incompetence never exhibit the distressing symptoms or show the gross lesions that are found in patients with incompetence of perforators just above the ankle.

You state that it takes less than an hour to examine both legs by thermography and that this method can be extremely accurate, but you have omitted to state how effective is this method in detecting all incompetent perforators. Mr. K. D. Patil and colleagues (p. 195) correctly detected 79 incompetent perforators in between 62 and 66 limbs, and Beesley and Fegan[1] correctly detected 40 incompetent perforators in 32 limbs using thermography. This is less than two perforators per limb. Neither we nor Mr. Patil investigated how many incompetent perforators were not detected by this method, but I am sure we would all agree that some remained undetected.

The clinical method of detecting incompetent perforators used by Mr. Patil and others revealed 50 sites of incompetence in 62-66 limbs (say 0·9 per limb), and he states he was surprised at operation to palpate fascial defects which had previously been missed. This suggests that the examination of the elevated limb was not performed pre-operatively. In our series, using the method described by Fegan[2] of palpating the elevated limb and then observing points of digital control of retrograde filling, we detected 46 incompetent perforators in 32 limbs.

The total number of incompetent perforators diagnosed pre-operatively by Mr. Patil and ourselves is far from satisfactory. Mr. Patil diagnosed in 62-66 limbs 50 clinically and 79 thermographically. We diagnosed in 32 limbs 46 clinically and 40 thermographically. In both series many of these markings were coincident. An estimate could be made of two correctly diagnosed incompetent perforators per limb, which figure is well below the number that, in our experience, is found when extensive operative exploration is performed.

The conclusions I feel emphasize the great difficulties of accurate pre-operative diagnosis of sites of incompetence and the advantages of compression sclerotherapy, where missed perforators can be detected and injected at the patient's second and subsequent visits. This is an accepted part of the treatment and is no embarrassment, while a second operation would often be declined.—I am, etc.,

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REFERENCES

1 Beesley, W. H., and Fegan, W. G., *British Journal of Surgery*, 1970, **57**, 30.
2 Fegan, W. G., *Varicose Veins: Compression Sclerotherapy*, London, Heinemann, 1967.

SIR,—I read with interest your leading article on the hidden perforating veins (24 January, p. 186), emphasizing the value of thermography in detecting incompetent perforating veins. The article by Mr. K. D. Patil and colleagues in the same issue of the *B.M.J.* and one by Beesley and Fegan[1] are at some variance in their results, which has unfortunately been overlooked by your leader writer. It would seem that most investigators using clinical methods of detection have a 50% ± 10% accuracy. The degree of accuracy by clinical assessment is necessarily influenced by the experience and practice of the examiner. It would seem the Dublin group with Professor W. G. Fegan have the advantage of numbers of patients for examination, yet the successful detection rate is still in the 50% range. Although these workers report a variation of 10% between clinical, infra-red, and phlebographic methods there does not seem to be a statistically significant difference between these methods.

In contrast Mr. K. D. Patil and his colleagues (24 January, p. 195) find a highly significant difference in favour of thermography. If an accuracy of 94% is reproducible by other clinics this will be a valuable asset in the aid of diagnosis and treatment. If the treatment is to be planned surgery, the highest degree of diagnostic accuracy is essential. One cannot agree therefore with the leading article that difficult cases only should be investigated by thermography. The "difficult case" is all too frequently the one which has been inadequately treated previously.

If, as the leading article suggests, lack of finance is the reason for not using better diagnostic methods, then surely a planned procedure such as surgery for chronic venous insufficiency should be reserved for occasions when full diagnostic facilities are available. Compression sclerotherapy in skilled hands offers the alternative of a more economic treatment with the advantage of assessment of therapeutic accuracy throughout the period of treatment.—I am, etc.,

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REFERENCE

1 Beesley, W. H., and Fegan, W. G., *British Journal of Surgery*, 1970, **57**, 30.

SIR,—Your leading article on the perforating veins of the lower limb (24 January, p. 186) is a good example of how misleading the use of percentages can be. Mr. K. D. Patil and others (p. 195) show merely that, in clinical localization of perforating veins in the lower limb, they were correct on 60% of occasions. This is no basis for your statement that "our fingers and eyes will detect only 60% of perforating veins." Since there is no way of knowing the total number of incompetent perforating veins present in any limb, we cannot know what percentage is found by any method.

Mr. Patil and colleagues were surprised to find that "palpation immediately before exploration revealed fascial defects at some of the clinically missed but thermographically positive sites." If, as it appears, they were palpating the leg with the patient lying down on the table, they were in fact examining the limb in a manner approaching that described by Fegan[1]. This finding, far from stressing the fallibility of the clinical method, shows, how in their own series, it might have produced better results if more thoroughly applied.—I am, etc.,

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REFERENCE

1 Fegan, W. G., *Varicose Veins: Compression Scleropathy*, 1967. Heinemann, London.

Hallucinogenic Effect of Nutmeg

SIR,—A patient tells us it is common knowledge among the drug-taking and hippie sub-culture that taking nutmeg is a potent way of taking a "trip." The hallucinogen in nutmeg is believed to be myristicin.

An intelligent 19-year-old female with a hysterical personality took one ounce of nutmeg in water and orange juice. She had five days previously taken L.S.D. with very little effect. She had also experimented with cannabis, but the only noticeable effect of this was that she developed a dry mouth. In contrast to this the effects of nutmeg were marked. At first she felt no effect, but after four hours she felt cold and shivery. Six to eight hours later she was vomiting severely. She saw faces and the room appeared distorted, with flashing lights and loud music. She felt a different person and everything seemed unreal. Time appeared to stand still. She felt vibrations and twitches in her limbs. When she shut her eyes she saw lights, black creatures, red eyes and felt sucked into the ground. Her mood was one of elation. She was taken by her friends to be seen by one of us (D.P.) as an emergency. She was admitted and quickly fell into a sound sleep. For the next week, however, she felt that she was walking in a cloud and complained that her thinking was confused and that she found it difficult to follow what people were saying. Her concentration seemed poor and lapses of attention were noticed.

The clinical features of this case have much in common with the effects of nutmeg ingestion previously reported.[1] The physical symptoms were unpleasant, and the girl states that she would not take nutmeg again because of these. In her case vomiting was the most severe physical side-effect. Severe physical collapse following ingestion of nutmeg occurs.[2] A dose of 10-15 g. however is required before acute intoxication occurs.[3] Despite the side-effects, however, it is probable that with the increased drug-taking among young people more cases of nutmeg intoxication will come to medical attention.—We are, etc.,

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3 Truit, E. B., jun., Duritz, G., and Ebersberger, E. M., *Proceedings of the Society for Experimental Biology and Medicine*, 1963, **112**, 647.

Fabric Softeners and "Proteinuria"

SIR,—This department is responsible for the screening of newborn infants for inborn errors of metabolism using urine-impregnated filter-paper, and recently we have had frequent false positive tests for proteinuria. Positive results for protein were obtained on the filter-paper using a spot test with tetrabromophenolphthalein, but tests using fresh liquid samples from the same child were negative.

We have now ascertained that these anomalous results were due to the mothers using fabric softeners in washing their children's nappies. These softeners consist of mixtures of amino esters, cationic amides, amido-amines, quaternary ammonium compounds, imidazolines, fluorescers, colouring

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