Herpes Simplex Cervicitis

SIR,—I was particularly interested in Dr. B. Naylor's comments on herpes simplex cervicitis (18 May, p. 428). It is true that an abundance of literature, mainly from North America, has been published on this subject. Since 1957 there have been eight publications, describing 65 cases, in which the virus has been isolated.¹⁻⁸ However, it was the French physician Rollet who first recorded acute ulceration of the cervix associated with vaginal discharge, which was thought to be herpetic in origin.^{9, 10}

Dr. Naylor rightly draws attention to the presence of multinucleate giant cells (Tzank cells or virocytes) which may be found in cytological smears taken from cases of herpes simplex cervicitis.⁴ Unless one is aware of their identity these cells may easily be confused with abnormal cells found in cancerous and precancerous conditions of the cervix, and their presence may lead to an erroneous diagnosis of malignant change.¹¹ Recently in Manchester, with the collaboration of my colleague Dr. M. Longson, of the virology department, we have isolated a large pock-forming genital strain of *Herpesvirus hominis* from a cervix, which has also produced large numbers of syncytia and multinucleate giant cells in tissue culture. It would seem to be the strain of virus which mimics carcinoma cell changes and for which cytologists and gynaecologists alike must remain vigilant. This is the first occasion on which an atypical strain of *Herpesvirus hominis* with such unusual characteristics has been isolated from a cervix, and a full report of the case will shortly be appearing.¹²—I am, etc.,

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Long-term Anticoagulant Therapy

SIR,—I read with interest the paper by Dr. R. D. Eastham (11 May, p. 337). Although using a different test (activated partial thromboplastin) his conclusion that patients with venous thrombosis appear to require more anticoagulant than those with arterial lesions confirms the observations of Nour-Eldin and Lewis,¹ who arrived at this conclusion from an analysis of the prothrombin time responses in 160 consecutive patients receiving anticoagulant therapy. The diminished tolerance to anticoagulants in patients with coronary artery disease and pulmonary embolism is most probably due to a disturbance of hepatic function (usually

present in patients with heart failure), rendering the liver more sensitive to these drugs² and/or affecting the production of prothrombin and other blood-clotting factors in the liver.—I am, etc.,

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Sterilization—Male or Female?

SIR,—There is a far more liberal and humane attitude in evidence nowadays among gynaecologists towards the control of families by sterilization when other means are unsuitable.

To control reproduction in a stable monogamous union it would seem far simpler, safer, and indeed cheaper and quicker to sterilize the husband. In practice in my experience in the National Health Service there is far more difficulty in obtaining sterilization in the male than in the female. Is it not time that this in so many ways undesirable state of affairs was ended?

I would like to suggest that in any such cases where the gynaecologist is of opinion that sterilization is desirable the husband should be approached (through his general practitioner if necessary) to find out if he could be persuaded to undergo sterilization. If he agreed this could surely be arranged by agreement between the gynaecologist and a surgeon at the same hospital.—I am, etc.,

Cymmer,
Glamorgan.

R. S. SAXTON.

The "Public Drunk"

SIR,—Dr. W. Watson (11 May, p. 362) may consider himself brave to have written and dispatched his simple and punitive solution to the problem of drunks cluttering up a casualty department. I would have thought his diatribe singularly ill-timed for two reasons: firstly, the growing recognition that fines are ineffective as a deterrent for habitual drunkards, and that some sort of treatment hostels should be provided; and, secondly, I note from the advertisement columns of the *B.M.J.* that it is proposed to appoint a consultant psychiatrist in Glasgow to deal with the local problem of alcoholism.

The picture of the alcoholic being a quiet and unobtrusive individual, decorously drinking himself to destitution at home, is of course nonsense. Many alcoholics in the course of their deterioration have committed the gravely antisocial acts which Dr. Watson seems to think occur only in the "public drunk." As for the concept of making people culpable for the acquisition of their illnesses, why stop at the injuries sustained by drunkards? Let us fine the obese for their gluttony, charge cases of cancer of the lung for wilful smoking, and set up a cash register at the venereal diseases clinics to tax tabetics. The prospects are limitless, and no doubt the legal profession would be delighted to arbitrate in cases of doubt.

It is a mistake to oversimplify complex medico-social problems such as drunkenness and delinquency and to impose arbitrary and

authoritarian solutions. It would be more pertinent to inquire why crimes of violence are apparently on the increase in Glasgow, and why there is such a high admission rate of alcoholics to Scottish mental hospitals. After all, diagnosis should precede treatment. Elementary, my dear Watson?—I am, etc.,

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P. M. J. O'BRIEN

Mothers and Children in Hospital

SIR,—Mrs. Judith Pead (4 May, p. 303) raises an important point when she says that mothers living in hospital with a sick child require clear information on how best to help in the ward. She suggests that the leaflet¹ produced by the National Association for the Welfare of Children in Hospital is a solution. But it is not, nor could it ever be.

A national pamphlet cannot provide the sort of local information needed by a resident mother. The association's leaflet is admirable, giving general advice to parents whose children are going to hospital, and is similar to the booklets which many children's units have issued for some years (these have the advantage of local detail). However, very few contain the particular sort of detail needed by a resident mother.

A recent survey of mothers living in hospitals with an ill child convinced me of their difficulties.² Most would have found it easier if their role had been clearer. They want an up-to-date information leaflet of their own about the actual unit in which they are living. They are anxious to help, and so they must be told both what they are expected to do and allowed to do for themselves, their child, and other children in the ward. They need to know the rules. They need to know a multitude of other small facts that will make their stay happier, ranging from where they can smoke to where they can wash and iron their clothes. Above all, the leaflet must tell them in capitals that they are not expected to stay with their child every minute of every day. Some regard living-in as a term of imprisonment and think they are not allowed out of the hospital.

The National Association for the Welfare of Children in Hospital has done its part in providing a general leaflet for parents who have to leave a child in hospital. It is now up to the paediatric units with rooms for mothers to produce their own detailed *vade mecum* for resident mothers. I hope that they will ask the resident mothers to help them write it.—I am, etc.,

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Haemophilus Septicaemia

SIR,—The article on haemophilus osteomyelitis and arthritis by Dr. R. J. Farrand and others (11 May, p. 334) prompts me to record briefly a child who was admitted under my care to this hospital.

An Indian boy, born 16 February 1966, had a history of fever, vomiting, and diarrhoea for three weeks. On examination he was a pale, apathetic child with no localizing signs. Investiga-