Nasal Cancer in the Shoe Industry

SIR,—In our article on "Nasal Cancer in the Northamptonshire Boot and Shoe Industry" (14 February, p. 385) we were unable to give estimates of incidence within the industry because we lacked comprehensive information on the numbers of men employed in the different departments. We have since received from the British Footwear Manufacturers' Federation national figures relating to 1949-61 inclusive giving the numbers of operatives in each sex employed in the various departments. The figures include the numbers of men and women employed in clicking, closing, pressing, lasting, finishing, and shoe room departments. In making the calculations in the Table the figures for 1949-61 have been averaged and the proportions applied to the Northamptonshire industry. If the cases of nasal cancer in males known to have occurred during the twenty year period 1950-69 are related to these populations we find that the risk is virtually limited to persons working in the press and finishing departments. The average incidence rate per annum for all types of tumour of the nasal cavity and sinuses in men working in the press and finishing departments is 0·14 per thousand: adenocarcinoma 0·07 per thousand; for other types of nasal tumour 0·07 per thousand. For males working in other departments of the industry the risk for all types of tumour is 0·01 per thousand per annum, a rate closely similar to that experienced by all males over 15 years of age in southern England.

The figures from the British Footwear Manufacturers' Federation show that less than 5% of women employed in the boot and shoe industry work in the press and finishing rooms. This explains the very low incidence of nasal cancer in women in the Northamptonshire footwear industry. To date we have information about only two women with nasal cancer in the footwear industry. One had worked for three years sanding heels and is presumably therefore one of the small minority of women who worked in the finishing department. The other worked for seven years in the closing rooms of a shoe factory.

Department	Population	Adenocarcinoma		Other Carcinomas		All Carcinomas	
		No.	Incidence*	No.	Incidence*	No.	Incidence*
Press and finishing rooms	5,000	7	0·07	7	0·07	14	0·14
Other depts.	10,660	–	–	2	–	2	0·01
Unclassified	–	2	–	2	–	4	–
Total	15,660	9	0·03	11	0·04	20	0·06

*Average annual incidence per thousand.

This additional information confirms that the risk of nasal cancer in the footwear industry is concentrated among the comparatively small number of persons engaged in dusty jobs. In this small group, almost all of whom are men, the risk approximates to that of carcinoma of the rectum.—We are, etc.,

E. D. ACHESON.
R. H. COWDELL.
B. JOLLES.

The University, Southampton.

Breathlessness and Anxiety

SIR,—Dr. N. C. Oswald and his colleagues (4 April, p. 14) suggest that there may be a case for greater use of ratings of neuroticism and anxiety in patients with bronchitis and asthma to help in management.

Another practical use to which such psychological tests could be put is as an aid in diagnosis. This was demonstrated by a study I carried out at the Myasthenia Gravis Clinic, Massachusetts General Hospital, Boston. The main purpose of the investigation was to determine if a simple questionary test of neuroticism could be of use in detecting those patients presenting with weakness and fatigue of psychological origin. Schwab and Perlo,[1] in a study of syndromes simulating myasthenia gravis, found that in 37·6% of the patients examined the symptoms were of emotional aetiology and were placed in the category of chronic fatigue syndrome. The Maudsley Personality Inventory (M.P.I.)[2] was given to 30 patients with this syndrome and also to controls matched for age, sex, and colour consisting of groups of 30 normals, neurotics, and myasthenic patients (duration less than two years). The neuroticism scores in the various groups are summarized in the Table. Those patients diagnosed as having a chronic fatigue syndrome scored significantly higher on the neurotic scale of the M.P.I. than did the normal controls (t-test, $p<0.001$). There was no definite cut-off point, but a score above 30 was suspect and should suggest further psychiatric assessment.

	Mean	S.D
M.P.I. manual norms	20·6	10·6
Normal controls	18·8	5·2
Neurotic controls	34·6	10·0
Short duration myasthenics	19·1	5·3
Chronic fatigue syndromes	38·6	9·3

The neurotic patient, with and without organic illness, is a frequently met problem in the general hospital, particularly in certain clinics.[3] It may be that there is a place for the wider use of short, self-administered personality questionaries to help detect the psychoneurotic subject.—I am, etc.,

H. BRIAN MCNAMEE.

Department of Psychiatry, Queen's University, Kingston, Ontario, Canada

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3 Davies, B., *Postgraduate Medical Journal*, 1964, **40**, 15.

Neurological Complications of Infective Endocarditis

SIR,—Your leading article (13 June, p. 619) on neurological complications of infective endocarditis omits to draw attention to cerebral abscess, which is one important and urgently remediable complication of this condition. Unfortunately, cerebral abscess may present as a neurological deficit of sudden onset, and in these circumstances it is dangerously easy to ascribe this mistakenly to an embolic or haemorrhagic incident. Physicians should be aware of this difficulty in diagnosis, and that it is now a wise measure to perform a radioactive brain scan on any patient with bacterial endocarditis who develops a focal neurological deficit or deterioration in the level of consciousness.—I am, etc.,

JOHN GARFIELD.

Wessex Neurological Centre, Southampton General Hospital, Southampton, Hants.

Soya Milk

SIR,—Your account of the appeal of the Secretary of State to referees in the case of the doctor who prescribed Soya Milk for milk allergy (*Supplement*, 16 May, p. 128) and the referees' decision that Soya Milk was not a drug which the executive council was bound to provide, is difficult to understand. The Standing Joint Committee on the Classification of Proprietary Preparations in the *Report on the Definition of Drugs (Borderline Substances)* gave a list of preparations which might be regarded as drugs and prescribed on E.C. 10 in the treatment of specified illnesses. The list of "Borderline Substances" is brought up to date in each issue of the Standing Joint Committee's *Proplist*. A soya-based milk substitute—Velactin (A. Wander Ltd.)—has been included in the list since its first publication. The "conditions in which it would be regarded as a drug" were originally given as "milk intolerance; lactose without sucrose intolerance." In *Proplist* for February, 1970, this is revised to "All forms of milk intolerance." Doesn't Soya Milk mean a soya-based milk substitute? Is milk allergy not included in all forms of milk intolerance?—I am, etc.,

T. P. EDDY.

Department of Human Nutrition, London School of Hygiene and Tropical Medicine, London W.C.1.

Child-resistant Containers

SIR,—The incidence of acute poisoning of children in Britain is rising rapidly and remorselessly. The most promising recent advance in the prevention of paediatric poisoning is the development in North America of the child-resistant medicine container.[1-5] Following the introduction of such containers poisoning from drugs has been reduced by as much as 90%; other poisonings—mainly from household products—have decreased by as much as 40%.[2 5] The success of child-resistant containers is in contrast to the failure of conventional forms of poison control directed towards improved

storage of chemical products and increased publicity of the potential dangers of chemical agents.[6] Legislation in Canada and the United States will shortly make safety containers mandatory for drugs and household products.[2 5]

In November 1969 the Liverpool Regional Hospital Board agreed that the Palm-N-Turn container should be introduced into the region and that this programme should start in Birkenhead. It is hoped that child-resistant containers will be adopted in other areas and that their use may be made compulsory throughout the country as soon as possible.—I am, etc.,

D. H. S. REID.

Children's Hospital,
Birkenhead, Cheshire.

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War Surgery in Nigeria

SIR,—I was very interested in the article by Mr. G. W. Odling-Smee (6 June, p. 592), particularly noting his views on major limb wounds in which fractures are combined with soft tissue injuries. I hope his advocacy of the use of immediate internal fixation in compound fractures is not taken at its face value without full reference to the paper by Dudley *et al.*[1] which he quotes. Too often one sees these injuries closed under tension or by unsafe local flaps and encased in plaster for six weeks with disastrous results. If internal fixation is to be used particularly when there is a skin defect there must be available "a team seized with the urgency of skin cover."[1] Trueta's work[2] and that of his predecessors and followers has frequently been mis-read or only half read by those responsible for the care of compound injuries, and the application of the principle of delayed primary skin cover too often ignored in the past, in war and peace.—I am, etc.,

B. S. CRAWFORD.

Plastic and Jaw Department,
Hallamshire Hospital,
Sheffield, Yorks.

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2 Trueta, J., *The Treatment of War Wounds and Fractures*. London, Hamish Hamilton 1939.

Ergotamine Tartrate in Migraine

SIR,—I am surprised that Dr. D. S. Freestone (6 June, p. 599) should be puzzled by the ineffectiveness of ergotamine tartrate shown by Dr. W. E. Waters (9 May, p. 325). The wonder is that the investigation, using a homoeopathic dose instead of a therapeutic dose, was ever undertaken.

For many years I, like Dr. Waters, followed the usage of textbooks and gave a dose of 1 or 2 mg. followed by 1 mg. half hourly. I was quite convinced that ergotamine tartrate was a drug of little value, except in so far as there was no other more effective drug in tablet form unless one happened to have discovered that a particular patient responded to some less conventional treatment, such as 400 mg. of sodium amytal.

One day I chanced to pick up a manual[1] in which I read that the American usage is to give 5 mg. initially followed by 2 mg. half hourly, if necessary up to the usual maximum dose of 10 mg. in a day. I now find that a single dose of 5 mg. is all that is needed to abort an attack of migraine in almost any patient unless vomiting necessitates an injection.—I am, etc.,

T. D. FITZGERALD.

Sheerness, Kent.

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Nifuratel for Trichomonal Vaginitis

SIR,—Drs. B. A. Evans and R. D. Catterall (9 May, p. 335) quote an early study by Dr. J. Delnon and myself on nifuratel[1] at the obstetrics and gynaecology clinic of the University of Berne. In further trials on 485 patients[2] I was able to compare the trichomonacidal activity of nifuratel (Magmilor; in Switzerland Macmiror) with that of metronidazole (Flagyl), referring also to my previous experiments with the latter product.[3]

The conclusions I came to are quite different from those reached by Drs. Evans and Catterall. In fact, in 1965-6, I observed that the cure rate attained by metranidazole was about 68%, and that by nifuratel about 80%.

In my experience, the activity of nifuratel in bacterial and mycotic infections was satisfactory in cases of mixed aetiology and in preventing mycotic superinfections, which often occur after treatment with metranidazole.—I am, etc.,

M. ARNOLD.

Baar, Switzerland.

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2 Arnold, M., *Therapeutische Umschau und medizinische Bibliographie*, 1966, **23**, 356.
3 Arnold, M., and Berger, M., *Gynaecologia*, 1961, **152**, 238.

SIR,—Drs. B. A. Evans and R. D. Catterall draw some rather rash conclusions from their comparison of anti-trichomonal activity between nifuratel and metronidazole (9 May, p. 335). The authors do not appear to have considered what is known of the epidemiology of trichomoniasis. The most detailed and up-to-date statistical data indicates that the incidence of trichomonas is about 10-15% in women generally and 70-75% in prostitutes.

Drs. Evans and Catterall neither treated the male partners nor considered the possibility of re-infection in the 12-week period which elapsed between the end of treatment and their last control. The fact that four patients presented with a gonorrhoeal infection during treatment is in itself very significant in this connexion.

Another questionable point is that the side-effects ascribed to nifuratel were general allergic reactions which occurred without any local intolerance, despite repeated insertions of pessaries into the vagina. The side-effects mentioned by the authors are more likely to be attributable to other drugs administered concurrently (penicillin, etc.) or taken by the patients in question.

These observations of mine are based on six years' experience with nifuratel (Magmilor) in hundreds of cases,[1] where I observed quite different results with no local or systemic side-effects. Treating trichomoniasis with nifuratel I attained approximately 93% recovery, which is a rate in agreement with that achieved by many authors in other countries. I stopped using metronidazole as the success rate was less than 70%.—I am, etc.,

ITALO SAGONE.

Milan, Italy.

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1 Sagone, I., *Minerva Ginecologica*, 1965, **17**, 654.

Pre-ulcerative Buruli Lesions

SIR,—In our recent paper on "Clinical Features and Treatment of Pre-ulcerative Buruli Lesions" (16 May, p. 390) it was not made clear that the five cases described were investigated bacteriologically, and that *Mycobacterium ulcerans* was isolated from the excised lesions in each case. We have commented[1] previously on bacteriological findings in lesions of different histological types.—I am, etc.,

IAN PHILLIPS.
Member of Uganda Buruli Group.

St. Thomas's Hospital,
London S.E.1.

REFERENCE

1 Uganda Buruli Group, *Lancet*, 1969, **1**, 111.

Sleep and Drug Overdose

SIR,—For some years I have followed Dr. Ian Oswald's work on sleep and related problems with interest and admiration so it is with some dismay that I read the article on late brain recovery processes after drug overdose (9 May, p. 318).

It may be that raised paradoxical (R.E.M.) sleep rebound indicates prolonged turnover of proteins in the cerebrum,[1] but it occurs in a variety of conditions—amphetamine withdrawal, barbiturate withdrawal, overdosage with tricyclic drugs, and after "E.C.T. overdosage." Dr. I. Haider and Dr. Oswald show that in Case 1 after an overdose of Mandrax R.E.M. sleep returned to normal according to their chart in 31 days, but in Case 4 after two episodes of overdosage with nitrazepam the R.E.M. remained abnormal for 33 days and more than 42 days.

In their third last paragraph they say that "nitrazepam is to be preferred to its contemporary rivals" because of its safety, but then go on to make a statement that indicates that co-ordination, emotional stability, and good judgement need not be