quantities by the Radiochemical Centre for use by investigators, who are continually evaluating its properties.¹ We have had the opportunity of testing this² and comparing it with the silicate and with yttrium-90 citrate from France. The silicate consistently gave good retention in the knee, equivalent to that previously found with the resin colloid, while the ferric hydroxide-based colloid and the citrate were less well retained in the knee. In addition the citrate was associated with early lymph node uptake of considerable amounts of radioisotope.

We have also analysed the chromosomal damage noted after treatment with these four radiocolloids and have found a low rate of chromosomal damage—equivalent to that after iodine-131 treatment for hyperthyroidism—with the ferric hydroxide and silicate forms of yttrium-90. With the citrate there was considerably more chromosomal damage, roughly equivalent to that found with gold-198.⁴

You mention that there is a reduction of lymph node uptake with hydrocortisone. This is noted only when using gold-198, with which there is a very considerable lymph node uptake of radioactivity. We have attempted the same work with yttrium-90 silicate, but because there is very little lymph node uptake with this latter preparation we have been unable to demonstrate material differences between hydrocortisone-treated patients and control patients in terms of lymph node uptake.—I am, etc.,

J. M. GUMPEL

Northwick Park Hospital and Clinical Research Centre,
Harrow, Middlesex

¹ Peacegood, J. A., Radiochemical Centre, Amersham. Private communication.

² Beer, T. C., et al., *Annals of the Rheumatic Diseases*, 1973, 32, Supplement, p. 41.

³ Gumpel, J. M., et al., *British Journal of Radiology*. In press.

⁴ Gumpel, J. M., and Stevenson, A. C., *Rheumatology and Rehabilitation*. In press.

Acneiform Lesions in Combined Rifampicin Treatment in Africans

SIR,—In treating urinary tuberculosis with daily rifampicin in combination with isoniazid and thiacetazone troublesome acneiform lesions have been observed in a significant number of Zambian African patients. The lesion disappeared spontaneously within three weeks after withdrawal of rifampicin. I report here eight such cases among 24 male patients.

Thirty-four adult African patients (30 men and four women) have been treated in our urology clinic for urinary tuberculosis in the past 18 months. Of these 34, 24 (20 men and four women) were treated with oral rifampicin 10 mg/kg (but not exceeding 750 mg) daily for the first 12 to 18 weeks in combination with oral isoniazid 300 mg and thiacetazone 150 mg daily, which was continued after the withdrawal of rifampicin. All were treated as outpatients and were seen every three weeks at the beginning of treatment while on rifampicin. Eight of the 20 men (and none of the women) developed chronic papular acneiform lesions on the face, neck, and shoulders. The lesions were severe in four, moderately severe in three, and mild in one. They developed gradually from around the fifth week to become severe from about the eighth to the tenth weeks.

In all eight cases withdrawal of rifampicin at the twelfth to the eighteenth week led to the disappearance of the lesions within three weeks. Only in one case was it necessary to withdraw rifampicin promptly at 12 weeks because of severe lesions which had to be treated by a dermatologist. The results of liver function tests and a blood count in these eight patients before and during treatment showed no significant changes and were within normal limits. Cutaneous reactions to rifampicin have been reported before.—I am, etc.,

UCHENNA NWOKOLO

University Teaching Hospital,
Lusaka, Zambia

¹ Aquinas, M., et al., *British Medical Journal*, 1972, 1, 765.

Treatment of Genital Herpes

SIR,—I was most interested in the letter by Dr. S. M. Laird and Mr. R. B. Roy (27 July, p. 255) reporting their successful treatment of genital herpes simplex infections with co-trimoxazole. I have been using this compound for type 1 H.S.V. infections with considerable success since March 1972.

Studies carried out at the Northern Regional bacteriology laboratory under Dr. H. Williams showed that trimethoprim inhibits the replication of H.S.V. in vitro, but only in concentrations above the serum level achieved with the normal (and clinically effective) dosage. This was difficult to understand until we observed that patients who were already receiving penicillin or ampicillin when they developed their H.S.V. infections did not benefit from co-trimoxazole and then recalled that penicillin is added routinely to virus cultures to prevent overgrowth with bacteria, which suggests that, at least so far as H.S.V. is concerned, there may be some antagonism between trimethoprim and the penicillins.

More recently Dr. E. G. Buchanan and I have separately treated some patients suffering from herpes zoster with co-trimoxazole, with quite good results. So far early relief from pain and rapid resolution of the rash with minimal scarring have been the most obvious features. This treatment is so simple—and produces such grateful patients—that it would certainly seem to merit widespread trials.—I am, etc.,

PAULA H. GOSLING

Craig Phadrig Hospital,
Inverness

Alternative Health Service

SIR,—Perhaps one of the more remarkable features of the current row over the economic failure of the N.H.S., has been the failure of all the political parties to put forward a realistic alternative to the present system. The non-viability of a "free" health service became apparent soon after it was born but no government has yet had the courage to admit this or the vision to make radical changes. Injecting more money at this stage would merely stave off the collapse for a short time.

I therefore suggest that it is up to us to explore the alternatives, even to the extent of

restructuring the whole service if necessary, rather than wasting time in the "us and them" squabble. The columns of the *B.M.J.* could provide the neutral ground for a dispassionate appraisal of the health services of other countries less bankrupt than our own. Let us hear about Australia, New Zealand, Denmark, Czechoslovakia, and other countries whose graduates are in Britain at the present time. Let us tap the wisdom of non-government financial experts like the directors of B.U.P.A. and invite the comments of the chairman of a large insurance company on the subject of universal insurance against loss of earnings and doctors' fees, etc. (How much would it save the tax payer if the Prudential ran the Health Service?) Where are the psychologists who gauged public reaction to decimalization so well?

These are the people whose opinions could collectively throw a lot of light on our seemingly hopeless situation and whose ideas, together with our experience, could help whichever government prevails out of the impasse.—I am, etc.,

P. JOAN BISHOP

Shirley, Surrey

N.H.S. Contraceptive Services

SIR,—I agree with Sir George Pickering and others (3 August, p. 340) that we ought to work the proposed free family planning scheme at once. It is necessary to our patients and the fee of £1.72, while it does not exactly make my mouth water, would be sheer extra buncie for the very large number of us who have never charged for contraceptive advice. The French Chamber of Deputies has recently voted that advising on contraception is "a medical transaction, like any other." There was one dissenter.

If the Secretary of State were to institute the scheme, allowing doctors to take part in it if they chose, I guess that half the G.P.s would be in it within a month and 90% within a year.—I am, etc.,

DAVID CARGILL

Maldon, Essex

Saudi Arabian Medical School

SIR,—I noticed that the 13 July issue of the *B.M.J.* (pp. xx-xxii) carried four large display advertisements for both preclinical and clinical teaching posts at the University of Riyadh Medical School, Saudi Arabia, and that all three specifically stated: "Applications are invited from male honours graduates." The advertisements also mentioned that the university had established a medical school in association with the University of London, which advises on "the appointment of academic staff." While I appreciate that as a result of cultural prejudices there may as yet be no female doctors in Saudi Arabia, I fail to see any objection to medical students being taught by women, and am amazed to find such sexist practices being openly supported by a British university.—I am, etc.,

SUSAN BARLOW

Department of Pharmacology,
Guy's Hospital Medical School,
London S.E.1