Giant Hogweed

SIR,—It seems appropriate at this time of the year to report a case of dermatitis due to the giant hogweed (*Heracleum mantegazzianum*).

A boy aged 7 years was seen on 5 June, two hours after playing with stems of the giant hogweed. He had raised erythematous patches on both forearms, the front of the neck, and both legs. There were several blisters of $\frac{1}{2}$ in. (1 cm.) diameter and two blisters of 1 in. (2.5 cm.) diameter on the neck. He was treated with a hydrocortisone spray. When he was seen a week later the blisters had dried up, but the livid discoloration of the skin remained. Two weeks after exposure to the plant, disfiguring purplish-brown pigmentation in all the affected areas was very marked.

It has been suggested that this is a phytophoto dermatitis due to sensitization of the skin to ultraviolet light a furocoumarin compound contained in the sap of the plant. There seem to be few references in the medical literature to giant hogweed dermatitis—although the plant, which grows to a height of 10–12 feet (3–4 m.), is not uncommon in waste spaces. The giant hogweed presents the danger of long-lasting and unsightly skin pigmentation in children or gardeners who come into contact with the sap in sunny weather.—I am, etc.,

Liverpool 17.

JANET H. SMELLIE.

REFERENCES

- ¹ Jones, J. G., and Russell, D. G., *Practitioner*, 1968, 200, 704.
- ² Birmingham, D. J., Key, M. M., Tubich, G. E., and Perone, V. B., *Arch. Derm.*, 1961, 83, 73.

Common Courtesy

SIR,—I am goaded into writing to you by my experiences over the last few months while applying, as a hospital junior doctor, for a post in general practice. I feel that I must comment on the extreme rudeness of some members of our profession. On four occasions I have submitted applications for positions advertised in the *B.M.J.*, but in three cases the principals of these practices, doubtless feeling safely anonymous behind the shield of their box numbers, have not even deigned to reply.

Is the flood of doctors into general practice, contrary to popular opinion, so great that these men would develop acute bouts of writer's cramp if they replied to all their applicants? Surely not in many cases, and even in these few instances these brilliant medical men must be capable of finding some ingenious way around the problem. When applying for positions recently I had a duplicated sheet produced detailing my qualifications and experience. Is a similar duplicated reply card even too much effort, or even a small advertisement saying the position has been filled? We do not ask for self-sacrificing behaviour from these doctors, only common courtesy.

Is it any wonder that young doctors are disillusioned when working in Great Britain? We have been brought up to believe that our profession places great store by ethics and courtesy, but in this short series of cases 75% of the doctors concerned were evidently willing to abandon even the most basic human etiquette when sheltered by anonymity.—I am, etc.,

Scarsdale Hospital
Chesterfield, Derbyshire.

K. T. SCHOLES.

Improvised Stretcher

SIR,—When dealing with road accidents it is essential to lift the injured persons from a vehicle with the utmost gentleness, and, if at all possible, in the position in which they are found. Within the confines of a saloon car this may be extremely difficult, using the normal points of access and relying upon gripping clothing without dragging or twisting the body, to say nothing of the contortions required on the part of the rescuer. Matters can be simplified by using one blanket in the following manner:

The aim is to put a cradle under the patient with the minimal disturbance, and to produce handholds at a distance.

One end of the blanket is rolled up twice, and the remainder infolded upon itself like a Venetian blind until a narrow strip is produced which can be slipped carefully under the patient's knees. With the roll behind the knees, the folded portion is brought backwards under the buttocks (which need to be lifted slightly) and then unfolded upwards between the seat and the patient. The patient is now cradled, he has not been disturbed, and he can be lifted out sideways supported and controlled by handholds at a distance. After extrication the patient may be lowered to the ground with the blanket protecting him below and above. By infolding the sides of the blanket it can now be used as a stretcher.—I am, etc.,

Catterick, Yorks.

KENNETH C. EASTON.

Pain in the Face

SIR,—Professor Henry Miller's McCurich Oration (8 June, p. 577) laid great emphasis on careful history-taking in the diagnosis of pain in the face. He also stressed the importance to the clinician of being familiar with certain symptom complexes to avoid unnecessary suffering through their over-investigation or a failure to recognize them. Migrainous neuralgia, he states, requires greater publicity,

for it is still subject to both these hazards.

The Merseyside and North Wales Faculty of the (then) College of General Practitioners published a survey of migrainous neuralgia in 1966.¹ This I believe to be the only extensive survey of the condition coming from general practice. Twenty-six cases were discovered in the practices of 233 general practitioners who covered a population of about 544,000.

I have reason to believe that this incidence is considerably higher. Contributing to the above survey sharpened my awareness of the condition, which often lies undiagnosed and untreated. Since taking over a small rural practice in Devon four years ago three clear-cut cases, all in males, have revealed themselves. To make a diagnosis of migrainous neuralgia, Professor Miller states, is not just academic in importance, for the condition is so eminently treatable. I have found in these cases, and others seen on Merseyside, that ergotamine tartrate by metered aerosol, which delivers just less than 0.5 mg. per dose, easier to administer and as effective as injection. It is important to ensure that the drug is administered prophylactically and according to the periodic pattern in the particular sufferer. This is in contrast to the use of ergotamine tartrate in migraine, which is administered at the onset of an attack. This distinction in treatment procedure emphasizes the need for separating the two conditions diagnostically, for occasionally they co-exist. I am, etc.,

C. H. STEWART-HESS.

Crediton, Devon.

REFERENCE

- ¹ Hardman, R. A., and Hopkins, E. J., *J. Coll. gen. Practit.*, 1966, 11, 195.

Chondrocalcinosis

SIR,—With reference to your leading article on chondrocalcinosis (2 March, p. 533), and especially to the diagnosis and heredity of the disease, several authors¹ in 1966 estimated the number of published cases at "more than 150"—263. But many of the case reports are incomplete from a diagnostic point of view. The incidence of the disease is probably higher than that suggested by the figures given above, since some cases are asymptomatic and many are certainly misinterpreted as rheumatoid arthritis. Others produce a sepsis-like clinical picture.

D. J. McCarty² gives the following diagnostic criteria for chondrocalcinosis: a case is considered "definite" if calcium pyrophosphate dihydrate (C.P.P.D.) crystals have been demonstrated in tissues or synovial fluid by definitive means (e.g., by the x-ray diffraction powder pattern with calculation of the interplanar spacings between the atomic sheets) or if crystals compatible with C.P.P.D. are demonstrated by compensated polarized light and typical calcifications are seen on roentgenograms. If only one of the latter criteria are found, a "probable" diagnosis is made. According to Curry *et al.*³ examination with polarized light microscopy is less satisfactory for differentiating between various types of arthritis. Free crystals of different types (including C.P.P.D.) can occur in the synovial fluid in various sorts of arthritis, and only if C.P.P.D. occurs in abundance is it a definite sign of chondrocalcinosis. From a diagnostic point of view,