(1) Aplasia following irradiation accidents where any single dose received was above 400 r, since the risk of death is greater than 50% above this level.¹

(2) Post-hepatitis aplasia. The mortality of this severe marrow depression is in the region of 10%,² and marrow transplantation has been successful in two recently reported cases.^{2,3}

(3) In severe aplasia when an identical twin donor is available, since marrow can be transfused without pre-graft immunosuppression and graft-versus-host disease does not occur.

(4) Children with aplasia seem to have a much better chance of a successful graft than do adults. In Storb's series of 24 patients⁴ a successful graft was obtained in seven of nine patients under 16 years of age compared with four of 13 aged 17 years and older. Furthermore, the encouraging figures that Storb presents represent results of transplantation in patients who had not been supported by full conventional treatment—half the patients had bacterial infections at the time of admission and most had received frequent transfusion therapy, both these features prejudicing the successful outcome. As Storb points out, early transplantation before major infection and refractoriness to platelet transfusions occur would offer much better results.

Now that more is known about the problems of graft rejection and graft-versus-host disease in man it seems right to be optimistic about the future of bone marrow transplantation in aplastic anaemia, and it is to be hoped that this procedure will be applied more often in appropriate cases.—I am, etc.,

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¹ Mathé, G., Amiel, J. L., and Schwarzenberg, L., in *Bone Marrow Transplantation and Leucocyte Transfusions*, p. 133. S. J. Ringfield, Thomas, 1971.

² Camitta, B. M., et al., *Blood*, 1974, 43, 473.

³ Royal Marsden Hospital Bone Marrow Transplant Team, *British Medical Journal*, 1974, 1, 36.

⁴ Storb, R., et al., *Blood*, 1974, 43, 157.

Idoxuridine in Herpes Zoster

SIR,—Dr. R. Dawber's paper (8 June, p. 526) in which he describes a double-blind trial of 5% idoxuridine dissolved in dimethyl sulphoxide (DMSO) topically applied at intervals to the visible lesions in zoster is interesting. However, statements are made in the paper which are inaccurate and must be challenged.

There is little basis for the postulate that "these results broadly agree with those of others." After we first showed that the relatively insoluble idoxuridine could be dissolved in DMSO and that the solution penetrated the skin and was active against herpes simplex virus,¹ we used intermittent topical application of a 5% solution to zoster. We applied it to the whole of the affected dermatome, not just to the visible lesions. Zoster, after all, is an affliction of the whole nerve, not just the skin.² We hoped that not only the visible skin lesions but most of the affected nerve would be reached. While most patients benefited, some did not, though our results were better than Dr. Dawber's. The reasons for proceeding to trial of a higher concentration of idoxuridine (40% in DMSO continuously applied) are given in

the paper Dr. Dawber cites.³ The results were much better; the pain lasted for a much shorter time (median 2.5 days) and, what is more important, this treatment was successful in nearly all cases. We did not "suggest" that 40% idoxuridine in DMSO continuously applied for four days was superior to 5% intermittently applied, we showed that this was so ($P < 0.00001$).

We have since carried out double-blind trials of 40%, 20%, and 5% idoxuridine in DMSO continuously applied, and found that 20% and 5% were significantly inferior to 40%. There was, however, no significant difference between 40% and 35% solutions. We have treated over 1,000 patients with 40% and lately 35% idoxuridine in DMSO continuously applied. Analysis of the results in 300 cases confirms the predictions of the trials. The median duration of pain was three days; 95.9% had pain for seven days or less, 79.6% for four days or less, and 45.0% for two days or less. Of the 4.1% who had pain for more than seven days, only one had pain lasting for as long as 30 days. Of the 300 31 got marked erythema and two weals from the DMSO. There was no "maceration" of the skin which we are falsely credited with having described in the treatment of zoster.

We have monitored our patients carefully for evidence of side effects on hepatic, renal, and bone-marrow function and on the eyes and found none. The statement that idoxuridine in high concentrations should "be reserved for life-threatening conditions such as herpes simplex encephalitis" is misleading for there is no sound evidence that intravenous idoxuridine has any consistent effect on herpes simplex virus encephalitis. In view of the variety of toxic effects and the relative difficulties of preparation of intravenous solutions of idoxuridine we and others now use cytosine arabinoside for this purpose.—We are, etc.,

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¹ MacCallum, F. O., and Juel-Jensen, B. E., *British Medical Journal*, 1966, 2, 805.

² Esiri, M., and Tomlinson, A. M., *Journal of the Neurological Sciences*, 1972, 15, 35.

³ Juel-Jensen, B. E., et al., *British Medical Journal*, 1970, 4, 776.

SIR,—Dr. R. Dawber's trial (8 June, p. 526) included patients from the age of 12 years upwards. Since herpes zoster in young people is a very mild illness with practically no pain and never followed by post-herpetic neuralgia, I think it is wasteful to treat such patients with anything more than the simplest of measures.

Dr. Dawber does not seem to have encountered any patients with post-herpetic neuralgia, even in the controls; the longest mean ($\pm$ S.E.) duration of pain is recorded as 19.5 ± 1.0 days. Since the report does not reveal the age distribution of the cases we really do not know how many elderly people (over 60 years) were included in the trial, and it is in this age group that post-herpetic neuralgia is a common complication.

Finally, it would have been of interest to know the segmental distribution of the lesions and particularly how ophthalmic herpes was treated.—I am, etc.,

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Removal of Fish-hooks

SIR,—The fishing season is now here and with it the inevitable increase in requests for the removal of fish-hooks from various parts of the body. The usual method for removing these hooks in casualty departments is to infiltrate the area with local anaesthetic, push the barb through the skin, cut off the barb, and remove the remainder of the hook. There is, however, a quick and effective method for removing hooks by using a piece of string. I do not think it is well known but as it saves time and trauma and can be done at the water's edge (as I did today) I think it could be more widely used.

The method is illustrated in the figure:

(1) A piece of string about a yard (or a metre) long is tied to form a loop. (2) The loop is passed over the hook and held as close to the skin as possible with the index finger of the left hand. (3) The middle finger and thumb of the same hand depress the eye end of the hook, which disengages the barb and ensures that during removal the flat outer edge of the hook presses against the skin. (4) The string is taken in the right hand and given a sharp pull with a good follow-through and the hook is removed through its point of entry. Advice to have a tetanus toxoid injection is a sensible precaution. I have used this method many times and large hooks are as easily removed as small ones. Its adoption may help our overworked casualty officers, as any doctor can use this "magic" string whenever a small boy, on the beach or by the river, asks, "Please, sir, can you take hooks out?"—I am, etc.,

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Serum Hepatitis Associated with Repeated Acupuncture

SIR,—The following report of a case of serum hepatitis after acupuncture draws attention to the possibility of this association. I understand that the needles used were sterilized by dipping them in a 1 in 20 solution of tincture of calendula (marigold flowers).

The patient, a woman aged 28, stated that she had had acupuncture every two to three weeks for the past year for the following conditions: periodic bouts of depression, acute bronchitis, acute coryza and sore throat, vaginal thrush, and "strained arms." When she acquired gonorrhoea, however, she was treated with penicillin. She also smoked cannabis and occasionally consumed enough alcohol to make herself frankly drunk. Two days after her last acupuncture session she complained of abdominal colic and loss of appetite and noticed that her urine was very dark and her stools pale. When admitted to hospital eight days later she was apyrexial, jaundiced, the liver was just palpable, and there were a few fading macular lesions on the forearms. The biochemical findings were those of acute

hepatitis and hepatitis-B antigen was shown to be present by both haemagglutination and electrophoresis.

This case cannot, of course, be claimed to provide proof of a causal association between acupuncture and serum hepatitis. The possibility of transfer of infection by an inadequately sterilized needle should, however, be borne in mind.—I am, etc.,

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Referees and Rejects

SIR,—The point made by Dr. D. F. Horrobin (27 April, p. 216) on referees and research administrators as barriers to scientific research certainly is topical in small countries where, as pointed out in your leading article (p. 185), personal aspects will come in, often to a dangerous extent. Professor J. M. Tanner (18 May, p. 381) asks for a precise blueprint of a system and I venture to suggest one which at the same time may illustrate some of the problems faced in this connexion by research workers in smaller countries.

(1) Editors should take more personal responsibility in estimating whether a paper may not, for example, require a longer summary than usual or a few pages less than average. As it is, one often feels that strict rules have been laid down to facilitate the running of the journal by clerks. It is true that acceptance of bad papers will in the long run ruin a journal but unjust rejection of a good paper will have its immediate effect on the author who, after all, is more important to research.

(2) Journals should give lists of their referees (for example, on their cover), with more than one expert in each field. This would serve to prevent the possibility that the same men could reject the same paper for more than one journal.

(3) Authors should be permitted to recommend one referee from this list and, if they want, to delete a name in their own case.

(4) Referees should make their remarks in better form than is often the case. Grammatical errors or clumsy constructions in manuscript from foreigners should be marked—for example, with question marks—suggesting that the referee respects the effort it is to present a paper in a language different from the author's own.

(5) Anonymity should extend equally to authors and referees, leaving both sides of the fence guessing. Self-justification is not restricted to authors, who could give their names on separate sheets.

(6) Editors should never at the same time serve as members of granting agencies.

(7) At least 75% of the members of these august bodies should have made contributions to research, and the chairman should belong to this category. Direct appointments by Ministers should not take place and membership should not extend to more than six years.

(8) Members of granting agencies should not be permitted to participate in the discussion of applications from their own institution unless called in for conference, as may be customary for others. It certainly is preferable that members should refrain from applications to their own agency during tenure of membership.

(9) Applicants should, in case of rejection, have access to the verbatim and full comments on their application and should have the opportunity to forward their own remarks and some access to appeal—for example, to experts abroad.

Generally, rules should be laid down to forestall unfortunate developments. It is well known that, not unlike politicians in some Eastern states, many members of the medical profession want to crown a career of influence ("medical politics") with the air of a scientist. If this happens often, the danger

is that scientific research will become a pyramid in each country, and the true scientists will go where freedom is—that is, where research is administered by scientists.

Perhaps I may add that through 38 years I have found referees helpful in nearly all cases, though in most cases there have also been various misunderstandings. The trend, however, is towards some reduction of the former quality and some increase of the latter. The animosity against publishing statistics on man to the same extent as on the mouse has, however, not changed.

I have only once seen an important constructive proposal from a referee. Since this happened with your journal I venture to submit the above comments.—I am, etc.,

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SIR,—Dr. D. F. Horrobin (27 April, p. 216) draws attention to the secrecy and fallibility of the procedures for assessing grants in Britain. New procedures are needed such that the applicant can react rationally to known criticisms, valid or otherwise, instead of having to ponder an unlimited number of conceivable ones. If necessary, subsequent correspondence could be strictly limited.

In the meantime research workers should feel no obligation to justify in detail their research proposals unless, in reciprocal courtesy, the funding agency agrees to justify the contrary view, at least briefly, should that be the outcome of the assessment procedures. Feedback of one sort or another has been in operation for many years in Canada and the United States and elsewhere, hence Professor J. M. Tanner (18 May, p. 381) seems to be incorrect in implying its impracticability.

The Medical Research Council and Department of Health and Social Security, having failed so far to respond constructively to the widespread requests for review of their procedures,¹⁻⁵ should not be surprised if an independent inquiry, as suggested by Professor V. R. Pickles (18 May, p. 382), is eventually set up.—I am, etc.,

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- 1 Dixon, B., *New Scientist*, 1974, 61, 522.
- 2 O'Brien, J. R., *Lancet*, 1973, 2, 1323.
- 3 Pickles, V. R., *Lancet*, 1974, 1, 620.
- 4 Renwick, J. H., *Lancet*, 1973, 2, 624.
- 5 Williams, B., *Lancet*, 1973, 2, 798.

Complication of Proximal Gastric Vagotomy

SIR—All surgeons interested in modern gastric surgery will have read with some concern the complication of lesser-curve necrosis after proximal gastric vagotomy described by Mr. J. F. Newcombe (10 March 1973, p. 610) and again by Mr. J. H. Wyllie (8 June 1974, p. 561). However, I hope none will be persuaded to abandon or not to adopt this important advance in gastric surgery.

We must not forget that bilateral selective vagotomy divides the arterial supply of the lesser curve completely from the cardia to the pylorus, while proximal gastric vagotomy preserves its arterial supply for some 10-12 cm above the pylorus. If lesser-curve

necrosis is a complication of vagotomy it must occur more frequently after bilateral selective nerve section than after the proximal gastric operation.

In some 1,000 bilateral selective operations performed between 1957 and 1970 and some 400 proximal vagotomies since 1970 I have never seen this complication and I am sure that others can record similar results.—I am, etc.,

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Hyperthyroidism and Giant-cell Arteritis

SIR,—Now that immunity is known to be altered in giant-cell arteritis the comparison between this disease and sarcoidosis¹ is closer than was earlier realized. The immune response may account for both the higher incidence of hyperthyroidism in the cases found by Drs. R. D. Thomas and D. N. Croft (25 May, p. 408) and the focal and granulomatous hepatitis, which has occasionally been reported.^{2,5} The systemic reaction satisfactorily explains the anaemia, raised E.S.R., and weight loss, and the immune reaction appears to prolong rather than curtail the inflammation. Giant cells are a feature of both the diseases, the duration of activity of each is similar, and the symptoms of both are controlled by small doses of prednisone. Giant-cell arteritis occurs after middle age, when arteries are more liable to atherosclerosis. The inflammation damages the arteries predominantly, and the lesions elsewhere remain subclinical. The occurrence of the arteritis only in the elderly is unexplained. But in patients whose immunity is already raised microembolism of atheromatous plaques⁶ might cause the focal arteritis. Thyroid biopsies and immune studies in prospective studies of cases of giant-cell arteritis are likely to be interesting. The patients with thyroid or liver involvement might at least show the immune reaction of sarcoidosis.⁷ The arteritic lesions are after all not unlike the granulomas seen at venepuncture sites in some cases of sarcoidosis. Myocardial sarcoidosis is being seen more often now.⁸—I am, etc.,

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- 1 MacGregor, G. A., *Lancet*, 1972, 1, 1067.
- 2 Hall, G. H., and Hargreaves, T., *Lancet*, 1972, 2, 48.
- 3 Long, R., and James, R., *Lancet*, 1974, 1, 77.
- 4 Gibbs, P., *Lancet*, 1974, 1, 351.
- 5 Barnes, C. G., *Lancet*, 1974, 1, 459.
- 6 MacGregor, G. A., *Lancet*, 1961, 2, 1160.
- 7 Caspary, E. A., and Field, E. J., *British Medical Journal*, 1971, 2, 143.
- 8 Fawcett, F. J., and Goldberg, M. J., *British Heart Journal*, 1974, 36, 220.

Ischaemic Colitis Due to Myxoedema

SIR,—We think it worth while to record the following case of ischaemic colitis secondary to myxoedema.

A 53-year-old woman presented with habitual constipation, shock, and abdominal distension. Vomiting had produced severe dehydration. Abdominal radiography showed considerable gaseous distension of the large bowel. After treatment with steroids, plasma expanders, and intravenous fluid replacement the blood pressure improved. At laparotomy the transverse colon was dilated and necrotic at the splenic flexure. Hard faeces obstructed the descending colon. The