factory certificates varies from country to country, and the regulations may well differentiate between those who travel by sea and those who travel by air. Passengers sometimes go armed with a doctor's note stating why they should not be vaccinated. This is very good, of course, but it should not be assumed that because a person has a good medical reason for not being vaccinated he will therefore be allowed free entry to another country. If the reason for refusing to vaccinate is a debatable one, such a certificate, unless worded diplomatically, may well militate against another doctor making good the deficiency.—I am, etc.,

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Malaria Risk to Travellers

SIR,—I write to congratulate you on your timely leading article (24 March, p. 691). I think most doctors now accept the possibility that a traveller may acquire an unusual infectious disease abroad and sometimes return with it to his home country. Unfortunately, there still seems to be some doubt about who should accept the responsibility for protecting him while he is abroad and when he returns. I would like to spell out my own views on this point.

The medical profession must be cognisant of protective measures such as vaccinations and malaria suppressives. It must also be aware of the possibility of imported disease as a potential menace to the individual or to him and to the community. To create this awareness the doctor must be conditioned to obtain a geographical history during the routine medical interrogation of every patient. This needs no elaboration here, except perhaps to point out the many excellent pamphlets available on the subject, notably the very clearly written booklet issued by the Ministry of Health and Social Security.¹ I agree with you that the W.H.O. document² on malaria risk should be issued to all agents and everyone else concerned with travel. The map in the document should hang in every doctor's office.

The public must equally be made aware of the risks run (however slight) in holiday or business trips or sojourn abroad, especially in the tropics and other areas of the developing world. In this respect the hard core of "travel agencies, tourist information centres, and other organizations dealing with international travel" have failed dismally. Their philosophy seems to be that their job is to move a passenger from point A to point B under reasonably clean conditions and take no further interest in his health either abroad or after return. This attitude is well illustrated by the response of a "spokesman" for a famous travel agency to a recent warning I gave about imported disease.³ He was quoted as saying: "The travel agent's duty is to pass on the Ministry of Health's instruction. It would be exceeding our job if we started laying down the law about people's health beyond what the Ministry of Health instructs us to do."⁴ Equally at fault are television, the newspapers, the glossy magazines, and other mass media which expend their winter energies pushing us into the sun without a breath of warning.

Aircraft corporations and owners also accept some responsibility. As a frequent

and world-wide traveller I have found B.O.A.C. takes more concern than most,⁵ but I would like to see more done to warn passengers who are entering or returning from endemic areas of malignant malaria. It is an international regulation that passengers must be warned about what to do if the plane falls into the sea. Why not also use the public address system to warn passengers that they are about to land in a malarious area and must take proper precautions or that they are returning from an endemic area and, if they get ill on return, must tell the doctor where they have been and when? Airports could also do much more to protect their passengers, especially on return from abroad. There should be notices in prominent places such as the Customs area and on passport desks, reminding passengers to seek medical advice if they should become ill and to tell the doctor where they have been.

It is clear that the responsibility will have to be shared by the medical profession (with the general practitioner in the front line) and by the public, including the passenger himself and all those concerned with his geographical movements. Looking after the health of the traveller is merely common sense and part of the national surveillance which is a necessary ingredient of international health control. To lose a returned traveller from an imported disease such as malaria through either medical or lay ignorance is not just unnecessary. It is disgraceful. I wish all of those involved in the big business of travel would appreciate this.—I am, etc.,

BRIAN MAEGRAITH

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¹ *Communicable Diseases Contracted Outside Great Britain* (Medical Letter 4/72). London, Department of Health and Social Security, 1972.

² World Health Organization, *Information on Malaria Risk for International Travellers*, reprinted from *Weekly Epidemiological Record*, 1973, No. 3, 25. Obtainable from W.H.O., 1211, Geneva 27, Switzerland.

³ *Medical News*, 1973, 5, 16.

⁴ *Daily Telegraph*, 19 February 1973, p. 17.

⁵ British Overseas Airways Corporation, *Welcome Aboard*, p. 41. London, B.O.A.C., 1973.

Medical Care for Visitors to E.E.C. Countries

SIR,—A fringe benefit of our joining the Common Market is the entitlement to medical treatment for holidaymakers and other temporary visitors to countries of the E.E.C. Perhaps wisely, this facility has not been widely publicized. In contrast to the effusive, immediate, and trouble-free availability of medical, surgical, dental, pharmaceutical, and ophthalmic services to all visitors to our shores (provided that we have not got wind that they have come here specifically for this purpose) entitlement in E.E.C. countries is denied to self-employed and non-employed persons and their dependents except on certain conditions in Denmark.

To obtain a "certificate of entitlement to medical benefits" (form E111) is no mean achievement. First one must obtain form CM1 from the Department of Health and Social Security or an employment exchange. Secondly, one must read six paragraphs of notes and then post a completed 14-item questionnaire to the local social security office. Once obtained, the certificate is valid

until one month after the date of intended return. A separate application must be made for every holiday, but if several temporary visits (for example, on business) are likely a certificate valid for an extended period can be obtained. Once abroad it behoves the holidaymaker to have at the ready leaflet SA28,¹ which gives general guidance to facilities in member countries (but not an authoritative statement of the law).

The many members of the medical profession who are self-employed will, no doubt, continue to insure themselves privately against the maladies which may afflict them and their dependents abroad. For the relatively small sum involved and the ease of obtaining insurance for private medical treatment, which at the same time obviates the possibility of a requirement to obtain a refund under state schemes, others would be well advised to follow suit despite their entitlement to benefit.—I am, etc.,

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¹ Department of Health and Social Security, *Medical Treatment for Holiday Makers and Other Temporary Visitors to Countries of the European Economic Community*. London, H.M.S.O., 1972.

Efficacy of Measles Vaccination

SIR,—I have been an advocate of measles vaccination with the live attenuated vaccine since it was first available for general use. Up to this year I have seen little measles in my practice and none among vaccinated children. During the current outbreak, however, I have seen two cases of severe measles in "protected" children.

If this experience is shared by other doctors, we will have to postulate that either the immunity from measles vaccination lasts for only a limited period or that the measles virus is undergoing an antigenic mutation. It would be unfortunate if we had to rethink the status of measles vaccination in clinical practice.—I am, etc.,

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Treatment of Acne Vulgaris

SIR,—In your leading article on antibiotics in acne vulgaris (13 January, p. 65) you accept rather uncritically, in my opinion, the position of Dr. Cuncliffe and Professor Shuster¹ that "a rational experimental approach to the treatment of acne should aim at reducing secretion of sebum by giving an antiandrogen or metabolic inhibitor or at decreasing resistance to the flow of sebum."

There is a considerable difference between measures that would enhance the natural flow of sebum to the surface and those that would inhibit the formation of sebum. An attempt to reduce plugging of occluded follicles has been the basis of most external treatments for acne, both traditional and modern. Such methods include the use of cleaners, mechanical abrasives, peeling agents such as sulphur and benzoyl peroxide, ultraviolet exposure, and, most recently, tretinoin. (There is some evidence that sulphur, benzoyl peroxide, and perhaps ultraviolet light have an antimicrobial effect as well.) Many of us who treat substantial numbers of acne

patients find such simple measures to be frequently if not universally successful.

The suggested use of antiandrogens and metabolic inhibitors to reduce sebum production is another matter altogether. For one thing, it has never been demonstrated that the oiliest areas of the face get the most acne. The lesions of acne do not occur in those sites where sebum flow is most profuse but only in those areas where the outflow of sebum to the surface is blocked. The validity of this statement may be confirmed if one will look carefully at any random group of acne patients.

The largest and most productive sebaceous glands are on the nose, yet pimples on the nose are characteristic only of very early adolescence, at a time when the remainder of the sebaceous follicles on the face are still quite inactive. As follicular development continues, sebum and pimples start to appear on the central portion of the cheeks; later they appear on the outer parts of the face and finally on the neck and back. Of particular interest is the fact that at the same time as the sides of the face become affected it is customary for the nose and central cheeks to become relatively free of lesions. Careful examination of such patients reveals that the nose and central cheeks are quite oily and shiny. They are free of active disease not because the production of sebum has lessened in those areas but because the follicles, now mature, have at last become capable of emptying themselves through adequate openings. This, in fact, is how one literally "outgrows" acne. The openings become enough to function while sebum production continues at a normal and natural rate.

Thus the suggested treatment of acne with antiandrogens and antimetabolites in addition to being potentially harmful through effects elsewhere in the body, is also not "rational."—I am, etc.,

E. W. ROSENBERG

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¹ Cunliffe, W. J., and Shuster, S., *Lancet*, 1969, 1, 685.

Vehicles for the Disabled

SIR,—As a general practitioner with several handicapped patients I would like to express my deep concern about the highly unsatisfactory invalid three-wheelers issued to the disabled by the Department of Health and Social Security. These have attracted widespread criticism in recent years, and when compared with an adapted four-wheeled car (which is comparable in cost to a three-wheeler) in the August 1969 edition of *Which?* they were described as "under-powered, unstable, unreliable, . . . , noisy, poorly heated, and did not ride very well."¹ They were summed up as "fairly disastrous" vehicles. To answer such criticisms a new three-wheeler—the P.70—was introduced in 1970. While improved features included a more powerful engine and automatic transmission, the light fibreglass body and inherently unstable concept of three wheels instead of four remained the same. This "improved" model was strongly criticized in a further *Which?* report in March 1972² and summed up as "still extremely hazardous" owing to lack of safety features.

Having personally tested the new P.70

three-wheeler, I found that the comments made in *Which?* and the frequent complaints of local disabled drivers about the instability of such vehicles and their proneness to being blown around in cross-winds were more than fully justified. In recent years three disabled drivers have been blown off the road in the Oxford area alone (one of whom was killed) and one of my patients recently suffered the same misfortune in the new P.70 three-wheeler, but luckily escaped alive.

It is to be hoped that more individual doctors, and the medical profession as a whole, will soon take a more active interest in supporting a call for urgent action to replace existing three-wheelers (except to the minority who cannot drive anything else) with an adapted four-wheeled car which is efficient and able to meet the safety standards of the twentieth century—a concession already enjoyed by war disabled persons and some categories of National Health Service patients. Any doctor who doubts the need for such proposals has only to inspect the controls and test-drive (not on a public road) any three-wheeler issued to his disabled patients by the Department of Health, and compare it with an automatic Mini-minor or similar small car for comfort, ease of control, and particularly safety, to realize the validity of the criticisms of such vehicles. Haematologists have already been strongly outspoken in successfully drawing attention to the dangers of three-wheelers for severe sufferers from haemophilia. Perhaps other doctors should show similar concern and adopt a similarly urgent course of action on behalf of their severely disabled patients.

I would be interested to hear from any doctor who has views on this subject and who would be willing to take an interest in support of trying to achieve safer vehicles for disabled drivers.—I am, etc.,

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¹ *Which?*, August 1969, p. 248.

² *Which?*, March 1972, p. 94.

Bone Marrow in Infectious Mononucleosis

SIR,—Your leading article, "Infection with E.B. Virus" (31 March, p. 757), contains the statement that "infectious mononucleosis does not involve the bone marrow." We wish to draw attention not only to our own series of nine patients,¹ but also to a pre-existing literature on this topic.

In our series, all specimens of sternal marrow showed marked hyperplasia affecting all cellular elements, and very occasionally the cellular features could be so bizarre as to raise the possibility of an early neoplastic process affecting one or more cell lines. From the literature we select the articles by Campbell,² Schleicher,³ Hovde and Sundberg,⁴ and Pease,⁵ all of whom noted involvement of the marrow either by hyperplasia or by granulomata or by both features in most of the patients studied. Further, since our own publication, Metcalf and Wahren⁶ have reported the presence in the serum of 44-100% of patients with infectious mononucleosis of a factor which possesses colony-stimulating activity on mouse bone marrow cells in vitro.

Hence all these reports lead us to conclude that infectious mononucleosis does indeed affect the marrow in a very interesting manner and that there can be from time to time close similarities between the marrow findings in infectious mononucleosis and other generalized lymphoproliferative states.—We are, etc.,

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¹ Boyd, J. F., and Reid, D., *Journal of Clinical Pathology*, 1968, 21, 683.

² Campbell, A. C. P., *Journal of Pathology and Bacteriology*, 1948, 60, 629.

³ Schleicher, E. M., *Acta Haematologica (Basel)*, 1949, 2, 242.

⁴ Hovde, R. F., and Sundberg, R. D., *Blood*, 1950, 5, 209.

⁵ Pease, G. L., *Blood*, 1956, 11, 720.

⁶ Metcalf, D., and Wahren, B., *British Medical Journal*, 1968, 2, 99.

Strychnine-containing Tonics

SIR,—Along with two colleagues we recorded, in 1971, the successful treatment of strychnine poisoning with diazepam.¹ The patient, a 13-month-old child, had accidentally swallowed Easton's tablets (formula A, B.P.C. 1963). These are a "tonic" and at the time contained 1 mg of st. chnine hydrochloride per tablet.² We cond. . . use of strychnine in any form because there is no evidence of any therapeutic value. Tolerance to strychnine is variable and as little as 2 mg has proved unpleasant to adults³; no one knows the effect a lower dose may have on children, but it might be fatal. In the 1968 revision of the B.P.C. the strychnine content of the formula A tablet was reduced to 0.1 mg, but the preparation was not withdrawn altogether, apparently because there was still a demand for it; the tablets are still being manufactured.

As no one knows the lowest fatal dose of strychnine in children, and as strychnine has no therapeutic indications, it seems improper to continue to produce any compound with any form of strychnine as its ingredient. Many "tonics" taste very pleasant, which makes them especially attractive to children.⁴

A brief scan of *MIMS* has shown that there are at least nine proprietary preparations still marketed as "tonics" which contain strychnine in various forms and in varying (sometimes unspecified) dosage. There may well be others, and we should therefore like to ask these questions: (1) As strychnine has no proved clinical value and is a known poison, does commercial success in so-called "tonic" sales outweigh the risk of unnecessary fatalities? (2) What company can justify the continuing manufacture of preparations containing this ingredient? (3) When are the drug companies going to withdraw these compounds in their present form? (4) Should not the Committee on Safety of Medicines be involved?

In the meantime we appeal to all doctors not to prescribe any of these so-called "tonics" and to try to retrieve any which may be in the possession of patients. Most patients are surely unaware that the tonic