treatment. Moreover, the treatment is logical because in most cases of embedding the shape of the nail is normal.

Since, however, the normal anatomy is preserved, an average follow-up of less than one year might be inadequate to determine the recurrence rate. Ingrowing toenails are multifactorial in their causation, but a very frequent finding is drastic cutting of the toenails,[1] which removes support from the pulp of the toe and allows it to prolapse around the edges of the nail. Therefore the long-term success of any conservative treatment of ingrowing toenail must depend on the careful elimination of causative factors, and in particular the avoidance of cutting the nails short.

The authors have correctly described the operation for segmental excision of the germinal matrix (first advocated by Heifetz[2]), but unfortunately they also call this operation a "wedge resection" procedure. The classical wedge resection operation consists of removal of an elliptical wedge of tissue consisting of nail wall, nail plate, and nail matrix. This is a highly unsatisfactory operation because the very structure which it is most important to expose fully—namely, the germinal matrix—is least well exposed because it lies at the apex of the wedge. Not surprisingly, this operation has a high recurrence rate and should not be confused with segmental excision of the germinal matrix.

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[1] Fowler, A W, *British Journal of Surgery*, 1958, **45**, 382.
[2] Heifetz, C J, *Journal of the Missouri State Medical Association*, 1945, **42**, 213.

SIR,—Articles on the treatment of ingrowing toenails appear at frequent intervals. I wonder if the simplest method has been forgotten.[1]

The sharp edge of broken glass is used to pare down the centre of the nail until the centre line is quite thin and the pink nail bed shines through. The instrument may be made from a microscope slide by making scratches on the opposite edges near the centre, then breaking it—if the slide is broken without first grooving with a file it fragments. After the nail is thinned the free edges can be raised by packing with pluglets of cotton wool; but this step is not usually necessary, as once the nail is thinned pressure on the underside of the toe causes the nail to buckle, lifting its edges from the inflamed area.

I have used this method since I saw it described and have had few or no failures. The patient hobbles into the surgery and 15 minutes later walks out in comfort.

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[1] Chapman, P F, *British Medical Journal*, 1934, **2**, 1073.

Depot neuroleptics in a community mental health service

SIR,—Although, like Dr B Blake (7 July, p 48), I have found clopenthixol decanoate (Clopixol) an effective antipsychotic in a number of schizophrenic patients with paranoid delusions and hallucinations inadequately controlled by other long-acting neuroleptic injections, in one respect my experience differs from his. I have encountered very few complaints of extrapyramidal or other side effects when using a starting dosage of 100-200 mg, and my impression is that side effects with this neuroleptic are less frequent than they are with other depot preparations. Clopenthixol decanoate does not appear to have a mood-elevating effect such as I have seen with flupenthixol decanoate (Depixol); but its effect on nuclear symptoms has enabled a number of patients to work in the community in quite demanding occupations.

I would be interested to hear from any reader who has experience of clopenthixol decanoate in patients with intractable obsessional neurotic illness. I have seen a reasonably successful response in such a patient who had failed to respond to all other treatment tried.

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Too few necropsies

SIR,—My efforts to build up a picture of the long-term behaviour of sarcoid heart disease[1 2] are repeatedly frustrated by the lack of adequate necropsy when the patient dies. The only ultimate proof of involvement of the heart with sarcoidosis is by necropsy histology. A number of patients with this diagnosis, who had been followed for many years, have had no necropsy after death, even though the desirability of this was abundantly clear and I am sure that the relatives would not have objected. In other cases—particularly coroners' cases—necropsy examination has been quite superficial and inadequate, and vital material in the heart has been thrown away without histological examination.

One imagines that my experience in sarcoid heart disease is not unique and I would make an appeal for a more energetic and careful necropsy policy where there is a good indication. I understand that there is a shortage of pathologists but that, on the other hand, pathologists have discussed with some concern the fall-off in necropsy rate—could some of this perhaps not be due to the lack of help given to the clinician by a less-than-thorough postmortem examination?

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[1] Fleming, H A, *British Heart Journal*, 1974, **36**, 54.
[2] Fleming, H A, *British Heart Journal*, 1979, **41**, 379.

History of medicine collections

SIR,—Your leading article (4 August, p 293) on the Wellcome Museum of the History of Medicine offers reassurance to many of us who have been concerned by the gradual disappearance of the museum from its familiar—and convenient—site on the Euston Road. Presumably we can now assume that the unique collection accumulated by Sir Henry Wellcome, much of it still not catalogued or documented, is now safe from threat of dispersal. It is heartening to learn that the new museum is maintaining the tradition of informing and entertaining the lay public, particularly the young, but also extending the opportunity for scholarship in this field. One hopes that amateur medical historians will be encouraged to make use of the collection and library facilities.

The expressed intention of developing an archive of contemporary medical objects is particularly important, because the efficiency of supplies officers for the NHS and the refurbishing of general practitioners' surgeries in recent years have resulted in a wholesale destruction of the nineteenth and early twentieth century which may result in a paucity of these specimens in most collections. Since inevitably display facilities in the new museum will be inadequate and duplication of items common, can we hope for the imaginative development of travelling collections or outstations for the museum? Many local museums and most if not all provincial medical schools would find room to display loan collections, perhaps on a rotating basis. They could also act as collecting stations for those impedimenta of medicine which are still collecting dust in the cupboards and cellars of practice premises. There are still wooden stethoscopes, glass and metal syringes, early obstetric forceps, and the like which will end up in the dustbin or a flea market unless a proper home is found for them.

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Measles and vaccine protection

SIR,—Dr G A Jackson's doubts about the efficacy of measles vaccination (4 August, p 332) may be very misleading. It appears that he has based his conclusions on the number of cases in vaccinated children as a percentage of the total number of notified cases of measles in a year. If he had taken the total number of vaccinated children in the district council area as the denominator he would have found about the 90% protection he was looking for.

Dr Jackson was wise not to use significance tests in the analysis of his results; with a response rate of 76% and doubtful validity of the answers to his questionnaire, it was certainly not worthwhile. It would have been useful for him to have defined the two levels of severity of the illness and the complications. A higher percentage of "severe" cases with "complications" in vaccinated children compared with unvaccinated children could also have been due to variability of the assessors—presumably the recipients of the questionnaire—that is, the parents.

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Rubella vaccination

SIR,—I refer to Dr T S Wilson's letter (28 July, p 272) which seemed to criticise a policy of screening adult women for rubella immunity. However, his doubts were not clear.

Dr Wilson wonders if the immense amount of laboratory investigation is "nowadays really necessary." Is he questioning the value of conducting such a survey at all? Is he questioning the habit of serotesting before vaccination? Is he suggesting that some condition obtains *nowadays* that formerly did not?

Congenital rubella is responsible for a high incidence of fetal death (spontaneous and therapeutic abortions), neonatal death, and, of course, congenital defects (deafness, cardiovascular abnormalities, mental retardation, blindness, spasticity, etc). In the UK, over 500 children were born between 1971 and 1978