Epilepsy and Driving

SIR,—The British Epilepsy Association, advised by its Medical Advisory Committee, and in consultation with the British Branch of the International League against Epilepsy, has prepared a leaflet for the guidance of general practitioners who are being asked for medical reports on patients suffering from epilepsy who wish to drive.

The new regulations, which came into force on 1 June, allow someone suffering from epilepsy to hold a driving licence provided that

(1) he shall have been free from any epileptic attack while awake for at least three years from the date when the licence is to have effect;

(2) in the case of an applicant who has had such attacks while asleep during that period he shall have been subject to such attacks since before the beginning of that period; and

(3) the driving of a vehicle by him in pursuance of the licence is not likely to be a source of danger to the public.

Where the applicant meets these requirements the medical officer of health is asking general practitioners to complete a report about the applicant.

The leaflet—*Driving Licences and Epilepsy*—is being distributed to general practitioners by local executive councils. Further supplies are available from the British Epilepsy Association.—We are, etc.,

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L.A.T.S. in Thyrotoxic Monozygous Twins

SIR,—The twins with thyrotoxicosis reported by Dr. W. M. Priest (25 July, p. 205) had evidence of long-acting thyroid stimulator (L.A.T.S.) and also thyroid antibodies. But the immune reaction of the two sisters may not have been the only genetic factor. Sarcoidosis is occasionally found with hyperthyroidism (and with Hashimoto's thyroiditis), and it sometimes occurs familially.[1] Eight identical twins were indeed reported in the literature.[2] The past histories of this interesting family may well be of particular relevance.—I am, etc.,

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REFERENCES

1 Karlish, A. J., and MacGregor G. A., *Lancet*, 1970 in press.
2 Scadding, J. G., *Sarcoidosis*, London, Eyre and Spottiswoode, 1967.

Dentistry, Herpes Zoster, and Varicella

SIR,—The report by Dr. R. J. West (25 July, p. 222) prompts us to draw attention to a point concerning facial herpes zoster which, we feel, is not clearly appreciated.

A large number of patients initially present with severe pain in the teeth, followed a few days later by the typical eruption. As most receive some dental attention, commonly extraction, the misconception arises that the dental procedure "injured the dental nerves" and precipitated herpes zoster. The following case is relevant:

A woman aged 52 years was referred to this hospital with severe toothache in the right upper jaw which had been present for five days. No dental cause could be found to account for the pain and no dental procedures were undertaken. Two days later the face became red and puffy over the distribution of the right maxillary division of the trigeminal nerve, and on the following day vesicles erupted on the face and in the mouth. These had the characteristic appearance of herpes zoster and the diagnosis was confirmed by a complement fixation titre of 1/320 on two occasions and by cytology. Subsequently the patient's pain disappeared without treatment and she suffered no complications.

Dr. West does not state the reason for the extraction performed in his young patient, but he does reach the intriguing conclusion that dental surgery is contraindicated in any patient incubating varicella. Would he suggest how we can determine whether or not a patient has varicella during the prodromal phase of the illness?—We are, etc.,

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Benign Gonococcaemia

SIR,—We were interested in the paper by Dr. C. B. Wolff and others 2 May, p. 271), having recently seen a patient with gonorrhoea who presented with pyrexia, skin lesions, and joint symptoms.

The patient was a 28-year-old unmarried man first seen on 9 June who complained of a painful left little toe since the previous day. There was redness over dorsum of the foot, and he also had a crop of blisters over both hands and pain in the right wrist. There were no urinary symptoms or urethral discharge. He gave a history of sexual intercourse three days previously and a past history of non-gonococcal urethritis in 1964.

On examination, he looked well but was febrile (99·6° F.), and had a scanty eruption of small pustules with rather necrotic centres over the extremities, with surrounding erythema. One lesion over the dorsum of the left little toe was associated with a low-grade cellulitis and there were lesions over left index finger, left thumb, and right hypothenar area. The right wrist was tender and slightly swollen. White blood count was 5,200/cu.mm. (neutrophils 46% and lymphocytes 43%) and the E.S.R. was 41 mm. in 1 hour. Gonococcal septicaemia was suspected, and two blood cultures were taken that day as well as swabs from lesions for bacteriological and viral studies. Gram staining of pus from the lesions revealed no organisms, and no pathogenic organisms were grown from blood cultures or lesion swabs. Wassermann reaction, R.P.C.F.T., and G.C.F.T. were negative.

A day later he was afebrile but *N. gonorrhoeae* were grown from a urethral swab, though an early morning urine passed immediately afterwards showed pus cells but no organisms. No bacteria were grown from a further blood culture after prostatic massage that afternoon. Further papular, pustular, and vesicular lesions, usually with surrounding erythema, appeared over the extremities during the following few days. The original lesions gradually subsided.

His signs and symptoms responded to a 10-day course of intramuscular penicillin (given together with oral probenecid)—that is, 5,000,000 units of crystalline penicillin and then 1,000,000 units six-hourly for three days and then 600,000 units procaine penicillin daily for six days.—We are, etc.,

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Meaning of "Dysuria"

SIR,—The leading article entitled "Dysuria in Women" (27 June, p. 741) uses this term as meaning "discomfort on passing urine." The *Shorter Oxford Dictionary* (3rd ed.) and Dorland's *Illustrated Medical Dictionary* (23rd ed.) both define this term as "painful or difficult urination."

It is not clear whether the editorial "discomfort" means pain or difficulty or both. Since painful micturition and difficult micturition have quite different clinical significance, it is to be doubted if the term "dysuria" is precise enough for use in scientific work.—I am, etc.,

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Distinction Awards and Pensions

SIR,—May I beg space to bring to the attention of the profession an anomaly in the distinction award system which, so far as I am aware, has not hitherto been publicized.

It has recently been stated by a member of the Review Body (*The Times*, 19 June), that the salary of a consultant ("including distinction award") averages £5,900. The implication is that most consultants hold such an award, but this is not so. After 22 years' service in the N.H.S. as a consultant my salary last year was £4,475. There are few general practitioners who do not earn as much at a much earlier age, while it is peanuts to the architect, accountant, or attorney of equal seniority. It is true that this can be boosted to the tune of about £1,000 p.a. by domiciliary work but this is undertaken outside normal working hours. It is also true that it counts towards one's pension.

At 60 a professional man naturally and wisely likes to ease off (or may be forced to), and he will have to do so on his domiciliary work because the conditions of his contract are such that he cannot opt out of the routine hospital commitments which earn him the bulk of his living. This means not only a fall in income but also in pension. It thus becomes economically advantageous for a fit consultant to retire at 60