cigarette manufacturers to carry out the necessary studies since it is impossible to patent any modification that might be suggested by such research. The massive investment in the development of artificial tobacco substitutes appears not to lead to any substantial improvement in safety, since the carbon monoxide yield remains unchanged and the tar : nicotine ratio is increased.

The reason for the introduction of tobacco substitutes is not to benefit the consumer but to increase the producer's profit. Since the tobacco industry lacks the financial inducement to try and introduce a safer cigarette, perhaps the introduction of a variable rate of duty on cigarettes, taxing safer cigarettes less harshly than those brands considered harmful, would be to the good of both manufacturers and consumers. Since the Government is involved in a campaign to lessen the hazards due to cigarette smoking, it would perhaps be appropriate for it to support research into the role of oxidants and other factors in smoking-related disease. The necessary money to finance this research could be found if the suggested levy on less safe cigarettes was used solely for this research.

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Classification of cigarettes

SIR,—In his recent article (12 June, p 1430) Dr M A H Russell discusses the desirability of smokers changing their brand of cigarette to gain a satisfying nicotine intake for the least intake of tar.

While agreeing with this aim, I wonder if a greater success would not be achieved if the figures for tar and nicotine yields were actually printed on the cigarette packets. Unless a smoker had access to the Health Departments' tables of tar and nicotine yields,¹ which are not publicised as widely as they might be, the present system of five categories stamped on the packets could be rather unhelpful to smokers attempting gradually to reduce their tar intake. This largely stems from the range of tar yields represented by each category. For example, in the "low tar" category the range is from 1.25 to 9.58 mg/cigarette and in the "low to middle tar" category from 11.16 to 15.89 mg/cigarette. Ranges similar in extent to that in the latter category are found in the other three groups. Without access to the tables it would be impossible to determine how much less tar a smoker would be exposed to by changing brands, especially within any one category.

At a time when increasing quantification of values is being sought the present system of classifying tar and nicotine yields is surely outmoded and if the Department of Health is serious in its desire for smokers to reduce their tar intake there can be little excuse for not printing actual values on cigarette packets. During a recent visit to Austria I was interested to note that this was already standard practice on all cigarettes offered for sale, including British brands.

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¹ Health Departments of the United Kingdom, *Tar and Nicotine Yields of Cigarettes*. London, DHSS, 1976.

Orf in Britain

SIR,—While admitting that a British doctor in the centre of a large city might see only an occasional case of orf (Dr Rupert Mason, 26 June, p 1587), the contrary is more likely to be the case for the rural practitioner. I recently reported a small epidemic in a rural area which occurred in the spring of 1975.¹

There is little doubt that the occurrence of this disease is associated with outbreaks of animal vesicular disease in sheep. This is common in farming areas and is due to a pox virus infection affecting the udders of lactating ewes, causing vesicular eruptions. The infection is so severe, and presumably painful, to the lamb that it may die through an inability to suckle. Infection of humans by the virus causes an eruption not unlike an infected wart which is given the name "contagious pustular dermatitis." The lesion is classically about 1 cm in diameter and has a firm, red base surmounted by a reddish blue capsule, which after a few days may turn into a greyish yellow vesicle with the appearance of a pustule. This may enlarge and become flat-topped, though the bulla often becomes encrusted and its centre may be umbilicated. If the lesion occurs adjacent to the nail bed it can be mistaken for paronychia. If such a mistaken diagnosis is made and the lesion incised the absence of pus or exudate should in itself provide a clue to the correct diagnosis.

It appears likely that the virus requires certain favourable climatic conditions for an epidemic to develop, and I suspect that these conditions coincide with lambing only in occasional seasons. When there is a serious outbreak among sheep the country doctor will almost inevitably see cases among his farming patients. Infection is most commonly by direct contact of infected animal to man and consequently the most frequently affected parts are the fingers and hands. However, it seems also likely that occasional infection is due to contact with contaminated fencing or hedgerows, and undoubtedly some of the cases I have seen have fallen into this category.

There is no effective curative treatment. The lesion is best left and, if possible, kept dry. The condition is always self-limiting and complete resolution within three to five weeks is the rule. Occasionally secondary bacterial infection complicates lesions of orf, but this usually responds to a course of an antibiotic, allowing natural resolution of the underlying virus lesion to take place.

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¹ Hall, M S, *Journal of the Royal College of General Practitioners*, 1976, 26, 203.

Genetic counselling in Huntington's chorea

SIR,—Drs Gillian M and N W Glendinning (3 July, p 46) are, of course, right that the family doctor is the ideal person to inform and support families in which a member has Huntington's chorea. First, however, the family doctor has to learn that a person on his list belongs to such a family, either from the individual himself or from a colleague who has made the diagnosis in the affected member. Perhaps in rural Somerset one may rely on this invariably taking place in one way or

another. It is not so over most of the country. When the diagnosis is made, say, in a 50-year-old patient neither the neurologist nor the family doctor will always see that this diagnosis is made known to all the patients' children, who may be scattered around Britain or even abroad, or to the children's family doctors. For example, we know of one family in which the mother died after 17 years in hospital; two years after her death her six adult daughters did not know of, or did not realise the significance of, the diagnosis.

We believe that individuals at risk have a right to know the truth of their situation, including the genetic risks, so that they themselves can make informed choices about family planning. We believe that suitable publicity will help to achieve this and alert families to the need to go to their family doctors for help. Methods of publicity must be constantly reviewed and adapted to current needs. We look forward to the day when all Huntington's chorea families are helped with "gentleness and care" by sympathetic family doctors like the Glendinnings.

After the recent film on Yorkshire TV and other publicity, Combat received 296 letters, mostly from Huntington's chorea families, only one of which was in any way critical. The common refrain in these letters was "we knew that Huntington's chorea was in our family but not what it meant for us and our children."

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Urinary retention in women

SIR,—Your leading article on this subject (26 June, p 1554) draws timely attention to the frequently underdiagnosed (and therefore often maltreated) condition of urinary retention. One of the difficulties is an adequate definition of acute and chronic retention. Doran and Roberts¹ state that acute retention of urine should be painful and acute in onset and that less than 1 l of urine should be obtained on catheterisation. Unfortunately this definition is too narrow and precludes some genuine cases in which retention is painless and where amounts of urine greater than this can be removed at the first episode of retention. Chronic retention was not defined by Fox *et al*,² but it may be considered to be the result of a single or repeated episode of acute urinary retention producing painless bladder distension, voiding taking place by overflow.

I would like to emphasize two points. Firstly, the role of drugs in causation of retention and difficulty in voiding, and secondly, the prodromal state of straining to void and a slow stream. In a series of 440 women seen over the last five years with voiding disorders who have been referred to urodynamic clinics, 27 (6%) had either acute or chronic retention or a noticeably slow stream. Of these five patients had a relevant drug