It is therefore conceivable, even when full allowance is made for the length of time the processes of the law can take, that a marriage could be annulled on this particular ground in the year 1967.—I am, etc.,

Birmingham 30.

A. I. ROITH.

* The Queen's Counsel who prepared the article comments that Dr. Roith is of course perfectly right in the point that he makes in his second paragraph, but he has perhaps gone too far in using the word inconceivable in his third paragraph. A case reported in *The Times*, 31 May 1967, says that on occasion a decree nisi may be granted in the Divorce Court as long as 25 years after the original proceedings had been started.—Ed., *B.M.J.*

Caterpillar Dermatitis

SIR,—I read the article on caterpillar dermatitis (6 May, p. 346) with interest, and appreciate the difficulty of persuading a mother that her eruption is due to irritants from caterpillar hairs when she states that she has not been in contact with caterpillars.

Professor D. J. Lee recently suggested a procedure that could be therapeutic if used early enough.¹ He advocates the use of sticking plaster to remove setae from the skin surface before they penetrate. Other methods of attempted removal tend to increase the numbers which penetrate.

May I suggest that Sellotape be applied to the suspect area? When this is stripped off it will not only remove caterpillar hairs and setae but will preserve them for identification under the microscope.

This method has long been used for the capture and identification of helminth ova; it enables the rapid identification of *Malassezia furfur* and similar organisms,² and has recently been advocated to demonstrate glass fibres in glass-fibre pruritus.³

Caterpillar hairs are readily demonstrated in this way, and even if the actual setae responsible for the individual papules may not always be displayed, much confidence will be added to the diagnosis if this simple procedure is used.—I am, etc.,

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- 2 Keddie, F., Orr, A., and Liebes, D., *Sabouraudia*, 1961, 1, 108.
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Treatment of Osteoporosis

SIR,—Mr. W. H. Gervis (13 May, p. 443) makes the revolutionary assumption that spinal extension supine exerts less compressive force on osteoporotic vertebral bodies than does extension in the prone position. Since the muscular forces acting on the spine are the same in both positions, the assumption is obviously incorrect. The supine position has the big disadvantage of stressing the spondylotic neck joints with approximately half the body weight. This leads in most cases to pain referred from these degenerate joints.

The treatment of osteoporosis, as the original article (29 April, p. 295) indicated, must be all-embracing, special attention being paid to the patient's diet and morale, and an attempt being made to render them more active. Deep breathing exercises help, though a certain amount of supervision is required, and a weak faradic stimulation of paraspinal and abdominal muscles has been found useful. It can be self-applied by a co-operative patient in the form provided by a gadget such as the Slendertone.—I am, etc.,

London W.1.

JOHN EBBETTS.

SIR,—While I agree most strongly with the value of hyperextension exercises, I find it difficult to understand what Mr. W. H. Gervis (13 May, p. 443) means by saying that these should be done supine because in the prone position the spine is still weight-bearing and the disc spaces under pressure. I find it impossible to correlate this with the intervertebral action of hyperextension when the vertebrae pivot on the apophyseal joints and widen the disc spaces, and it seemed to me that this would be unaffected whether the patient was prone or supine. However, to satisfy myself I conducted the following experiment.

A suitable subject was x-rayed (a) in natural decubitus, (b) lying prone in forced hyperextension, and (c) supine on the head and buttocks in forced extension as suggested. It will be seen (see Table) that in hyperextension the disc space is increased whether the patient is supine or prone, but that there is slightly more increase in the spaces when

Distance Between Vertebral Bodies

Lumbar Space	Anterior Lip			Middle			Posterior Lip		
	Prone	Supine	Neutral	Prone	Supine	Neutral	Prone	Supine	Neutral
1/2	35	26	22	30	22	17	17	17	13
2/3	35	26	22	30	22	22	17	17	17
3/4	39	35	26	35	30	26	26	22	22
4/5	35	35	30	35	30	26	22	22	22
5/SI	48	43	35	35	35	30	22	22	22

Distances expressed as percentages of vertebral body height.

hyperextension is carried out prone. The distances are expressed as percentages of the vertebral body height in order to avoid any unequal distortion due to the x-rays, although in fact the vertebral heights were similar in all three x-rays.—I am, etc.,

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REFERENCE

- 1 Bell, G. H., Dunbar, O., and Beck, J. S., *Calc. Tiss. Res.*, 1967, 1, 75.

Insulin Resistance

SIR,—The article on insulin resistance by Dr. W. G. Oakley and others (15 April, p. 134) has made interesting reading. Recently, we studied two Nigerian patients who showed resistance to insulin.¹ Indirect evidence of an inhibitory factor in their sera was obtained and a distinction was made from the specific diabetic types reported in the past from the tropics.² In both patients interruption in insulin administration for a long period occurred before the development of resistance. Prednisone was administered for only ten days, and in spite of this short period of administration reduction in insulin requirement occurred.—I am, etc.,

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Lagos.

B. K. ADADEVOH.

REFERENCES

- 1 Adadevoh, B. K., and Olatunbosun, D. A., *Ghana med. J.*, 1966, 5, 12.
- 2 Tulloch, S. A., *Diabetes Mellitus in the Tropics*, 1962. Edinburgh.

Ingrowing Toenails

SIR,—I notice that the correspondence on the subject of "Ingrowing Toenails" that I followed with interest in Singapore has received another mention by Dr. M. Shun-Shin (20 May, p. 510). This minor though important problem seems to receive attention piecemeal rather than as a rounded-off subject.

From the considerations of causation and treatment ingrowing toenails are of two groups. (1) The nail is deformed or at fault, and this requires treatment. (2) The soft tissues are at fault and it is they that require attention.

In the first group the nail is deformed in its own right, as it were, or secondarily distorted by trauma, old infection, or interference. One common type of nail is the nail which though otherwise normal rolls deeply on a uniform longitudinal axis, sometimes the two sides almost meeting, pinching into the nail-bed. Treatment is required for relief of pain and mechanical awkwardness, as well as for any infecting condition that supervenes. Operation consists in removal of the complete nail, proximal nail bed, and all the growing area at the base effectively. The basal skin flap is moved distally to meet the proximal edge of the remaining nail bed. As anyone who has regenerated an avulsed big toe nail knows, the open area becomes quite hard, firm, and non-tender with time.

In the second group the condition starts with infection in the soft tissues at the side of the toenail, the toenail being normal, or exactly the same size and shape as that of the digit of the other side where there is no trouble at all. I have often confirmed this by careful observation and measurement. I have never seen this condition occur in people who habitually do not wear socks and closed shoes. First the soft tissue at the side of the nail becomes red and painful, then a full-scale cellulitis supervenes. The final stage occurs when the soft inflamed swollen nail-fold is pressed against the lateral nail-edge, which like a knife with butter pressed against it enters the tissue causing severe pain and further inflammation, and now presents as the fully developed ingrowing toenail met with in casualty. To treat this condition with local applications of ointments, pretty coloured dyes, caustics, and the like is useless.

Bearing in mind the method of causation, treatment is logical. First the foreign body embedded in the tissues must be removed. As infection is under the nail at the edge, a pair