is often intense. The absence of an obvious lesion to the inexperienced eye, associated with what appears to be an almost hysterical reaction to pain, often leads to these patients being labelled neurotic and they suffer their miseries undiagnosed, in some instances for years. In two of my patients delay in diagnosis was respectively four years and 15 years.

I would particularly emphasize the vital diagnostic point of temperature sensitivity; in women immersion of the affected hand in washing-up water or hanging up clothes to dry in cold weather can precipitate unendurable pain which constitutes a severe disability.— Iam, etc.,

N. H. PORTER

Hove, Sussex

SIR,—In the final sentence of your leading article (10 March, p. 565) you state that in treating subungual glomus tumours the whole nail should be removed. It should be pointed out that this is not the case. With advancing techniques in hand surgery such a deforming operation is not required. The tumour can be removed through a critically placed dorsilateral incision. This heals without troublesome scar and leaves the nail intact.—I am, etc.,

HUGH BROWN

Newcastle upon Tyne

SIR,—In your leading article on glomus tumours (10 March, p. 565) one site for their occurrence was not mentioned which might be important, and that is the anal region.

It happens that some patients with haemorrhoids or other anal lesions have discomfort which seems to be quite out of proportion to the clinical picture. From the histological examination of material sent to the laboratory it seems likely to me that a glomus tumour might form in that region, where vascularity is variable and innervation so high. And it would be extremely difficult to locate a very small lesion exactly in that site.—I am, etc.,

H. RUSSELL

Edinburgh

Deputizing Services

SIR,—The article by Dr. B. T. Williams and others on the B.M.A. Deputizing Service in Sheffield (10 March, p. 593) appears to have been written in a defensive tone. We hear nothing of the positive virtues of the service (perhaps because there are none) and precious little justification for it. For instance, we read that "the concept of personal doctoring was not threatened," but on the other hand the authors do not suggest that it is in any way enhanced. The logic of their arguments I find difficult to follow.

The authors state: "The patients of subscribing doctors had an approximately even chance of having their calls directed to the deputizing service at night. The patients of non-subscribing doctors may also have had an appreciable chance of having their calls directed to someone other than their own doctor, such as one of their partners or a doctor in an off-duty rota; how often this occurred cannot be estimated. Thus the minute proportion of consultations that were transferred to the deputizing service in Sheffield was hardly enough to make any impact on the doctor-patient relationship." Yet, in a previous paragraph they say that by one calculation (the number of claims to the executive council for night calls made by the deputizing service compared with the total in Sheffield) the deputizing service is handling 92% of such cases. Although it is apparently likely to be an overestimate, it is still hardly a "minute proportion."

They pass the buck as regards the employment of junior hospital doctors, saying that "In the absence of information about the off-duty time available to them in their hospital posts no comment can be offered about the possibility of conflict between their work for the deputizing service and their hospital responsibilities." Surely these doctors are, strictly speaking, in breach of contract with their employing hospital authority.

They give two reasons why they consider deputizing services not to be a temporary phenomenon. Firstly, they state that they help the singlehanded doctor who would otherwise not get any time off duty. I am sure no one would wish to take issue with this. But then they go on to say, "The other reason is that group practices make a considerable use of deputizing services" (60% of practices of three or more being the figure quoted). Yet there is no explanation as to why this should be so. Surely a doctor in a group practice of, say, three does not mind being on call one night in three. Is the explanation that these doctors do not like doing night calls? It would have been interesting to hear what was the net cost to the doctor after tax and midnight to 07.00 hours visiting fees had been deducted.

The final argument I would disagree with is over the advantages of being seen by one's own doctor or his partner. The authors say that "if . . . group practices of a dozen doctors envisaged in the Todd Report materialize, many patients are likely to be no more familiar with some of their doctors' partners than they are now with the doctors of the deputizing services." The largest practice in Sheffield today (and after all, we are dealing with the present) is five. I would have thought there was a far better chance of being seen by a doctor whom the patient knows and who knows the patient if a member of the practice attends rather than if a deputizing service doctor attends. Further, this argument is no defence for an unfamiliar doctor attending and should merely be taken as a warning of the dangers of very large group practices.—I am, etc.,

I. P. F. MUNGALL

Royal Hospital,
Sheffield

Herpes Simplex and Zoster

SIR,—Dr. J. Pearce (17 March, p. 679), referring to the topical use of idoxuridine for the treatment of herpes zoster, states that he has found that "this preparation is not readily available in most hospital pharmacies and . . . most dispensing chemists are unable to provide it and are under no obligation to do so."

The preparation of idoxuridine recommended for this purpose is a solution in dimethylsulphoxide, and it seems likely that it is the dimethylsulphoxide rather than the idoxuridine which would be subject to supply problems. Idoxuridine is in the *British Pharmacopoeia* and eye drops (0·1%) and ointment (0·5%) are generally available. Supplies of the *B.P.* quality of the substance itself could also probably be obtained to special order—that is, within a few days—by pharmacists.

There is, however, no "medicinal quality" of dimethylsulphoxide, which is not the subject of any *B.P.* monograph, and so far as I am aware no licence has been granted by the licensing authority under the Medicines Act for any medicinal product containing this substance. The "commercial grade" would be considered to be unsuitable for use in medicinal products, and the very expensive spectroscopic grade would therefore have to be purchased. Any pharmacist who sought advice on the use of dimethylsulphoxide would, I know, be told of the possible toxic nature of the substance and of the fact that no licensed medicinal product containing it is on the market in Britain.

Quite apart from any supply problems, a pharmacist would, I am sure, wish to stress the possible dangers associated with the use of dimethylsulphoxide. It is particularly unusual for doctors in general practice to prescribe any medicinal product containing, as an ingredient, a substance which has not ben subjected to the licensing procedure and, therefore, a close examination of data on toxicology.—I am, etc.,

JOHN FERGUSON
Assistant Secretary,
Pharmaceutical Society of Great Britain

London W.C.1

SIR,—The pain of postherpetic neuralgia can be one of the most distressing and relentless that elderly people have to bear. Corticosteroids, if given early enough, seem to prevent the neuralgia, and the slight risk involved is well justified, as I think any patient suffering over many years would agree.

This slight risk can be reduced to triviality if corticotrophin (ACTH) is used. To elderly patients I give 4 IU daily for four days and then four more doses on alternate days. This seems adequate, with no pain following and no side effects.—I am, etc.,

JAMES RICHARDSON

Malvern, Worcs.

SIR,—I should like to support Dr. J. M. S. Pearce's contention (17 March, p. 679) that, contrary to Dr. B. E. Juel-Jensen's views (17 February, p. 406) that the use of corticosteroids should be discouraged in the treatment of acute herpes zoster, there is in fact a very good case for their use. After the publication of Elliott's paper[1] I started to use prednisone in the doses he recommended for all my elderly patients with acute zoster and was most impressed not only with the almost immediate disappearance of pain, but also with the total elimination of postherpetic neuralgia. Unfortunately, one 90-year-old woman developed zoster encephalitis from which she died, and I discontinued the practice.

Gold[2] holds the view, albeit unsubstantiated, that IgG levels are not depressed by the administration of corticosteroids and that no harm is done by them. I believe it needs