cheeks (see fig.). These were entirely painless, and in fact the patient herself was initially completely unaware of them. There was no associated lymphadenopathy. Examination of other mucous membranes showed no evidence of ulceration. Swabs sent for bacteriological studies revealed no yeasts or organisms of Vincent's angina, and grew nothing on culture. Her white blood cell count and temperature remained within normal limits.

The patient denied any trauma but did admit to sucking her slow-release potassium tablets; she apparently swallowed all her other medications. The potassium supplements were changed to an effervescent form, and over the course of the next 7-10 days the ulcers healed completely.

Slow-release tablets of potassium chloride have been formulated because it is thought that rapid release of potassium chloride over a short segment of intestine is the precipitating factor in the ulceration produced by enteric-coated supplements.³ With these preparations the solubility of potassium chloride is reduced by partially coating the crystals with an inert insoluble wax and with a sugar rather than enteric coating. The tablets release potassium chloride over a period of four hours compared with 15 minutes for those that are enteric-coated.³ Studies with slow-release potassium preparations have shown that the potassium chloride is effectively absorbed and does not produce side effects.⁴ However, under the unusual circumstances of the tablets being sucked it seems that high concentrations of potassium chloride are in contact with relatively small areas of mucosa and can thus induce ulceration.

I would like to thank Dr. Andrew Allison for his help and encouragement and for his permission to report this case.

—I am, etc.,

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¹ Baker, D. R., Schrader, W. H., and Hitchcock, C. R., *Journal of the American Medical Association*, 1964, **190**, 586.

² Lindholmer, B., Nyman, E., and Räf, L., *Acta Chirurgica Scandinavica*, 1964, **128**, 310.

³ Martindale, *Extra Pharmacopoeia*, 26th edn., ed. N. W. Blacow. London, Pharmaceutical Press, 1972.

⁴ Wynn, V., *Lancet*, 1965, **2**, 1241.

Post-herpetic Pruritus

SIR,—In September 1973 a 35-year-old man developed pain in his right upper arm and shoulder. A few days later he developed typical lesions of herpes zoster on the inner

aspect of the right upper arm and the right side of the upper trunk. The rash was severe but eventually settled and apart from the scars of shingles he was left with severe intractable irritation around the right axilla and right upper inner arm, together with some pain in the right shoulder region. Clinical examination revealed scars of herpes zoster predominantly in the dermatomes of T2 and T3 and there was hypoaesthesia in the region of T2 on the inner upper arm. Haemoglobin, full blood count, and erythrocyte sedimentation rate were all normal and no abnormality was seen on x-ray of his chest and right shoulder. X-ray of his upper spine merely showed degeneration of the eighth dorsal disc. Despite treatment for almost a year with various local preparations (including steroid creams) and systemic therapy with various antihistamines, sedatives, analgesics, and carbamazepine the severe pruritus has persisted, overshadowing his shoulder pain.

Post-herpetic neuralgia is rare in young people, and though severe itching can occur as a troublesome sequel to herpes zoster,¹ it is by no means common. This young man has been unfortunate on both counts. The zoster-varicella virus causes acute inflammation at some point in the course of the first sensory neurone, the dorsal root ganglia and corresponding sensory ganglia of cranial nerves being the commonest sites. Microscopic changes include haemorrhage and infiltration with mononuclear cells, and in severe cases fibrosis and secondary degeneration can occur. These changes can lead to persistent post-herpetic symptoms. This man has post-herpetic neuralgia, hypoaesthesia, and severe pruritus in the root distribution.

It is generally accepted that post-herpetic neuralgia is very resistant to therapy and this case report illustrates that post-herpetic pruritus can be just as aggravating to the physician as well as the patient.—I am, etc.,

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¹ Brain, W. R., and Walton, J. A., *Brain's Diseases of the Nervous System*, 7th edn. London, Oxford University Press, 1969.

La Condition Humaine

SIR,—Sympathy must of course be given to a number of Dr. S. Bradshaw's views (14 September, p. 682), but somewhere his tocsin has become intoxicated and his carillon most definitely cracked. It seems that the blind villain and its skivvy arrived from outer space after Queen Victoria died. Just how did science and technology arise? Slowly and gradually and basically of God; Christians must believe this. Can Adam now replace the fruit and tiptoe through the unknown grass again with Eve, ignorant even of their nakedness? Science means knowledge, and unless Dr. Bradshaw is a fundamentalist he will probably agree that total ignorance is not necessarily the most blessed state for human beings. When we knew little we were not so far from the animals. As knowledge has advanced so have our capacities for evil and the worship of false gods; so also, I firmly believe, has our capacity for collective good. It is not science and technology that is the anti-Christ but our

own faults, and this has been so from the time of Herod.—I am, etc.,

JAMES MILLAR

Oxford

Value of Hospital Case Notes

SIR,—During the course of a broadcast presentation on "Family Practice" on B.B.C.4 on the evening of 1 October a general practitioner referred to the fact that on certain hospital notes were printed the words, "Not to be seen by the patient." He commented that the reason for this was not to avoid the patient's embarrassment by finding out what might be the matter with him, but because the content of the notes was "rubbish." He repeated this statement and in spite of a telephone call to the B.B.C. to ask that this wholesale criticism of the hospital service should be withdrawn, no further comment was made.

It is most regrettable that any member of our profession should allow himself to make such sweeping condemnatory statements of other sections of the profession at a time when we are trying to overcome the barriers which still exist still between those responsible for primary care and those working under similarly difficult conditions in the hospital service. If this public statement is allowed to go unchallenged it remains as a sad indictment of literally thousands of over-worked hospital residents who have insufficient secretarial assistance and whose notes on the whole are comprehensive and dependable. One wonders whether this particular practitioner considered that the notes that he himself wrote during his resident posts were worthy of such a description.—I am, etc.,

D. F. ELLISON NASH

London S.E.19

Lead and Intelligence

SIR,—Your leading article (28 September, p. 761) is acceptable as a grudging admission that a problem exists in relation to the effects of lead on behaviour. As a review of the recent work on this important subject, however, it is inadequate on several counts.

There is now a great deal of evidence that lead can adversely affect behaviour, most often by the production of hyperactivity. On this account the correlation between I.Q. and educability does not always hold in the children affected because of their poor attention span. It is curious that this observation was not commented upon since it is one of the most significant made by Byers and Lord in their classic paper which appeared in 1943.¹

Again, in addition to the negative findings of Lansdowne *et al.*,² which were criticized by a number of authors³⁻⁵ as to both methodology and conclusions, one would have wished to see some of the more recent reports included which show clearly that behavioural changes can be induced by relatively modest body burdens of lead. A study from El Paso⁶ states unequivocally that "children with blood lead levels $\geq 40 \mu\text{g}/100 \text{ ml}$ have diffuse and subtle impairment of the fine motor, perceptual, and visual perceptual skills." When it is realized that in many American cities 25-30% or more of the children examined in large screening programmes have blood lead levels greater