prosthetic fitting are particularly important. Such small faults as oedema of the stump and contractures at the hip or knee can cause disproportionately long delays and further morbidity. Doctors and physiotherapists have to ensure the proper bandaging of the stump, the provision of fracture boards, correct position of the limbs in bed, and regular prone lying as well as purposeful exercises.

Surely successful recovery and rehabilitation after amputation will depend on the team's close attention to such details of post-operative care as much as on the choice of operation.—I am, etc.,

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W. Y. LOEBL.

Functional Dermatoses

SIR,—In his article on management of psychosomatic disorders (21 December, p. 753) Dr. Denis Leigh gives a useful review that is well geared to the needs of the general practitioner. However, he does less than justice to the weight of evidence that incriminates psychological factors in the causation and perpetuation of skin disorders, and points to emotional disturbances being primary as well as secondary to the rash.

Having spent a few years investigating this aspect of the functional dermatoses gathered under the heading eczema and dermatitis, I would like to limit my comments to them. In a recent paper¹ a brief description has been given of 73 consecutive cases diagnosed as eczema in the skin outpatient clinic of the Middlesex Hospital and studied intensively from a psychiatric point of view. Of these, two-thirds complained spontaneously of new psychological symptoms or (the rather smaller proportion) admitted to them on direct inquiry; while the third who denied such symptoms were shown to be abnormal in a number of ways when compared with control groups, and evidence was put forward that their relative lack of psychological reaction to stress was a sign of a type of psychological defence structure which itself predisposed them to psychophysiological reaction instead. It was suggested that these two groups could be conveniently labelled "unstable" and "superstable."

Great care was taken in the study to distinguish between symptoms that were part of a neurotic personality disorder (which was clearly present in 60%), and those that were "new," and therefore to be viewed as a psychological stress reaction or psychiatric illness (which could be diagnosed in 56%, predominantly mixed anxiety and depressive states). Depression was usually mild or partially suppressed, and clinically there were several very persuasive instances of eczema substituting for the affective disorder.

Very commonly eczema patients express their emotional distress as psychophysiological symptoms (often gastrointestinal ones), and the somatic bias is, as one would expect, particularly marked in the superstable group. However, the point I want to emphasize is that, contrary to Dr. Leigh's assertion that psychiatric symptoms in skin disorders are almost always secondary, in the cases investigated by me they more commonly preceded the eczema. This is not to say that irritation, disfigurement, or the doctor-patient relationship do not lead to or exacerbate the

emotional distress, but new psychological or psychophysiological symptoms preceded the eczema by a period of up to a year in 34%, and more than a year in 27%. The mean duration of eczema in the "unstable" and "superstable" groups was identical (11 months), which does not support the judgement that psychological symptoms were secondary to a rash of long standing, rather than primary or concomitant.

What is the practical importance of these findings? At present, the results of treating established cases of eczema are far from satisfactory, whether undertaken separately or together by dermatologist and psychiatrist. The psychosomatic split in our profession fosters the split in the patient which leads to his skin becoming the repository of his own dis-ease, so that painful facts, feelings, or fantasies can be shut out of awareness.

Until the profession has healed its own splits, and recognition that all patients are "psychosomatic" has transcended polemics, it is likely to be the general practitioner who can best hold the balance from which the patient can learn to own his skin and the distressing feelings expressed by its dysfunction, and to do something about them. Inquiry about psychological or psychophysiological symptoms and their time relation to the onset of the rash can aid such understanding. This would be of practical help even if the most appropriate thing that he can do is to refer the patient to a dermatologist or psychiatrist (preferably in a setting where both specialists are available), after duly preparing the patient for a referral that he might resent or fear rather than welcome.—I am, etc.,

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REFERENCE

- ¹ Brown, D. G., *J. Psychosom. Res.*, 1967, 11, 27.

Bilateral Tension Pneumothorax in Newborn

SIR,—The letter from Mr. I. V. Lishman and Dr. F. Mansfield (11 January, p. 121) draws attention to the difficulties in emergency treatment of tension pneumothorax.

When serving with a field surgical team in 1965 I devised a simple method for first-aid drainage of air or blood from the pleural cavity. It requires a Steriflex or similar intravenous saline-giving set with attached needle. The bag is held upright below chest level, a top corner cut off, and part of the contents spilled out. The needle is then inserted into the pleural cavity and air and blood will flow into the bag, where the remainder of the saline acts as a seal.

The advantages of an underwater drain are combined with the use of innocuous saline. I have achieved rapid drainage of 1½ litres of blood by this method. The procedure takes about 20 seconds. It can be safely used as a first-aid measure, even if there is doubt as to whether there is air or blood in the pleural cavity. I find the eighth interspace in the mid-axillary line the most convenient for first-aid.—I am, etc.,

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Onion and Blood Fibrinolytic Activity

SIR,—Dr. I. S. Menon and others (August 10, p. 351) have reported that addition of onion in the diet increases the fibrinolytic activity of blood and inhibits the shortening of fibrinolytic activity of blood produced by the butter diet. We³ have observed that addition of onion to a butter diet not only inhibited the action of butter on fibrinolytic activity of blood but also inhibited the hypercholesterolaemic action of butter. Our opinion differs in this respect with the observations of Dr. Menon and his colleagues, who failed to demonstrate the hypercholesterolaemic action of butter in adequate quantity in the diet, while other workers^{1,2,4,5} in this field of research are of the opinion that butter, which is a saturated animal fat, produces hypercholesterolaemia.

Further we have observed that addition of onion in the butter diet also protected significantly the action of butter on increased levels of beta lipoproteins and beta lipoprotein cholesterol of blood. However, the coagulation time was not significantly affected after the addition of onion in the butter diet.

Thus we agree with Dr. Menon and others that onion resulted in increase in fibrinolytic activity of blood with or without addition of butter fat in the diet. But, in addition, onion also protected the adverse reaction in blood serum cholesterol levels and lipoproteins produced by butter diet alone.—We are, etc.,

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- ⁴ Keys, A., Anderson, J. T., and Grande, F., *Lancet*, 1957, 1, 787.
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Otitis Externa

SIR,—In connexion with your leading article "Otitis Externa" (11 January, p. 70) I would like to draw attention to a paper on a simple treatment for chronic otitis externa.¹ The treatment is outlined as follows.

The external auditory canal is filled with ointment squeezed from a tube. The ointment used can be either 1% hydrocortisone in a simple ointment base or the ointment base itself—90% white soft paraffin B.P. and 10% wood alcohol ointment B.P. A strip of ½ in. (12 mm.) ribbon gauze is then inserted into the ointment and carried down into the canal with aural forceps until it is beyond the reach of the patient's finger. This dressing is left in situ for a week. Most patients do not need more than one or two dressings, and the cure rate is 100% in an average time of two weeks in a series of over 200 patients.

For acute otitis externa this treatment is effective and soothing. The oedema and pain due to the intense swelling are relieved with the first dressing, which is carried out more easily than the method described in your leading article because it is easier to glide the ribbon gauze into the lubricated canal. The ointment preparation used in these cases is a tetracycline hydrocortisone