paid substantially less. This situation was aggravated by the fact that the need for earnings of many workers in ancillary professions was not as great then as it is today. This was also true of many of the leaders of the profession.

I believe that a situation has been reached where so many paramedical staff have left the service or been distributed away from direct care of patients that the body of tradition and knowledge needed to train high-grade paramedical staff has been lost for ever. I believe that the profession has been lamentably wrong in assuring the public that they get an excellent service—excellent value for money perhaps, but we spend only 4-6% of our gross national product on health care, which compares badly with other countries, and finally the country gets what it pays for. There still exist "centres of excellence" where the quality of care is magnificent, but for the rest of the country the quality of care is falling, and I doubt if the situation can be saved.

The next move I anticipate is for the senior representatives of the profession to be asked to co-operate in cutting the service. Undoubtedly the proportion of gross national product spent on health care is so low that a comprehensive service cannot be provided on its budget. The profession must avoid any such involvement at all costs. If cuts are to be made in the service, and this seems inevitable, the Government must be seen to be directly responsible.—I am, etc.,

P. R. J. VICKERS

Gosforth,
Newcastle upon Tyne

Severed Digits

SIR,—We were pleased to see your leading article on digital replantation (11 May, p. 291) drawing the profession's attention to the possibilities that now exist of saving many of these severed parts.

Research into microvascular surgery was started at this unit in 1965, the first successful digital replantation being achieved in 1967. Since then digital replantation or transplantation has been performed in this country on various occasions. In this unit seven cases (nine digits) have been operated on successfully, the most recent involving the total amputation of the middle three digits of the right hand.

Heparin has certainly helped to make these successes possible, but it should be emphasized that the acquisition of the necessary sophisticated surgical techniques requires a prolonged apprenticeship with experimental animals and is even more important. It is also a great advantage if more than one surgeon in a unit is trained in these skills, so forming a microvascular surgery team. Once learned, these techniques can be used not only for the replantation of severed parts but for the free transplantation of large blocks of tissue which would otherwise require multi-stage procedures. They also provide the basis for organ transplantation in small experimental animals: an invaluable experimental model in studying the mechanism of graft rejection. In this unit well over 500 kidney transplants have been performed in the rabbit and the rat with a technical success rate of over 90%.

Once problems of graft rejection are solved,

microvascular surgery will form the basis of a new concept in plastic surgery with the use of free transplants of cadaveric tissue.—We are, etc.,

JOHN R. COBBETT
JOHN E. BOWEN

Queen Victoria Hospital,
East Grinstead,
Sussex

Psychiatry in the Soviet Union

SIR,—I read with great interest the article by Professor J. K. Wing (9 March, p. 433), in which he touches on the wide range of psychiatric assistance available in the U.S.S.R. and writes about the high standard of such assistance which has been achieved over the last few decades. One also has to agree with him that it would be beneficial for English specialists to acquaint themselves with the work of Soviet psychiatrists and that they could learn something from one another.

In the article a great deal of attention is paid to outpatient psychiatric treatment, questions of diagnostics, and legal psychiatric tests in the U.S.S.R. At the same time it should be noted that a number of the statements made in the article with regard to forensic psychiatric tests and the principles used in diagnosing schizophrenia may call forth various ambiguous interpretations on the part of the reader and give him the impression that in the Soviet Union psychiatry is used in the struggle against "dissidents." His judgement in this connexion may be linked with the fact that Professor Wing has said that he does not agree with the doctrine of diagnostics used in Soviet psychiatry and proceeds from diagnostic criteria recognized by a number of English psychiatrists.

The reader would have a more correct idea about these questions if Professor Wing, in speaking of schizophrenia and its diagnostic limits from the point of view of English psychiatrists on the one hand and the "Snezhnevsky school" and the American scientists on the other, had cited the points of view of universally known German, Swiss, Austrian, and French psychiatrists. The clinical psychiatric views of many of them are closer to those held by Soviet Scientists than to those from which Professor Wing proceeds.

For the purpose of showing that judgements with regard to forensic psychiatry and diagnostics are objective, Professor Wing ought to have thrown light on, what I believe is an important fact, that on 15 October 1973 a conference took place at the Serbsky Institute of Forensic Psychiatry. Thirteen psychiatrists from various countries in Western Europe and from the U.S.A. took part, including members of the Executive Committee of the World Psychiatric Association, at which Professor Wing was present. The participants in the conference were acquainted in detail with the state of forensic psychiatry in the U.S.S.R. and with the principles used in diagnosing psychiatric patients in legal cases. With the help of a simultaneous translation they took part in the examination of one patient typical of that group of the mentally sick with regard to whose psychiatric illness Professor Wing voices doubt. All the participants in the conference agreed that he was suffering from a psychiatric illness and that this excluded

responsibility on his part. Those taking part in the conference were also given the case histories of the patients suffering from mental disorders who are frequently mentioned in the foreign press as examples of "dissidents" who are allegedly being "persecuted" with the help of psychiatry. Like the Executive Committee of the World Psychiatric Association, for ethical reasons, I shall not give their names. I should like to stress that the participants in the conference discussed each of the case histories of the patients in detail and special note is made of this in the Executive Committee's protocol on the conference.

On the basis of this discussion the participants in the conference assessed the professional level and system of psychiatric tests at the Serbsky Institute in a positive light. Those participating in the conference, like the Executive Committee of the World Psychiatric Association, verified that all five of the so-called dissidents, who had previously been acknowledged as irresponsible, were suffering from mental illnesses during the legal examination.

For my part, I consider that more should be made of the wealth of experience Soviet forensic psychiatry has at its disposal. The data of many German, Swiss, and French psychiatrists also point to the distinctive features of the socially dangerous activities of obviously irresponsible patients suffering from delusions. Particularly in the case of paranoid delusions (*les idéalistes passionnés*, to use the terminology of French authors) these activities are frequently accompanied by outwardly well-ordered behaviour, characterized by single-mindedness and even cunning planned actions (V. P. Serbsky). The main feature of such patients is their dissimulation and their false but unshakeable belief that they are quite mentally sound.

At present forensic psychiatry is an extensive and many-sided branch of psychiatry in general. It covers many questions which need to be worked out and discussed. Impartial scientific discussion of the genuinely actual problems of diagnostics, treatment, tests, and rehabilitation of patients suffering from mental illnesses within the framework of international scientific contacts will facilitate the mutual enrichment of knowledge and the success of our science.—I am, etc.,

GEORGI MOROZOV
Corresponding Member of the Academy
of Medical Sciences of the USSR

V. P. Serbsky Institute of Forensic Psychiatry
Moscow

Bone Marrow Transplantation in Aplastic Anaemia

SIR,—Dr. C. G. Geary's excellent survey of acquired aplastic anaemia (25 May, p. 432) provided rather an unenthusiastic view of bone marrow transplantation as an effective means of therapy in aplasia, and I would like to draw attention to the fact that though it is too early to provide good statistical evidence that bone marrow transplantation offers a better chance of survival than does conventional therapy, there already exist a variety of situations in which a marrow graft is strongly indicated whenever a suitable donor is available. These are:

(1) Aplasia following irradiation accidents where any single dose received was above 400 r, since the risk of death is greater than 50% above this level.¹

(2) Post-hepatitis aplasia. The mortality of this severe marrow depression is in the region of 10%,² and marrow transplantation has been successful in two recently reported cases.^{2,3}

(3) In severe aplasia when an identical twin donor is available, since marrow can be transfused without pre-graft immunosuppression and graft-versus-host disease does not occur.

(4) Children with aplasia seem to have a much better chance of a successful graft than do adults. In Storb's series of 24 patients⁴ a successful graft was obtained in seven of nine patients under 16 years of age compared with four of 13 aged 17 years and older. Furthermore, the encouraging figures that Storb presents represent results of transplantation in patients who had not been supported by full conventional treatment—half the patients had bacterial infections at the time of admission and most had received frequent transfusion therapy, both these features prejudicing the successful outcome. As Storb points out, early transplantation before major infection and refractoriness to platelet transfusions occur would offer much better results.

Now that more is known about the problems of graft rejection and graft-versus-host disease in man it seems right to be optimistic about the future of bone marrow transplantation in aplastic anaemia, and it is to be hoped that this procedure will be applied more often in appropriate cases.—I am, etc.,

A. J. BARRETT

Department of Haematology,
Westminster Hospital,
London S.W.1

¹ Mathé, G., Amiel, J. L., and Schwarzenberg, L., in *Bone Marrow Transplantation and Leucocyte Transfusions*, p. 133. S. J. Ringfield, Thomas, 1971.

² Camitta, B. M., et al., *Blood*, 1974, 43, 473.

³ Royal Marsden Hospital Bone Marrow Transplant Team, *British Medical Journal*, 1974, 1, 36.

⁴ Storb, R., et al., *Blood*, 1974, 43, 157.

Idoxuridine in Herpes Zoster

SIR,—Dr. R. Dawber's paper (8 June, p. 526) in which he describes a double-blind trial of 5% idoxuridine dissolved in dimethyl sulphoxide (DMSO) topically applied at intervals to the visible lesions in zoster is interesting. However, statements are made in the paper which are inaccurate and must be challenged.

There is little basis for the postulate that "these results broadly agree with those of others." After we first showed that the relatively insoluble idoxuridine could be dissolved in DMSO and that the solution penetrated the skin and was active against herpes simplex virus,¹ we used intermittent topical application of a 5% solution to zoster. We applied it to the whole of the affected dermatome, not just to the visible lesions. Zoster, after all, is an affliction of the whole nerve, not just the skin.² We hoped that not only the visible skin lesions but most of the affected nerve would be reached. While most patients benefited, some did not, though our results were better than Dr. Dawber's. The reasons for proceeding to trial of a higher concentration of idoxuridine (40% in DMSO continuously applied) are given in

the paper Dr. Dawber cites.³ The results were much better; the pain lasted for a much shorter time (median 2.5 days) and, what is more important, this treatment was successful in nearly all cases. We did not "suggest" that 40% idoxuridine in DMSO continuously applied for four days was superior to 5% intermittently applied, we showed that this was so ($P < 0.00001$).

We have since carried out double-blind trials of 40%, 20%, and 5% idoxuridine in DMSO continuously applied, and found that 20% and 5% were significantly inferior to 40%. There was, however, no significant difference between 40% and 35% solutions. We have treated over 1,000 patients with 40% and lately 35% idoxuridine in DMSO continuously applied. Analysis of the results in 300 cases confirms the predictions of the trials. The median duration of pain was three days; 95.9% had pain for seven days or less, 79.6% for four days or less, and 45.0% for two days or less. Of the 4.1% who had pain for more than seven days, only one had pain lasting for as long as 30 days. Of the 300 31 got marked erythema and two weals from the DMSO. There was no "maceration" of the skin which we are falsely credited with having described in the treatment of zoster.

We have monitored our patients carefully for evidence of side effects on hepatic, renal, and bone-marrow function and on the eyes and found none. The statement that idoxuridine in high concentrations should "be reserved for life-threatening conditions such as herpes simplex encephalitis" is misleading for there is no sound evidence that intravenous idoxuridine has any consistent effect on herpes simplex virus encephalitis. In view of the variety of toxic effects and the relative difficulties of preparation of intravenous solutions of idoxuridine we and others now use cytosine arabinoside for this purpose.—We are, etc.,

B. E. JUEL-JENSEN
F. O. MACCALLUM

Department of the Regius Professor of Medicine
Radcliffe Infirmary,
Oxford

¹ MacCallum, F. O., and Juel-Jensen, B. E., *British Medical Journal*, 1966, 2, 805.

² Esiri, M., and Tomlinson, A. M., *Journal of the Neurological Sciences*, 1972, 15, 35.

³ Juel-Jensen, B. E., et al., *British Medical Journal*, 1970, 4, 776.

SIR,—Dr. R. Dawber's trial (8 June, p. 526) included patients from the age of 12 years upwards. Since herpes zoster in young people is a very mild illness with practically no pain and never followed by post-herpetic neuralgia, I think it is wasteful to treat such patients with anything more than the simplest of measures.

Dr. Dawber does not seem to have encountered any patients with post-herpetic neuralgia, even in the controls; the longest mean ($\pm$ S.E.) duration of pain is recorded as 19.5 ± 1.0 days. Since the report does not reveal the age distribution of the cases we really do not know how many elderly people (over 60 years) were included in the trial, and it is in this age group that post-herpetic neuralgia is a common complication.

Finally, it would have been of interest to know the segmental distribution of the lesions and particularly how ophthalmic herpes was treated.—I am, etc.,

HYMAN DAVIES

Salford

Removal of Fish-hooks

SIR,—The fishing season is now here and with it the inevitable increase in requests for the removal of fish-hooks from various parts of the body. The usual method for removing these hooks in casualty departments is to infiltrate the area with local anaesthetic, push the barb through the skin, cut off the barb, and remove the remainder of the hook. There is, however, a quick and effective method for removing hooks by using a piece of string. I do not think it is well known but as it saves time and trauma and can be done at the water's edge (as I did today) I think it could be more widely used.

The method is illustrated in the figure:

(1) A piece of string about a yard (or a metre) long is tied to form a loop. (2) The loop is passed over the hook and held as close to the skin as possible with the index finger of the left hand. (3) The middle finger and thumb of the same hand depress the eye end of the hook, which disengages the barb and ensures that during removal the flat outer edge of the hook presses against the skin. (4) The string is taken in the right hand and given a sharp pull with a good follow-through and the hook is removed through its point of entry. Advice to have a tetanus toxoid injection is a sensible precaution. I have used this method many times and large hooks are as easily removed as small ones. Its adoption may help our overworked casualty officers, as any doctor can use this "magic" string whenever a small boy, on the beach or by the river, asks, "Please, sir, can you take hooks out?"—I am, etc.,

PHILIP A. JONES

Llanelli, Carmarthen

Serum Hepatitis Associated with Repeated Acupuncture

SIR,—The following report of a case of serum hepatitis after acupuncture draws attention to the possibility of this association. I understand that the needles used were sterilized by dipping them in a 1 in 20 solution of tincture of calendula (marigold flowers).

The patient, a woman aged 28, stated that she had had acupuncture every two to three weeks for the past year for the following conditions: periodic bouts of depression, acute bronchitis, acute coryza and sore throat, vaginal thrush, and "strained arms." When she acquired gonorrhoea, however, she was treated with penicillin. She also smoked cannabis and occasionally consumed enough alcohol to make herself frankly drunk. Two days after her last acupuncture session she complained of abdominal colic and loss of appetite and noticed that her urine was very dark and her stools pale. When admitted to hospital eight days later she was apyrexial, jaundiced, the liver was just palpable, and there were a few fading macular lesions on the forearms. The biochemical findings were those of acute