patients find such simple measures to be frequently if not universally successful.

The suggested use of antiandrogens and metabolic inhibitors to reduce sebum production is another matter altogether. For one thing, it has never been demonstrated that the oiliest areas of the face get the most acne. The lesions of acne do not occur in those sites where sebum flow is most profuse but only in those areas where the outflow of sebum to the surface is blocked. The validity of this statement may be confirmed if one will look carefully at any random group of acne patients.

The largest and most productive sebaceous glands are on the nose, yet pimples on the nose are characteristic only of very early adolescence, at a time when the remainder of the sebaceous follicles on the face are still quite inactive. As follicular development continues, sebum and pimples start to appear on the central portion of the cheeks; later they appear on the outer parts of the face and finally on the neck and back. Of particular interest is the fact that at the same time as the sides of the face become affected it is customary for the nose and central cheeks to become relatively free of lesions. Careful examination of such patients reveals that the nose and central cheeks are quite oily and shiny. They are free of active disease not because the production of sebum has lessened in those areas but because the follicles, now mature, have at last become capable of emptying themselves through adequate openings. This, in fact, is how one literally "outgrows" acne. The openings become enough to function while sebum production continues at a normal and natural rate.

Thus the suggested treatment of acne with antiandrogens and antimetabolites in addition to being potentially harmful through effects elsewhere in the body, is also not "rational."—I am, etc.,

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¹ Cunliffe, W. J., and Shuster, S., *Lancet*, 1969, 1, 685.

Vehicles for the Disabled

SIR,—As a general practitioner with several handicapped patients I would like to express my deep concern about the highly unsatisfactory invalid three-wheelers issued to the disabled by the Department of Health and Social Security. These have attracted widespread criticism in recent years, and when compared with an adapted four-wheeled car (which is comparable in cost to a three-wheeler) in the August 1969 edition of *Which?* they were described as "under-powered, unstable, unreliable, . . . , noisy, poorly heated, and did not ride very well."¹ They were summed up as "fairly disastrous" vehicles. To answer such criticisms a new three-wheeler—the P.70—was introduced in 1970. While improved features included a more powerful engine and automatic transmission, the light fibreglass body and inherently unstable concept of three wheels instead of four remained the same. This "improved" model was strongly criticized in a further *Which?* report in March 1972² and summed up as "still extremely hazardous" owing to lack of safety features.

Having personally tested the new P.70

three-wheeler, I found that the comments made in *Which?* and the frequent complaints of local disabled drivers about the instability of such vehicles and their proneness to being blown around in cross-winds were more than fully justified. In recent years three disabled drivers have been blown off the road in the Oxford area alone (one of whom was killed) and one of my patients recently suffered the same misfortune in the new P.70 three-wheeler, but luckily escaped alive.

It is to be hoped that more individual doctors, and the medical profession as a whole, will soon take a more active interest in supporting a call for urgent action to replace existing three-wheelers (except to the minority who cannot drive anything else) with an adapted four-wheeled car which is efficient and able to meet the safety standards of the twentieth century—a concession already enjoyed by war disabled persons and some categories of National Health Service patients. Any doctor who doubts the need for such proposals has only to inspect the controls and test-drive (not on a public road) any three-wheeler issued to his disabled patients by the Department of Health, and compare it with an automatic Mini-minor or similar small car for comfort, ease of control, and particularly safety, to realize the validity of the criticisms of such vehicles. Haematologists have already been strongly outspoken in successfully drawing attention to the dangers of three-wheelers for severe sufferers from haemophilia. Perhaps other doctors should show similar concern and adopt a similarly urgent course of action on behalf of their severely disabled patients.

I would be interested to hear from any doctor who has views on this subject and who would be willing to take an interest in support of trying to achieve safer vehicles for disabled drivers.—I am, etc.,

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¹ *Which?*, August 1969, p. 248.

² *Which?*, March 1972, p. 94.

Bone Marrow in Infectious Mononucleosis

SIR,—Your leading article, "Infection with E.B. Virus" (31 March, p. 757), contains the statement that "infectious mononucleosis does not involve the bone marrow." We wish to draw attention not only to our own series of nine patients,¹ but also to a pre-existing literature on this topic.

In our series, all specimens of sternal marrow showed marked hyperplasia affecting all cellular elements, and very occasionally the cellular features could be so bizarre as to raise the possibility of an early neoplastic process affecting one or more cell lines. From the literature we select the articles by Campbell,² Schleicher,³ Hovde and Sundberg,⁴ and Pease,⁵ all of whom noted involvement of the marrow either by hyperplasia or by granulomata or by both features in most of the patients studied. Further, since our own publication, Metcalf and Wahren⁶ have reported the presence in the serum of 44-100% of patients with infectious mononucleosis of a factor which possesses colony-stimulating activity on mouse bone marrow cells in vitro.

Hence all these reports lead us to conclude that infectious mononucleosis does indeed affect the marrow in a very interesting manner and that there can be from time to time close similarities between the marrow findings in infectious mononucleosis and other generalized lymphoproliferative states.—We are, etc.,

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¹ Boyd, J. F., and Reid, D., *Journal of Clinical Pathology*, 1968, 21, 683.

² Campbell, A. C. P., *Journal of Pathology and Bacteriology*, 1948, 60, 629.

³ Schleicher, E. M., *Acta Haematologica (Basel)*, 1949, 2, 242.

⁴ Hovde, R. F., and Sundberg, R. D., *Blood*, 1950, 5, 209.

⁵ Pease, G. L., *Blood*, 1956, 11, 720.

⁶ Metcalf, D., and Wahren, B., *British Medical Journal*, 1968, 2, 99.

Strychnine-containing Tonics

SIR,—Along with two colleagues we recorded, in 1971, the successful treatment of strychnine poisoning with diazepam.¹ The patient, a 13-month-old child, had accidentally swallowed Easton's tablets (formula A, B.P.C. 1963). These are a "tonic" and at the time contained 1 mg of st. chnine hydrochloride per tablet.² We cond. . . use of strychnine in any form because there is no evidence of any therapeutic value. Tolerance to strychnine is variable and as little as 2 mg has proved unpleasant to adults³; no one knows the effect a lower dose may have on children, but it might be fatal. In the 1968 revision of the B.P.C. the strychnine content of the formula A tablet was reduced to 0.1 mg, but the preparation was not withdrawn altogether, apparently because there was still a demand for it; the tablets are still being manufactured.

As no one knows the lowest fatal dose of strychnine in children, and as strychnine has no therapeutic indications, it seems improper to continue to produce any compound with any form of strychnine as its ingredient. Many "tonics" taste very pleasant, which makes them especially attractive to children.⁴

A brief scan of *MIMS* has shown that there are at least nine proprietary preparations still marketed as "tonics" which contain strychnine in various forms and in varying (sometimes unspecified) dosage. There may well be others, and we should therefore like to ask these questions: (1) As strychnine has no proved clinical value and is a known poison, does commercial success in so-called "tonic" sales outweigh the risk of unnecessary fatalities? (2) What company can justify the continuing manufacture of preparations containing this ingredient? (3) When are the drug companies going to withdraw these compounds in their present form? (4) Should not the Committee on Safety of Medicines be involved?

In the meantime we appeal to all doctors not to prescribe any of these so-called "tonics" and to try to retrieve any which may be in the possession of patients. Most patients are surely unaware that the tonic