goes into the pipe, and the ends of the flattened bar permit dorsiflexion but not plantar flexion. Patients with polio may have shortening of the affected legs and need a shoe raise, which may be made out of layers of tropical sheets glued together with a final layer of car tyre.

The items described above have all been made and put to practical use in a district hospital. Furthermore, I have found that these simple, durable aids serve their purpose equally as well as their western counterparts.

Recommended reading

Simple Orthopaedic Aids by Chris Dartnell. This covers how to set up a workshop and gives full details and simple drawings of the production of orthopaedic aids using simple materials. It is available from the Leonard Cheshire Foundation International, Leonard Cheshire House, 26-29 Maunsel Street, London SW1P 2QN, price £2.50 plus p and p.

Poliomyelitis, a guide for developing countries including appliances and rehabilitation for the disabled by Dr Huckstep. Churchill Livingstone.

Footwear manual on leprosy. Available from the London leprosy mission (contact Jean Watson).

Clinical Algorithms

Generalised pruritus

ROBERT H CHAMPION

I can still remember the misery of itching with a combined attack of chickenpox and German measles and after 36 hours of sleepless torment the itching coming through the euphoria of 30 mg morphine. Many would hardly believe how itching can dominate life. It is often the symptom that brings patients with skin disorders to their doctors. Almost half of all patients with rashes complain of itching at some time, even those suffering from disorders like psoriasis or pityriasis rosea that are said not to itch. We are all taught that generalised itching without primary lesions (and distinguishing primary lesions from the secondary ones produced by scratching is not always easy) should ring an alarm bell in our minds. The first thing to consider when a patient complains of generalised itching without any rash is whether a medically trained eye can detect some subtle change not noticed by the patient. This too may be harder than it sounds. Most doctors must have gratified a colleague by missing what later emerged as typical scabies. The commonest type of minimal rash to present with itching is the drying out of the skin, usually called asteatotic eczema but also sometimes called senile pruritus, a term that means different things to different people. Jumping to the diagnosis of senile pruritus because the patient is old is almost as hazardous as diagnosing menopausal pruritus because the patient is 50 or psychogenic pruritus because the patient admits to some stress.

Having established that generalised itching is not associated with any detectable change in the skin, it is next essential to exclude a systemic cause. This may be a well established and obvious disorder such as chronic renal failure or obstructive jaundice. Often, however, patients with Hodgkin's disease, polycythaemia, or iron deficiency present with generalised itching. The role of zinc deficiency as a cause of itching cannot yet be evaluated. Diabetes is often included in lists of such causes, but the association is relatively rare. Diabetes may, however, often present as anogenital pruritus and candidiasis.

A simple battery of tests can easily be devised to exclude most systemic causes of itching (see algorithm). About half the patients with generalised itching without primary skin lesions eventually get better without any other diagnosis than idiopathic generalised pruritus. Prolonged observation may, however, be needed to exclude, for example, Hodgkin's disease or biliary cirrhosis.

Treatment

Treatment can be fairly simple if there is a diagnosable and removable cutaneous or systemic cause. All too often such common diagnoses as eczema defy treatment and still require symptomatic treatment for itching. Topical corticosteroids can be effective when appropriately applied to inflammatory skin disorders. The result tends to be disappointing when they are applied to itching skin without any lesions. If there is no gross rash a topical emollient such as aqueous cream may provide as good relief as anything. Calamine lotion tends to be too drying if used for more than a day or two. Active ingredients applied to control itching tend to be disappointing. Crotamiton (Eurax) may be useful. Topical local anaesthetics and antihistamines are best avoided.

There are no specific drugs that will do for itch what opiates and analgesics will do for pain, though antihistamines are often prescribed with this aspiration. The newer, peripherally acting antihistamines such as terfenadine and astemizole are valuable for disorders such as urticaria, in which histamine may play a part, but can be expected to be little more than placebos when a central effect is needed. A centrally acting, more sedative antihistamine such as trimeprazine or promethazine hydrochloride (Phenergan) may then be more successful. H_2 antagonists such as cimetidine have been used with success in small numbers of patients with itching due to several systemic causes but have often failed in other trials. So far the indications for cimetidine in the general management of itching have not been adequately assessed. It is certainly not a panacea.

Another fairly simple empirical remedy for many types of generalised itching with normal skin is ultraviolet radiation. The mode of action is not certain.

Some patients, perhaps surprisingly, need advice about not getting too hot, not having very hot baths, wearing comfortable loose clothing, avoiding harsh clothes next to the skin, and taking care with alcohol. Itching is, moreover, a symptom that may be alleviated by any measure that encourages the patient to relax. Thus various therapeutic possibilities are raised, from placebos to tranquillisers, hypnotherapy, acupuncture, and many others. The use of these must depend on the experience and inclinations of the practitioner.

Further reading

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