

congestion or haemangiomatic dilatation, making them more likely to displacement. Nevertheless, this careful study successfully questions orthodox views on the cause of haemorrhoids.

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- <sup>5</sup> Virchow, R, *Die Krankhaften Geschwülste*. Berlin, Hirschwald, 1863.
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- <sup>12</sup> Sappey, Ph C, *Traité d'Anatomie Descriptive*, 2nd edn, vol 4, p 276. Paris, Delahaye, 1972.
- <sup>13</sup> Hunt, A H, *A Contribution to the Study of Portal Hypertension*, p 61. Edinburgh, Livingstone, 1958.
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## The problem of rosacea

Imagine being asked to invent a new disease—one designed to cause as much embarrassment to the patient as possible. The specification might run like this: first select a group of people who are already rather sensitive, with a tendency to blush easily. Next, use the only area of skin which cannot be hidden from view—the face. Cover this with a bumpy redness. Add a scattering of pustules and a tendency for the nose to grow red and clown-like. Build in a popular myth that these changes are due to heavy drinking, so that an element of mockery will surround the patient wherever he goes. Finally, devise a treatment, such as using topical fluorinated steroids, which patients are keen to use as it seems to help in the short term but which actually makes the face much redder in the long run.

The specification is, of course, that of rosacea; but its treatment is not simply a matter of getting rid of a few rather amusing pustules. Patients with rosacea may be quite seriously depressed,<sup>1</sup> and rosaceous keratitis (found in 19 of a consecutive series<sup>2</sup> of 57 patients referred to a skin clinic) may lead to permanent impairment of vision.<sup>3</sup>

Luckily the tetracyclines provide a treatment which is highly effective against the pustular and papular elements of the disease. The dose needed is small, usually 250 mg twice a day, but as in acne treatment may need to go on for several months. In one series<sup>4</sup> 68 patients whose skin had cleared with tetracycline stopped treatment after six months: 17 relapsed immediately, and the overall relapse rate was 69% for patients followed up for a maximum of four years. Patients with rosacea tend to be older than those with acne, in whom this type of treatment has seemed to be singularly free from severe systemic side effects,<sup>5 6</sup> and it is reassuring that in a recent survey<sup>7</sup> of 246 patients, including 38 with rosacea, on low dosage long-term tetracyclines, no clinically significant abnormalities of liver or kidney function were found, though these do occur with higher doses.

The eye changes in rosacea are of two main kinds. Blepharitis and a suffused conjunctivitis are common and non-specific, while rosaceous keratitis is highly specific. There is a small but

growing body of evidence that this keratitis may also respond to systemic tetracyclines,<sup>8 9</sup> and that relapses may occur when treatment is stopped,<sup>4</sup> suggesting perhaps that the mechanisms underlying the eye changes may be similar to those in the skin. Ampicillin is also helpful in rosacea,<sup>10</sup> but it is still not established that the beneficial effect of antibiotics is due to bacterial suppression. The microbiology of rosacea may well be as unexpectedly complex as that of acne.<sup>11</sup>

It would be nice to pretend that our current treatment regimens are solidly based on a full understanding of the cause of the disease, but this is not so. Theories tend to run ahead of facts in rosacea, as in so many fields in medicine. Indeed Sneddon, in the first proper trial to confirm the value of tetracycline in rosacea, commented<sup>8</sup> that "there must be few diseases which cause more emotional flushing in the supporters of the various theories of causation than rosacea." Borrie<sup>12</sup> had described these hypotheses as varying "from something alkaline in the stomach to something horrid in the cowshed." Marks<sup>1</sup> took on the task of critically re-examining the main ideas in the light of his experience of 92 patients with rosacea; none could be supported. Even the latest opinions, invoking vasoactive substances such as bradykinin, have little evidence in their favour. There are still vacancies in the cowshed.

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<sup>5</sup> Gilgor, R S, *North Carolina Medical Journal*, 1972, **33**, 331.

<sup>6</sup> Osment, L S, and Hammack, W J, *Southern Medical Journal*, 1970, **63**, 1156.

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<sup>9</sup> Marmion, V J, *Proceedings of the Royal Society of Medicine*, 1969, **62**, 11.

<sup>10</sup> Marks, R, and Ellis, J, *Lancet*, 1971, **2**, 1049.

<sup>11</sup> Savin, J A, *British Journal of Dermatology*, 1972, **86**, **suppl 8**, 3.

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## Measuring blood pressure

The need for a standard routine for measuring the blood pressure has been emphasised recently<sup>1</sup> and is clearly important in the diagnosis and assessment of hypertension and in supervising treatment when more than one observer may record the findings. Differences in the methods used in different countries have also given rise to problems in evaluation of research studies.<sup>2</sup>

Mercury manometers are to be preferred to aneroid gauges, which, though less expensive and in some ways more convenient, need frequent checks to avoid error. Whenever possible extrinsic factors tending to produce a rise in pressure should be avoided. The subject should be warm and relaxed. The blood pressure will fall to very low levels in conditions of complete relaxation, but measuring the basal pressure after a long rest<sup>3</sup> is usually impracticable, and the usual criteria of hypertension will not then be applicable—so that the problem of assessment is more difficult. As a practical compromise the patient should rest semirecumbent for several minutes without smoking before the blood pressure is taken.

The size of cuff to be used has given rise to some debate. Ideally, the cuff should have a width 40% of the circumference of the arm to produce even occlusion of the brachial artery—too narrow a cuff on a fat arm gives a falsely high reading and