from the eating of tinned fruits and certain vegetables—than ever they did in their natural existence. Yet, as said, many manifestations of the saccharine disease are now becoming common in them, which shows the much greater importance of over-consumption in the production of many saccharine manifestations. And since sugar is by far the most refined carbohydrate, it is in sugar that this over-consumption is always most conspicuous and most in need of correction.—I am, etc.,

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2 Schaefer, O., *Nutrition Today*, 1971, **6**, 8.

SIR,—I read with great interest the paper by Mr. Denis P. Burkitt (3 February, p. 274). Few would disagree with his list of diseases characteristic of modern Western civilization, but his contention, based on epidemiological evidence, that the lack of fibre in food is the common aetiological factor in these diseases seems unlikely.

It is a reasonable assumption that there may be an association between gall stones and large-bowel cancer because both are possibly related to bile salt/bile acid metabolism—the former to abnormalities in the synthesis and/or secretion of bile salts,[1 2] and the latter to the subsequent metabolism of these compounds in the gut by the intestinal flora, particularly bacteroides, to possible carcinogenic substances with a steroid configuration.[3] A retrospective study was therefore carried out[4] to try to prove this association, comparing the incidence of gall stones in a group of patients with large-bowel cancer, a group with diverticular disease of the colon, and a matched group of controls. Unfortunately, although the known association between diverticular disease of the colon and gall stones[5 6] was confirmed, there was no difference in gall stone incidence between the control group and those with large-bowel cancer.

There is no doubt that all three diseases are very common, but to tie them all together with a fibreless diet seems too much of a simplification in this complicated world. There is very little doubt that diverticular disease of the colon develops with lack of dietary fibre,[7] and recent work showing that bile is only intermittently lithogenic[8] seems to confirm that a motility factor must be important in gall stone formation. The only thread of hope available for tying all three diseases together will be the discovery that some patients taking this Western diet secrete bile which may be lithogenic, carcinogenic, or both. Studies are proceeding along these lines.—I am, etc.,

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1 Small, D. M., *New England Journal of Medicine*, 1968, **279**, 588.
2 Heaton, K. W., and Read, A. E., *British Medical Journal*, 1969, **3**, 494.
3 Hill. M. J., *et al.*, *Lancet*, 1971, **1**, 95.
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Viral Infection and Renal Transplant Rejection

SIR,—The paper by Dr. J. D. Briggs and others (2 December, p. 520) reporting an apparent association between influenza virus A infection and the initiation of acute rejection in three out of five cadaver kidney transplants in Glasgow is important. Whether it is true that the virus stimulated the cell-mediated immunity of the patients awaits proof (Mr. W. T. Morris, 10 February, p. 355). However, the questions raised are important both in the context of renal transplantation and in that of glomerulonephritis.

Before complicated and possibly inconclusive experiments are begun with lymphocytes, influenza virus, and influenza vaccine, we suggest a simple project which may support the Glasgow group's ideas. Influenza is most common between November and March, and epidemics occur relatively briefly during this period.[1] If such a viral infection plays a part in initiating an acute renal transplant rejection the frequency of such rejections should be increased during the winter months—and particularly during epidemic peaks. The trends in the weekly incidence of influenzal infections have been documented by the Public Health Laboratory Service for many years. We do not have access to sufficient records of acute renal transplant rejection to compare dates of rejection with the recorded prevalence of influenza, but if a number of transplant units were to pool their records an answer should rapidly become available. A study involving the years 1967 to March 1973 should be the most fruitful.

Would any transplant groups be prepared to write to us to begin such a collaborative study?—We are, etc.,

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1 Miller, D. L., Pereira, M. S., and Clarke, M., *British Medical Journal*, 1971, **1**, 475.

Postherpetic Neuralgia

SIR,—In his excellent article (17 February, p. 406) Dr. B. E. Juel-Jensen states that in acute herpes zoster the use of corticosteroids must be discouraged. In the context of a neurotropic virus infection this seems reasonable, yet I believe the risks have been exaggerated. Thus in the 17 cases of disseminated zoster infection reported by Merselis *et al.*[1] 11 of the patients had leukaemia or other serious conditions which could be expected to depress immune responses. In the other six cases in healthy subjects the dissemination of the rash produced no more serious affliction than chickenpox. In a report of 70 patients Scheie and Alper[2] found no complications after corticosteroid therapy.

Though it is clear from Dr. Juel-Jensen's previous papers that idoxuridine significantly reduces the duration of pain in zoster, I have found that this preparation is not readily available in most hospital pharmacies, and, perhaps more important, most dispensing chemists are unable to provide it and are under no obligation to do so.

In the Mayo Clinic series of 916 untreated patients[3] the overall risk of postherpetic neuralgia was of the order of 10%, but in those aged over 60 it was over 50%. I know of no double-blind controlled trials on the effects of corticosteroids in acute zoster, but uncontrolled observations are impressive and strongly suggest that the duration of initial pain is reduced to an extent comparable to that obtained by treatment with idoxuridine. More important is the apparent and striking reduction of postherpetic neuralgia (see table). Elliott[4] initiated treatment within 10 days of the rash and gave prednisone 60 mg daily for a week, 30 mg daily for a second week, and 15 mg daily for a third week. I have obtained similar results starting with 60 mg daily and reducing the dose by 5 mg daily to zero. Until idoxuridine 40% in dimethyl sulphoxide is more widely available the use of corticosteroids should be considered in elderly subjects in whom there is a high risk of postherpetic pain.—I am, etc.,

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1 Merselis, J. G., Kaye, D., and Hook, E. M., *Archives of Internal Medicine*, 1964, **113**, 679.
2 Scheie, H. G., and Alper, M. C., Personal Communication to Elliott.[4]
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Patient Series	Corticosteroids			Controls		
	No. of Patients	Neuralgia	Complications	No. of Patients	Neuralgia	Complications
Elliott, 1964[4] .. .. .. Average age 71	16	—	—	10	2	—
Pearce, 1973 (unpublished) .. Average age 67	8	—	—	14	8	—

Tragic Dilemma

SIR,—The leading article (9 December, p. 567) and correspondence in recent issues of the *B.M.J.* under this heading raise issues beyond those already ventilated.

It would appear that the instigators of the action were medically qualified consultants and not the director of social services. In such circumstances the main criticism cannot be levelled at the social services department as Dr. D. E. Ford does in his letter (6 January, p. 48). I am concerned at the possibility that our medical colleagues may have reached their decision to pursue their course of action without considering all the implications, and possibly without seeking the views of colleagues who, though not directly involved at this stage, would be at a later date—for example, a consultant psychiatrist in the care of mental handicap.

With reference to the long-term considerations I pose a number of questions:

(1) Does the director of social services intend to maintain parental rights and rear