CORRESPONDENCE

Correspondents are asked to be brief

Ankylosing Spondylitis D. K. Sambrook, F.R.C.S.....	46	Epidemic Ataxia in Western Nigeria T. S. David-West, PH.D.....	49	Pancreatin as a Source of Hospital-acquired Salmonellosis H. F. Frost, and G. Farkas, M.R.C.V.S.....	51
Sex and the Single Girl P. L. C. Diggory, F.R.C.S.....	46	Dressler's Syndrome B. J. Hutchcroft, M.R.C.P.....	49	Controlled Drinking for Alcoholism J. Merry, M.D.....	51
Skin Trauma and Corticosteroids B. S. Crawford, F.R.C.S.....	46	Food and Cyanide A. G. Freeman, F.R.C.P.....	49	Donors for Organ Grafting H. Hillman, PH.D., and T. M. Aldridge, M.A.....	51
Abnormal Cells and Hodgkin's Disease S. Varadi, M.D., F.R.C.PATH.....	47	Neuromuscular Involvement in Pituitary Gigantism C. Lucey, F.R.C.P.I.....	49	Severe Toxaemia of Pregnancy D. D. Mathews, F.R.C.S.ED.....	51
Chemotherapy and Leukaemia J. E. Parker, M.B.....	47	Amantadine-induced Aggressiveness M. Rizzo, M.D., and P. L. Morselli, M.D.....	50	Research in Psychiatry J. D. E. Knox, F.R.C.P.ED.....	52
Teaching Nutrition H. P. Vaishnava, F.R.C.P.ED.....	47	Varieties of Smoke N. J. Gray, M.R.A.C.P.....	50	Lead Poisoning M. Goldman, M.B.....	52
Screening for Glaucoma G. Pincherle, M.R.C.P.....	47	Presenile Dementia C. D. Marsden, M.R.C.P., and M. J. G. Harrison, D.M.....	50	Index of Bed Occupancy R. D. C. Southcott, F.R.C.S.....	52
Sleep and a Bedtime Beverage I. Oswald, M.D.....	48	Abortion and Miscarriage R. F. R. Gardner, M.R.C.O.G.....	51	New Consultant Contract A. H. James, F.R.C.P.....	52
Febrile Convulsions in Early Childhood B. W. Lewis, M.R.C.P., D.C.H.; D. Morton, M.R.C.G.P.; S. Spragge, M.D.....	48	Epitaph for the M.C.H.C. R. J. Crawford, M.B.....	51	Sir Paul Chambers's Inquiry M. C. T. Morrison, F.R.C.S.....	52
Mode of Action of Verapamil R. H. Anderson, M.D.....	48				

Ankylosing Spondylitis

SIR,—In the "Second Opinion Please" (13 May, p. 400) discussion between Dr. T. R. Cullinan and Dr. B. Christie a case of ankylosing spondylitis in a young man is described.

The point I wish to take up is the consultant's objection to irradiation because of the risk, and also because, according to him, radiotherapy would give "symptomatic relief in 75% of cases . . . the relief is often short-lived."

I would certainly not agree with either of the last two statements concerning the relief obtainable in this disease from radiotherapy. On the basis of personal experience of several hundred cases, I would say that irradiation of the painful joints gives almost complete relief of pain in at least 90% of patients, and this relief usually lasts several years, and sometimes it appears to be permanent. I have seen this in several patients whom I have followed up for more than 20 years.

Relief of pain and associated spasm in severe, progressive cases of ankylosing spondylitis is often dramatic. In such cases x-ray therapy is literally a life-saving treatment, in that most cases are arrested for many years and patients are able to return to work. Some regain almost full range of movements in the affected joints, but this will only occur if treatment is not delayed too long.

As to the risks of radiotherapy, the survey of Court-Brown and Abbott¹ of 9,364 patients who had been irradiated for ankylosing spondylitis showed an increased risk of leukaemia of between 5 and 10 times, as compared with the non-irradiated population in the same age groups. A more extensive survey by Court-Brown and Doll² put the mortality from leukaemia in such patients at 10 times the level in the general population. In practical terms this means a risk of something like 0.5% of patients treated. Admittedly, this is a grave possi-

bility, but are not the alternatives of treatment with butazones and steroids also dangerous? They have to be continued indefinitely and they do not give nearly such complete relief as radiation.

Dudley Hart³ stated "Deep x-ray is the only form of therapy which goes on producing beneficial results after the period of therapy is over. With all other forms of therapy such as butazolidin, analgesics, and steroids, the effects stop as soon as treatment is discontinued." A full review of the pros and cons has been published.⁴—I am, etc.,

D. K. SAMBROOK

Radiotherapy Department,
Singleton Hospital,
Sketty, Swansea

¹ Court-Brown, W. M., Abbott, J. D., *Lancet*, 1955, **1**, 1283.

² Court-Brown, W. M., Doll, R., *British Medical Journal*, 1958, **2**, 181.

³ Hart, F. Dudley, *Clinical Radiology*, 1961, **12**, 130.

⁴ Sambrook, D. K., *Rheumatism*, 1963, **19**, 30.

Sex and the Single Girl

SIR,—Drs. C. McCance and D. J. Hall (17 June, p. 694) are to be warmly congratulated upon a most significant and illuminating piece of social research. Aberdeen has long enjoyed an exceptionally high standard of gynaecological and of medical care generally, and the reputation of the University Student Health Service is particularly high. Therefore it is unlikely that the inadequacies disclosed in the field of sexual knowledge and of contraceptive practice will be bettered at other universities.

The authors deduce from the large and forthcoming response to their questionnaire that the present generation of students are very willing to discuss sexual topics at a serious level with anyone who shows concern or interest. One may hope that this

conclusion is treated seriously by those doctors responsible for the welfare of students in other universities, but would it perhaps be too much to hope that student nurses may be considered a comparable group and that those of us who have some responsibility for their education and health be stimulated to provide proper sex education and freely available contraception?

One important point is tacitly assumed in this, as in most modern surveys—namely that it is nowadays the responsibility of the female to obtain and use contraception. This is a reversal of the social pattern when I was a student. It might help if we knew something similar about the sexual practices of the unmarried male undergraduates.—I am, etc.,

PETER DIGGORY

London W.1

Skin Trauma and Corticosteroids

SIR,—I was interested in Mr. D. J. David's article on "Skin Trauma in Patients Receiving Systemic Corticosteroid Therapy" (10 June, p. 614) because this type of injury has assumed the proportions of a minor epidemic. Apart from prevention, the problem is to persuade our accident department colleagues to refer cases initially to a plastic surgery unit rather than to wait for sloughing and infection to set in. In principle it is not always realized that lacerated wounds are fundamentally different from incised wounds and require a different method of management. The temptation to use sutures in these cases can be almost overwhelming, but it usually ends in disaster.

In the type of injury described I have found that in some cases the flap need not be totally sacrificed provided the thinned and frayed edge is trimmed away and the haematoma evacuated. No sutures are used, but the flap is allowed to shrink and is gently held in place by a few adhesive strips. The use of bed rest and elevation for a few