In any event, it is unwise to lay down a rigid code of conduct in these matters. I am advised by experienced nurses here, however, that it is never necessary to strike a patient.—I am, etc.,

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New-style Cold Abscesses

SIR,—Because of the postal strike, your leading article on "New-style Cold Abscesses" (30 January, p. 247) was seven weeks old when I first read it. I do not want to comment on its surely incorrect opening statement, which others may be expected to criticize with authority, but may I please have the space to note some experiences of cases of "new-style cold abscesses" that indicate that not all lesions conforming clinically to this pattern are in fact tuberculous?

I have histological material from 12 examples of such lesions in patients who were living in the British Isles at the time of the diagnosis. The tuberculous nature of the lesion was proved in two cases by culturing typical human strains of *Mycobacterium tuberculosis* and presumed in two further

Chromomycotic cold abscess. Fungal elements with the morphological appearances of *Phialophora gougertii* in the tuberculoid lining of the subcutaneous cavity. They are not always as numerous as in this selected field. The natural brown colour of the fungus makes its histological recognition in haematoxylin-eosin preparations usually quite straightforward, particularly when the tissues are not overstained with eosin. In the specimen photographed, the organisms have been made more obvious by the staining method, which blackens them. (Grocott's hexamine silver method. $\times 195$.)

cases in which scanty acid-fast bacilli were found in the sections. Acid-fast bacilli were looked for unsuccessfully in sections in the eight other cases; neither culture nor guinea-pig inoculation was attempted in these cases. Four of the eight apparently non-tuberculous cases were instances of chromomycotic cold abscess, the condition that Mariat and his colleagues¹ named "phaeo-sporotrichosis", surely a regrettable coinage. The diagnosis of chromomycosis was made by finding the characteristic brown fungi in the histological sections (Figure). *Phialophora gougertii*, the fungus that is believed to be the usual cause of this form of chromomycosis, was grown from the lesion in the only case among these four in which culture was undertaken. This was the case of an Irishwoman who had never been out of the British Isles. She gave a clear history that the lesion began to appear six weeks after deeply pricking the affected part of the forearm on earth-soiled barbed wire while extracting an impacted terrier from a rabbit burrow in County Louth.

Thus, of the 12 cases, four may be regarded as tuberculous, four as chromomycotic, and four as of undetermined nature (no cultures, and no organisms seen in sections). As there is ordinarily no difficulty in seeing the pigmented fungi in chromomycotic lesions, it is less likely that the four cases of unknown cause were chromomycotic than that they were tuberculous, particularly as tubercle bacilli are often difficult to demonstrate histologically in some cold abscesses that can be shown bacteriologically to be tuberculous. Other possible causes were also considered, without furthering the diagnosis of these four cases.

Four of the 12 patients had active pulmonary tuberculosis, bacteriologically confirmed. They included one of the two patients in whose cold abscesses acid-fast bacilli were seen histologically, one of the two from whose lesions *Myco tuberculosis* was grown, one of the patients with a chromomycotic abscess, and one of those whose abscesses were of uncertain nature. The presence of sputum-positive pulmonary tuberculosis does not indicate that a cold abscess is necessarily tuberculous.

Clinically, there was nothing to distinguish the tuberculous cold abscesses from the chromomycotic cold abscesses or from the abscesses of uncertain nature. Histologically, the only certain distinctive feature was the demonstrable presence of acid-fast bacilli or brown fungi. All the lesions were single and subcutaneous. None was in direct connexion with any deeper-seated disease. All eventually healed. Recovery was quickest in the cases in which the lesion was totally excised, with or without preliminary aspiration; it was delayed in those in which the abscess was incised, because secondary septic infection followed incision in every case and necessitated postponement of the eventually curative excision.

Of the four patients with a proved tuberculous cold abscess, one had arrived from India six months before symptoms began, one from Malaysia 21 months before, one from Pakistan 3½ years before, and one (aged 22) had never been out of Scotland. Of the four patients with a chromomycotic cold abscess, one already had symptoms three months before leaving Pakistan, one had arrived from Uganda a year before symptoms began, one from India 20 years before, and one (the Irishwoman referred to above) had never been out of the British Isles. Of the four patients whose abscesses are of unknown cause, one had arrived from Iran seven months before symptoms began, one from India 1½ years before, one from Pakistan three years before, and one was an Englishman ordinarily resident in London but a frequent world-wide traveler.—I am, etc.

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¹ Mariat, F., Segretain, G., Destombes, P., and Darrasse, H., *Sabouraudia*, 1967, 5, 209.

Access and Attitudes to Smoking

SIR,—The recent report of the Royal College of Physicians *Smoking and Health Now*¹ recommends steps towards reducing the accessibility of cigarettes for children by strengthening sales regulations and by the abolition of all cigarette vending machines

in public places. Dr. Myer Goldman (9 May 1970, p. 364) reminded us that at any age a child can buy cigarettes from an automatic machine.

In recent inquiries in two secondary schools in the City of Portsmouth, we have found that just over 70% of boys aged 14 (age group totalled 105 boys) had tried a cigarette (closely similar to the national experience recorded by J. M. Bynner²), over a third at that age stated that they were smoking regularly, and indeed a number were smoking an average of more than five per day already. In the girls' school about 73% of those aged 14 (age group totalled 48) had tried a cigarette, a higher proportion than the boys were regularly smoking (54%), and unfortunately those smoking an average of five per day were 25% of the age group.

It was surprising to note that, in an admittedly small sample, 19% (20/105) of boys under the age of 16 who were regular smokers stated that they smoked in front of their parents. Girls considered their parents even more permissive, because over 33% (23/68) of girls under the age of 16 who were regular smokers stated that they smoked in front of their parents.

At the boys' school 43% of the regular smokers (regular smokers were 186 out of 614 boys questioned) said that they would like to give it up. This corresponds with Bynner's findings. At the girls' school 50% of the regular smokers (regular smokers were 85 out of 244 girls questioned) said that they would like to give it up.

Children's assessments of parental attitudes may be somewhat distorted, but their estimate of parental permissiveness may well involve relative ease of availability of cigarettes in the home. It seems to me, therefore, that parents are one of the important target groups for our efforts to gain allies in the community.

Meantime, surely, the obvious ease of supply through cigarette vending machines could be closed with very little inconvenience to the general public.—I am, etc.,

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¹ Royal College of Physicians of London, *Smoking and Health Now*. London, Pitman, 1971.

² Bynner, J. M., *The Young Smoker*, London, H.M.S.O. 1969, P.25

"You"

SIR,—With the publication of *You* the medical profession has certainly descended from its pedestal into the market place with a resounding wallop, and I have no doubt that many of my very respected colleagues are quivering with fury. Personally I am delighted. It was inevitable in this day and age that sex should have been used to sugar the pill of health education, but the articles on this subject are so full of good sense that they put the profession in the lead for thinking on this subject, and that, of course, is where we should be.

However, there are obviously problems associated with giving medical instruction in the form of popular journalism. I came across a good example when surreptitiously glancing through the latest issue of the woman's magazine *She* (May 1971, p. 129). An article ingeniously entitled "The post-op flop," had courageously tackled the problem of instructing patients regarding intercourse