarus. Clarke's Nigerian figures of 25% scabies in Lagos, published in 1959,[1] were almost unbelievable, since I had by then become convinced that scabies with us was confined to the white population. When Dr. Roger Harman visited us in 1962, after his stay in Ibadan, we were eager to ask him how many acari he had seen recovered from patients. Because of his short stay there he gave a guarded answer, and could not solve the mystery. Then from about 1965 onward a slow trickle of Bantu patients with readily demonstrable scabies started coming our way. The flow gained in strength over the ensuing three years, until it became torrential by the middle of 1968. At this time the skin outpatients' department had doubled its patient turnover, 50% of the cases being scabies. The epidemic was then taken in hand by the local health department and the numbers are declining steadily.

From these experiences, hitherto unreported, we must agree fully with Dr. Ive that clinical statistics for scabies in dark skins are liable to both clinical error and genuine fluctuation. Moreover, it seems now quite probable that an epidemic affecting one population group need by no means spill over into another living in the same locality—as seen by our experience in Pretoria and his in Durham. Let me assure any doubters that if our acarus of scabies is fastidious, the local *Treponema pallidum* is not.—I am, etc.,

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REFERENCE

1 Clarke, G. H. V., *Skin Diseases in the African*, 1959, p. 1. London.

SIR,—Dr. F. A. Ive in his letter (14 December, p. 706) said that he doubted very much whether scabies was a common disease in Africa. We, situated on the edge of the Kalahari desert, are in the midst of yet another major outbreak among the Setswana tribe. At a rough estimate we have treated 2,600 cases in the last six months, and at our daily outlying clinics have been treating as many as 30 cases of scabies at one session.

We find that the isolated case and the inpatient respond extremely well to Ascabiol (benzyl benzoate), provided this is used correctly. The outpatient receives his first bath and an application of benzyl benzoate in the hospital, and the mother is asked to watch and learn how to do both. His clothes are also washed. However, with such a widespread epidemic he is likely to be reinfected, and we, being two doctors to 350 inpatients and serving outpatients and district clinics over an area of 5,000 square miles, are unable to supply the mass treatment that would obviously be preferable. We have, it is true, never isolated the acarus, not having the facilities, but the lesions are very typical, being small white papules always in the interdigital webs and very commonly spreading from the wrists and axillae to cover the trunk and lower limbs, and occasionally, although very rarely, the face. They always respond to correct treatment with Ascabiol. They are very irritating to the patient, especially at night, and they commonly become secondarily infected in these people, who live in extreme poverty.

I also quote Michael Gelfand in the *Sick African*[1] (without which, together with Hamilton Bailey's *Emergency Surgery*,[2] no doctor should contemplate leaving London airport), where he says, "Scabies is encountered throughout the natives of Africa"—however, perhaps he has never been to Nigeria ? (14 December, p. 706.)—I am, etc.,

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REFERENCES

1 Gelfand, M., *Sick African*, 3rd ed., 1957. Cape Town.
2 *Hamilton Bailey's Emergency Surgery*, 1967, edited by T. J. McNair, 8th ed. Bristol.

SIR,—I was interested in Dr. F. A. Ive's letter (14 December, p. 706) regarding the rarity of the demonstration of the acarus of scabies in Africa. Some points occur to me.

There is, firstly, the changing pattern of disease, which is often quite rapid in a developing country. In 1962 I pointed out that the incidence of scabies had apparently dropped from 25% to 11% in the decade ending in 1960.[1] The enormous sales of such toilet articles as monosulfiram soap must have been having some effect!

Secondly, as regards the differential diagnosis from onchocerciasis. Undoubtedly the latter can mimic scabies, and this is the origin of the French term *gale filarienne*. Although they are sometimes similar, it is usually easy to differentiate the two. The distribution confined to one segment of the body and residence in an endemic area are perhaps the most important clues.

Thirdly, it is certainly true that most practitioners in Africa (as probably elsewhere) do not confirm the diagnosis of scabies by finding the acarus. With vast hordes of patients there is simply not the time, and the demonstration would only probably be attempted for teaching purposes.—I am, etc.,

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REFERENCE

1 Clarke, G. H. V., *Brit. J. Derm.*, 1962, **74**, 123.

Amputations for Ischaemia

SIR,—Your leading article on amputation for ischaemia (11 January, p. 69) belittles the role of the team of doctors and physiotherapists whose attention "boosts the patient's morale if it does nothing else." May I suggest that such a team can be of greater importance than you indicate ? In these elderly patients rapid mobilization and early