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 drugs[2] 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.,

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Glamorgan.

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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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 leaflet[1] 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. Investi-

gations: chest x-ray normal; Hb 55%; W.B.C. 7,100 with normal differential; iron deficiency on the blood film; E.S.R. 138 mm. in one hour; Paul–Bunnell test negative. Blood culture revealed *Haemophilus influenzae* type B sensitive to all the usual antibiotics except sulphonamide. This child was treated with ampicillin and made a good recovery.

My point in recording this case history is to emphasize that septicaemia due to *Haemophilus influenzae* may not be as rare as we had thought and one can easily envisage such a child as I have mentioned developing osteomyelitis due to this organism.—I am, etc.,

J. L. GREAVES.

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Monoamine Oxidase Inhibitors and Anaesthesia

SIR,—The risks involved in anaesthetizing patients receiving monoamine oxidase inhibitors have been largely eliminated in the West Dorset Group of Hospitals by the adoption of the following routine for admission of cases from the surgical waiting-list.

(1) Every patient is instructed to bring with him any pills, medicines, etc., he is currently receiving.

(2) The patient's general practitioner is sent a form several days before the day of admission informing him of the proposed admission. This form is prestamped and returnable, and contains the following questionary:

"What drugs is the patient currently receiving? If the patient has received steroids during the past two years or monoamine oxidase inhibitors during the past two weeks please give details."

This procedure has been in operation for nearly two years and has proved to be very valuable, thanks to the co-operation of the general practitioners in the area.—I am, etc.,

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Idiopathic Facial Palsy

SIR,—Mr. John Groves (24 February, p. 508) has performed a valuable service in drawing attention to the possibility that lack of properly matched controls vitiates the conclusion of Dr. D. Taverner and others (9 December 1967, p. 581) that A.C.T.H. is of proved benefit in the treatment of Bell's palsy. They say that they are convinced of its efficacy, but the fallibility of personal conviction or clinical impression is too well known to warrant further comment. Moreover, in that part of their previous trial where properly matched controls were used no significant difference between the treated and the untreated groups was shown.

The observation of Mr. Groves, that as one sees cases in hospital series earlier in the course of Bell's palsy so does the denervation rate lessen, is confirmed by the following figures in a series of 128 cases of complete unilateral Bell's palsy referred for electrodiagnostic testing. These cases were seen on the first occasion at any time up to 28 days from the onset of the condition, and the denervation rate (the criteria for denervation being those described by Taverner *et al.*[1]) was 40%. If out of this series those seen up to 21 days are studied then the denervation rate drops to 33%. In cases up to 14 days the denervation rate is 29%, up to 7 days 20%, and if those seen only up to 5 days are selected the rate is 13%.

None of those patients had any treatment designed to prevent denervation, and this denervation rate of 13% is the same as in Taverner's five-day series, in which those patients predicted to be in danger of denervation had been treated with A.C.T.H. Thus it becomes clear that a five-day treated series can be compared with a concurrent five-day untreated series only to give a valid comparison, whereas Taverner and his colleagues have compared a five-day treated series retrospectively with a 14-day untreated, thus giving a built-in bias of considerable magnitude in favour of the method of treatment. This method of comparison amply illustrates the dictum quoted by Bradford Hill[2]: "The assessment of therapeutic activity by the use of retrospective controls is an inherently fallacious method."

So far the criticisms and comments of Mr. Groves have remained unanswered—perhaps because they are unanswerable.—I am, etc.,

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Zinc Sulphate and Bedsores

SIR,—Acceleration of the healing time of open wounds in a small group of young men who were given zinc sulphate 220 mg. three times daily by mouth has been reported,[1] with no undesirable side-effects. The same treatment was given to six elderly people who had bedsores at the time of admission to a geriatric unit.

Case 1.—80-year-old man with a bedsore on the right heel, 6.5 cm. by 6 cm. by 5 cm.; full thickness loss of skin; present at least one month; no sign of healing. Zinc sulphate 220 mg. given three times daily for 33 days was associated with complete healing and new epithelium.

Case 2.—73-year-old man with diabetes who had a perforating ulcer on sole of right foot, 5 cm. by 2 cm.; full thickness loss of skin, and present "for a long time." Zinc sulphate was given three times daily for 27 days, after which partial healing was observed but patient insisted on going home. Fifty days later the patient was seen again. Treatment had probably been discontinued, but there remained only three "islands" of broken skin, 1 cm., 1 cm., and 0.5 cm. in diameter.

Case 3.—70-year-old man with a bedsore on his right heal, 6 cm. by 6 cm. by 5 cm.; full thickness loss of skin and involvement of underlying tissues; present for at least four months. Zinc sulphate three times daily produced no effect for one month, after which healing began and became complete in 106 days.

Case 4.—70-year-old woman with bedsore on her right heel, 5 cm. by 4 cm., full thickness loss of skin, and present for at least three months. Zinc sulphate was given three times daily for 66 days, when complete healing was noted.

Case 5.—81-year-old woman with a superficial ulcer over the sacral region and bedsores on both heels, with full thickness loss of skin at the left heel. Zinc sulphate was given three times daily for 17 days, when both heels were noted to be healed.

Case 6.—84-year-old woman developed a deep sacral sore 8 cm. by 6 cm. with a track at least 0.5 cm. diameter into underlying tissue during treatment for a perforated gall bladder. The ulcer showed no sign of healing after 12 months, during which time energetic treatment included two surgical toilet operations. Zinc sulphate was given twice daily with no effect for about one month, after which healing was noted, and at the moment there is residual superficial loss of skin 2 cm. by 0.5 cm.

Pories *et al.*[1] indicated that "zinc is the metal moiety in a number of essential enzymes," and that "zinc is preferentially concentrated in healing tissues with a peak activity in the first days after injury." Zinc sulphate was given in the above cases in addition to standard treatment for bedsores, and control cases were not included. Experienced members of the nursing staff thought that healing was promoted, the final stage of healing was not delayed compared with previous treatment regimens, and "new skin" appeared over the ulcer.

No ill effects have been seen in the six cases, and, though the initial results are encouraging, further evaluation of the effectiveness of zinc sulphate, the minimum dose required, and the mode of action is required. It is hoped that the above cases will be reported in more detail elsewhere.—I am, etc.,

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Paracervical Block with Bupivacaine

SIR,—I have read with interest Mr. D. H. Gudgeon's article (18 May, p. 403).

I have just completed a series of 100 cases of paracervical block with bupivacaine 0.5% with adrenaline 1:200,000. My initial experience with 0.25% was the same as Mr. Gudgeon's in that the duration of analgesia was about three hours. I did not feel that this was sufficiently long, and have found that the higher dosage gives a much improved duration of effect. We have, however, noted the occurrence of severe foetal bradycardia on a few occasions, and the occurrence of this complication has never been satisfactorily explained, but from the work of other authors adrenaline does not appear to be implicated. I feel that if Mr. Gudgeon's series had been rather longer foetal bradycardia might well have been observed.

It is hoped that our results will shortly be published.—I am, etc.,

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Cirrhosis of the Liver

SIR,—I was interested to read the article on cirrhosis of the liver by Dr. A. E. Read (17 February, p. 427), as it concisely and lucidly presented the generally accepted British views on hepatic cirrhosis. Certain differences stand out in marked contrast with the disease seen in India, where it is no less common. They are as follows.

Alcohol in the aetiology of disease can be totally ruled out. One hardly ever comes across a cirrhotic who has ever consumed alcohol. Cirrhosis in adults is also far more common in Hindu males who are traditionally vegetarian. They come from a poorer socio-