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.,

RONALD CARRUTHERS.

Department of Dermatology,
General Hospital,
Launceston, Tasmania.

REFERENCES

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- 2 Keddie, F., Orr, A., and Liebes, D., *Sabouraudia*, 1961, 1, 108.
- 3 Peachey, R. D. G., *Brit. med. J.*, 1967, 2, 221.

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.,

Accident and Orthopaedic
Department,
Bedford General Hospital,
Bedford.

J. C. WATTS.

GEORGE H. BELL.

Department of Physiology,
Queen's College,
Dundee.

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.,

University of Lagos
Medical School,
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

of very fine scissors can be pushed proximally under the nail and a triangular offending piece cut away. The first part of this operation, though fearsome looking, is almost painless, but closing the scissors pushes the nail edge further laterally, and causes sharp pain. A straight distal pull completes the removal of the nail piece. In scary subjects a small basal block with 1% lignocaine can be used, but I have never had to do so. Next the new nail edge has to be prevented from cutting into the soft tissue by packing with a small amount of cotton-wool as often as required, and the removal of all pressure by socks and shoes. The ideal is to wear an open sandal, as in the tropics. This must be continued till the nail is fully grown again, and the soft tissues have returned to normal, a matter of three months at least. Next the soft-tissue infection is dealt with by systemic antibiotics and local spirit-based applications, and treatment continued till the soft tissue returns to its normal bulk, at least three weeks, but sometimes never. Future prevention is by careful attention to foot hygiene, correct socks and footwear, keeping the skin of the folds tough and dry, and at the first sign of swelling or redness the re-commencement of lateral packing with cotton-wool, to keep soft tissue and nail edge from contact.

In a certain number of cases recurrence is inevitable because of permanent soft-tissue thickening, refusal to avoid trauma and badly fitting footwear, poor co-operation, and in some cases borderline nail deformity, either original or caused by the infection. Operation consists in excising a longitudinal "V" section of nail edge and nail bed, together with as much of the nail fold as is necessary, and a thorough excision of all the corresponding part of the basal growing area. The skin edge is sutured to the nail-bed edge. Healing is very slow, but gives a perfect result permanently. I prefer to wait till sepsis is eradicated before operating, as the basal dissection can enter the interphalangeal joint.

Ingrowing toenails occur almost exclusively in the large toes, and more commonly on the lateral side.—I am, etc.,

Walton on Thames, K. F. D. SWEETMAN.
Surrey.

The Scabies Epidemic

SIR,—Two recent cases illustrate an important point. The first, a man in his 40's, had itched for six months. It began shortly after a road accident and was said by two medical boards to be nervous in origin and secondary to his accident. The lesions consisted of a few scratch marks on the limbs and a pin-point vesicle without erythema on the side of one finger and another on the outer side of one foot. Being slightly suspicious I examined scrapings of the roof of each vesicle in potash solution and found, surprisingly, an acarus in each. Re-examination of the patient revealed no clinical evidence of scabies. There were no burrows, the distribution was quite atypical, the lesions exceedingly few, and there was no family history of itching.

The second case, an 8-year-old boy, was seen in February 1967 with an eruption of non-specific scattered papules in the limbs and trunk, some urticated, some excoriated. Although the appearance was not particularly like scabies, scrapings from the fingers and

feet were examined, with negative results. He was treated as a case of papular urticaria for the next three months, during which time another dermatologist agreed with this diagnosis. Today the lesions were similar but rather more numerous. There was no clinical evidence to suggest scabies except a widespread itchy rash. Scrapings were again negative. However, his father on questioning revealed that the rest of the family had begun to itch in the past four weeks. The father had minimal non-specific eczematized papules on the fingers and wrists. I scraped one patch of eczema and found an acarus in a potash preparation.

These two cases, the like of which I have frequently seen, show that scabies is often atypical. The contention of Dr. L. J. Bacon (6 May, p. 373) that the diagnosis of scabies depends upon finding a live acarus is misleading. I agree with him and with Professor J. T. Ingram (20 May, p. 506) that extracting an acarus from a burrow is relatively simple and very gratifying (except to the acarus). What if there is no burrow to be seen; if the eruption is atypical and very scanty, as is often the case in clean persons; and if there is as yet no family history? Demonstration of a live acarus in such cases is well-nigh impossible, whereas the examination of potash scrapings is a very easy, quick, and reliable method of confirmation. It is clear to me that the diagnosis of scabies does not depend on finding a live acarus but on the recognition of the pattern of the eruption, on familiarity with individual lesions and with complications, on awareness that atypical cases are common and that the disease has a familial or domiciliary incidence. Above all it depends on the constant suspicion that an itchy patient may have scabies, even though the evidence is scanty. Microscopic confirmation is a desirable addition to this list, whenever possible.

Control of scabies depends not only on accurate diagnosis but on adequate treatment. Failure of the latter is usually due either to inadequate application of the chosen medication or to omission to treat all contacts. Your leading article (22 April, p. 193) rightly emphasizes the latter but might for completeness' sake have included the baby-sitter as a possible source of infestation. Inadequate application of medicament usually means applying it to the visible spots only. I find that to overcome this it is often necessary to tell a patient in detail how to apply the preparation, and that when I say "the whole body below the collar line" I mean just that. As for contacts, all should be treated whether they show signs of the disease or not—remembering that the symptomless incubation period may last from one to two months.—I am, etc.,

J. O'D. ALEXANDER.

Department of Dermatology,
Royal Infirmary,
Glasgow C.4.

SIR,—Professor J. Ingram's assertion in his letter on scabies (20 May, p. 506) that the risk of benzyl benzoate dermatitis can be forgotten, as it is so rare, needs I think to be qualified. This is so if the emulsion is applied only in the prescribed manner—that is, applications on two or three successive days only.

I recently had a patient who, as the result of some earlier failure of communication, had for a long time been intermittently dabbing

benzyl benzoate on herself wherever she had an itchy spot. This resulted in a severe dermatitis.

I make a point of ensuring that a patient with scabies understands that the application must not be repeated after the prescribed treatment.—I am, etc.,

B.F.P.O. 34,
Germany.

M. B. MUMMERY.

Benzyl Benzoate

SIR,—The recent increase in the incidence of scabies has drawn the attention of one of us to the important fact that a proportion of cases have not responded to treatment with benzyl benzoate application (B.P.). At first one was inclined to blame the patients for not carrying out the treatment as instructed, but on questioning this seemed doubtful.

Samples of commercially available benzyl benzoate application (B.P.) have been examined and some have been found not to comply with the *British Pharmacopoeia* requirements. A considerable variation in the physical properties of the product from different manufacturers was found and in one instance the benzyl benzoate content was as low as 20.7%.

It is suggestive, but not conclusive, that this may be contributing to failure in the treatment of some cases of scabies and we feel that further investigation is necessary.—We are, etc.,

JOHN L. FRANKLIN.

Westminster Hospital, J. A. BAKER.
London S.W.1.

Mental Health Services for Children

SIR,—Congratulations to the *British Medical Journal* for the enlightened first leader on the occasion of Mental Health Week (3 June, p. 585). The problems of the mentally ill adolescent have been much in the news recently, but there are still only 11 units in the country with some 230 beds, and hardly any specially trained staff. The child psychiatric service, because it does not deal with "hooked" pop singers, has had little publicity. There are only some 400 child psychiatric beds, and very few family units where the parents can also be accommodated. But, as your leader points out, it is not only beds that are missing.

The family doctors of this country are being besieged with the emotional problems of families on their lists, which amount to possibly 50% of all attendances. Taking an average of 4.5 items of service per person this gives the staggering total of over 100 million such items a year.

It is pertinent to ask what is being done by the chain of "child guidance clinics" to help the general practitioner in this mammoth task? The answer, needless to say, is practically nil, as most of the high-powered child psychiatrists, psychiatric social workers, and educational psychologists are analytically orientated, and direct their energies towards a very few children. The urgent waiting-list in many areas is three to six months.

Let us have a new look at the services and see if it is not possible to use the few highly skilled workers where they are most needed—to support the family doctor.—I am, etc.,

Ilford,
Essex.

ARNOLD ELLIOTT.