ceptives have been more widely publicized. Equally disturbing is the increased rate of venereal disease among the young. If the British Medical Association can spend time in warning the public of the health hazards of smoking, why does it consistently neglect its duty in warning young people of the health hazards of sexual promiscuity?—I am, etc.,

DONALD M. BOWERS

General Hospital,
Hexham,
Northumberland

Pesticides and Priorities

SIR,—Because of holidays I have just read your leading article entitled "Pesticides and Priorities" (5 June, 546). I think it is to be deplored that one of the mouthpieces of the medical profession should be so outspoken on matters about which there is little factual knowledge either for or against this question of pesticides and the abuse of chemicals.

In the context of present knowledge it would have been better to show some humility and admit that we don't really know just what the danger to man now or in the long term may be, but that the evidence from natural history would suggest we should be most vigilant at the very least until we really know. Anyone reading your leading article would assume that it is legitimate medical practice to ignore some facts so long as investigations do not reveal a pathological condition. In ordinary medical practice it is not usual to dismiss a complaint merely because our tests are all negative.

Health is not just merely the absence of demonstrable disease, and when long-term effects might reasonably be suspected when dealing with cumulative poisons it surely behoves us to be hesitant in expressing an opinion.

Those manufacturers of pesticides and those industrialists who produce toxic chemicals as a waste product will be encouraged by this article, and speaking as an ordinary member of the general public I, for one, will not question, as you seem to do, the expenditure involved in further detailed study.—I am, etc.,

J. H. MACLOUGHLIN

Newtownabbey,
Co. Antrim

Successful Treatment of Digital Vasospasm

SIR,—I should like to report the remarkable arrest and reversal of gangrene and the regeneration of nails on three fingers in an elderly patient with severely impaired circulation. The patient, a woman aged 71 who had controlled hypertension, was seen in May 1967. She had gangrene of the right middle finger owing to severe vasospasm. Other fingers of the hand became cyanosed intermittently, and she required strong analgesics on account of the severe pain. In July 1967 the finger was amputated. Later, a paronychia arose in the left index finger and, within two weeks, gangrene developed in this and the left ring finger. After four weeks, the little finger on the right hand became gangrenous also. Attempts to control the severe digital vasospasm with Hexopal (inostil nicotinate) and Cyclospasmol (cyclandelate) were without effect.

In October 1967 Bradilan (tetranicotinoyl-fructose) 3 tablets q.i.d. was started, and being well tolerated, dosage was increased to 4 tablets q.i.d. Over the next eight months there was no progression of gangrene; pain disappeared except during very cold weather. The gangrenous tip of the left index finger separated, leaving a healthy stump, and a new nail grew. During cold weather there was slight pain and cyanosis in the digits, which quickly responded to an increase in Bradilan to 5 tablets q.i.d.

Twenty months later, the fingers showed marked improvement in colour and a sharp demarcation between the healthy and gangrenous parts. In August 1970, the terminal phalanx of the left middle finger underwent spontaneous amputation, leaving a healthy stump.

Now, four years after the onset of gangrene, the sole problem is the terminal phalanx of the left ring finger. There is a sharp line of cleavage and it has almost completed auto-amputation like its neighbour.—I am, etc.,

J. LISTER SMITH

Heswall,
Wirrall, Cheshire

Typhus in South Africa

SIR,—I should be interested to know why Dr. J. G. Bissenden (22 May, p. 467) says that epidemic louse-borne typhus is not recorded in South Africa. I have only today notified four cases of louse-borne typhus, all of which have been confirmed by rickettsial complement fixation tests.

These are by no means the first cases of typhus which we have had in this hospital. We have had a sporadic but steady influx of cases during the last four years.—I am, etc.,

W. M. BROWNE

All Saints Hospital,
Transkei,
South Africa

Routine Refractions

SIR,—In the report of the Ophthalmic Group Committee (*Supplement*, 3 July, p. 21), it is reported that "the General Optical Council had approved the issuing of reminders by registered opticians under certain strict conditions . . ." This approval has been used by the ophthalmic and dispensing opticians alike in two ways. Firstly, with each pair of glasses dispensed goes a reminder that the patient should have his eyes examined in two years time. Secondly a reminder is sent in two years that it is advisable that he should have his eyes examined now.

Is a routine two-yearly refraction really necessary? In my view it is quite unnecessary except for school children with myopia or with a moderate to high degree of hypermetropia. These need routine 6-12 monthly refractions. The remainder fall into three groups:—

20-40 years.—Changes of refraction in this group of patients are rare. If there is change in refraction, the patient will notice it. Hence there is absolutely no indication for routine two-yearly refractions.

40-60 years.—Presbyopic refractive changes occur in this group. Indication for refraction varies from two years to five.

Over 60's.—In this group refractive changes are rare unless the patient has developed a cataract, when he would generally be seen in the hospital. Moreover any change in refraction is obvious to the patient, who would then seek advice.

The other question to be asked is, do the routine two-yearly examinations help detect glaucoma after the age of 40? The only type of glaucoma detectable by ophthalmoscopy is chronic simple glaucoma. In this case they are not candidates for routine refraction but for detailed hospital examination. Thus in my view there is no indication for reminders for routine two-yearly refraction, directly or indirectly, above the age of 20. It unnecessarily creates anxiety and fear about their sight in otherwise symptomless and content patients.

To help the patient I would suggest the following: a detachable portion to be added to the existing form O.S.C. 2. This would be given to the patient with the glasses and would contain the advice: "Now you have received your new glasses you would like to know when to have your next examination. If you are aged (a) 20-40, in five years time; (b) 40-60, between two to five years depending upon when these feel inadequate; (c) over 60's, in five years time. Should you have any trouble with your eyes within this time, consult your family doctor immediately."—I am, etc.,

R. S. MAHTO

Bath

Medical Eye Centres

SIR,—The function of medical eye centres does not appear to be widely appreciated by members of the medical profession.

Mr. J. Harper, a dispensing optician, illustrates their functions as follows.

The general practitioner, on referring a patient for an eye test for the first time, issues form O.S.C.1. The patient then has free choice of going to either the ophthalmic optician or the medical eye centre. At the medical eye centre he is examined by an ophthalmic medical practitioner—who may be one of the surgeons from the local hospital—and if spectacles are necessary these are dispensed by the dispensing optician. If the ophthalmic medical practitioner diagnoses an abnormal condition, the patient is referred back to the general practitioner with form O.S.C.18, and the general practitioner can then direct the patient to the hospital if he so wishes.—I am, etc.,

G. L. M. BLAIR

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Surrey