treatment. Moreover, the treatment is logical because in most cases of embedding the shape of the nail is normal.

Since, however, the normal anatomy is preserved, an average follow-up of less than one year might be inadequate to determine the recurrence rate. Ingrowing toenails are multifactorial in their causation, but a very frequent finding is drastic cutting of the toenails,¹ which removes support from the pulp of the toe and allows it to prolapse around the edges of the nail. Therefore the long-term success of any conservative treatment of ingrowing toenail must depend on the careful elimination of causative factors, and in particular the avoidance of cutting the nails short.

The authors have correctly described the operation for segmental excision of the germinal matrix (first advocated by Heifetz²), but unfortunately they also call this operation a "wedge resection" procedure. The classical wedge resection operation consists of removal of an elliptical wedge of tissue consisting of nail wall, nail plate, and nail matrix. This is a highly unsatisfactory operation because the very structure which it is most important to expose fully—namely, the germinal matrix—is least well exposed because it lies at the apex of the wedge. Not surprisingly, this operation has a high recurrence rate and should not be confused with segmental excision of the germinal matrix.

A W FOWLER

Bridgend General Hospital,
Bridgend, Mid Glam

¹ Fowler, A W, *British Journal of Surgery*, 1958, **45**, 382.
² Heifetz, C J, *Journal of the Missouri State Medical Association*, 1945, **42**, 213.

SIR,—Articles on the treatment of ingrowing toenails appear at frequent intervals. I wonder if the simplest method has been forgotten.¹

The sharp edge of broken glass is used to pare down the centre of the nail until the centre line is quite thin and the pink nail bed shines through. The instrument may be made from a microscope slide by making scratches on the opposite edges near the centre, then breaking it—if the slide is broken without first grooving with a file it fragments. After the nail is thinned the free edges can be raised by packing with pluglets of cotton wool; but this step is not usually necessary, as once the nail is thinned pressure on the underside of the toe causes the nail to buckle, lifting its edges from the inflamed area.

I have used this method since I saw it described and have had few or no failures. The patient hobbles into the surgery and 15 minutes later walks out in comfort.

R B USHER SOMERS

Sark, Channel Islands

¹ Chapman, P F, *British Medical Journal*, 1934, **2**, 1073.

Depot neuroleptics in a community mental health service

SIR,—Although, like Dr B Blake (7 July, p 48), I have found clopenthixol decanoate (Clopixol) an effective antipsychotic in a number of schizophrenic patients with paranoid delusions and hallucinations inadequately controlled by other long-acting neuroleptic injections, in one respect my experience differs from his. I have encountered very few complaints of extrapyramidal or other side effects when

using a starting dosage of 100–200 mg, and my impression is that side effects with this neuroleptic are less frequent than they are with other depot preparations. Clopenthixol decanoate does not appear to have a mood-elevating effect such as I have seen with flupenthixol decanoate (Depixol); but its effect on nuclear symptoms has enabled a number of patients to work in the community in quite demanding occupations.

I would be interested to hear from any reader who has experience of clopenthixol decanoate in patients with intractable obsessional neurotic illness. I have seen a reasonably successful response in such a patient who had failed to respond to all other treatment tried.

BRENDA GRANT

Runwell Hospital,
Wickford, Essex SS11 7QE

Too few necropsies

SIR,—My efforts to build up a picture of the long-term behaviour of sarcoid heart disease¹ are repeatedly frustrated by the lack of adequate necropsy when the patient dies. The only ultimate proof of involvement of the heart with sarcoidosis is by necropsy histology. A number of patients with this diagnosis, who had been followed for many years, have had no necropsy after death, even though the desirability of this was abundantly clear and I am sure that the relatives would not have objected. In other cases—particularly coroners' cases—necropsy examination has been quite superficial and inadequate, and vital material in the heart has been thrown away without histological examination.

One imagines that my experience in sarcoid heart disease is not unique and I would make an appeal for a more energetic and careful necropsy policy where there is a good indication. I understand that there is a shortage of pathologists but that, on the other hand, pathologists have discussed with some concern the fall-off in necropsy rate—could some of this perhaps not be due to the lack of help given to the clinician by a less-than-thorough postmortem examination?

H A FLEMING

Regional Cardiac Unit, Papworth Hospital,
Cambridge CB3 8RE

¹ Fleming, H A, *British Heart Journal*, 1974, **36**, 54.
² Fleming, H A, *British Heart Journal*, 1979, **41**, 379.

History of medicine collections

SIR,—Your leading article (4 August, p 293) on the Wellcome Museum of the History of Medicine offers reassurance to many of us who have been concerned by the gradual disappearance of the museum from its familiar—and convenient—site on the Euston Road. Presumably we can now assume that the unique collection accumulated by Sir Henry Wellcome, much of it still not catalogued or documented, is now safe from threat of dispersal. It is heartening to learn that the new museum is maintaining the tradition of informing and entertaining the lay public, particularly the young, but also extending the opportunity for scholarship in this field. One hopes that amateur medical historians will be encouraged to make use of the collection and library facilities.

The expressed intention of developing an archive of contemporary medical objects is

particularly important, because the efficiency of supplies officers for the NHS and the refurbishing of general practitioners' surgeries in recent years have resulted in a wholesale destruction of the nineteenth and early twentieth century which may result in a paucity of these specimens in most collections. Since inevitably display facilities in the new museum will be inadequate and duplication of items common, can we hope for the imaginative development of travelling collections or outstations for the museum? Many local museums and most if not all provincial medical schools would find room to display loan collections, perhaps on a rotating basis. They could also act as collecting stations for those impedimenta of medicine which are still collecting dust in the cupboards and cellars of practice premises. There are still wooden stethoscopes, glass and metal syringes, early obstetric forceps, and the like which will end up in the dustbin or a flea market unless a proper home is found for them.

SYDNEY BRANDON

University Department of Psychiatry,
Leicester Royal Infirmary,
Leicester LE2 7LX

Measles and vaccine protection

SIR,—Dr G A Jackson's doubts about the efficacy of measles vaccination (4 August, p 332) may be very misleading. It appears that he has based his conclusions on the number of cases in vaccinated children as a percentage of the total number of notified cases of measles in a year. If he had taken the total number of vaccinated children in the district council area as the denominator he would have found about the 90% protection he was looking for.

Dr Jackson was wise not to use significance tests in the analysis of his results; with a response rate of 76% and doubtful validity of the answers to his questionnaire, it was certainly not worthwhile. It would have been useful for him to have defined the two levels of severity of the illness and the complications. A higher percentage of "severe" cases with "complications" in vaccinated children compared with unvaccinated children could also have been due to variability of the assessors—presumably the recipients of the questionnaire—that is, the parents.

K SHEIKH

Stoke Poges, Bucks SL2 4PH

Rubella vaccination

SIR,—I refer to Dr T S Wilson's letter (28 July, p 272) which seemed to criticise a policy of screening adult women for rubella immunity. However, his doubts were not clear.

Dr Wilson wonders if the immense amount of laboratory investigation is "nowadays really necessary." Is he questioning the value of conducting such a survey at all? Is he questioning the habit of serotesting before vaccination? Is he suggesting that some condition obtains *nowadays* that formerly did not?

Congenital rubella is responsible for a high incidence of fetal death (spontaneous and therapeutic abortions), neonatal death, and, of course, congenital defects (deafness, cardiovascular abnormalities, mental retardation, blindness, spasticity, etc). In the UK, over 500 children were born between 1971 and 1978

who were subsequently registered as congenital rubella cases (11 August, p 396). The Office of Health Economics estimated that between 200 and 250 children are born annually (in non-epidemic years) with congenital rubella syndrome.² After the 1978 epidemic, 1500-2000 rubella-damaged babies are expected to be born this year.³

An estimate of the cost of the care of a person living from 16 to 65 years of age in a Spastics Society home is £173 000 at present day costs. If loss of earnings is added at, say, £5 000 per annum, the total cost becomes £373 000. Clearly the costs vary with the degree of handicap. It is therefore against the background of this order of expense that one should evaluate a screening programme. However, I think it is debatable whether any screening programme should have to justify itself on the basis of economics alone.

Is, then, Dr Wilson questioning the habit of serotesting before vaccination? We know that rubella vaccine can be teratogenic, but this varies with the immune state of the mother at the time of vaccination, the gestational age of the fetus, and the type of vaccine used. One study⁴ of 65 seronegative women vaccinated in early pregnancy who went to term showed that all were delivered of normal babies. The study estimated the risk of major malformations to be less than 5.5%. However, doubts about the safety of the vaccine become irrelevant in a properly designed survey, which would exclude pregnant women at the time of vaccination and provide effective contraceptive advice for three months afterwards. A compromise may be the policy of taking and storing blood at the time of immunisation, testing it only if it is subsequently discovered that, inadvertently, the woman was pregnant. On the basis of the results, a therapeutic abortion may be advised.

Certainly a screening programme involving adult women is difficult and costly. Certainly the uptake rate will be less than 100% but I would not like to predict the 25% suggested. However, these are no reasons for abandoning the attempt to prevent some rubella-damaged children.

R G H BETHEL

Englefield Green, Surrey TW20 0PF

¹ Wells, N, *Birth Impairments*, p 27. London, Office of Health Economics, 1978.

² *British Medical Journal*, 1978, 2, 1441.

³ Preblud, S R, et al, *British Medical Journal*, 1978, 2, 960.

Labetalol in severe tetanus

SIR,—We read with interest the reports of treatment with labetalol in tetanus (28 April, p 1121; 28 July, p 274), and wish to report our experience of continuous intravenous infusion of labetalol in a patient whose arrhythmias and hypertension persisted intermittently for three weeks.

A 70-year-old woman pricked her finger while gardening and the wound became infected. Trismus developed six days later and after a further two days she developed respiratory spasms and paroxysms of supraventricular tachycardia and hypertension. She was paralysed with intravenous pancuronium, ventilated, and sedated with large doses of diazepam and phenoperidine. Repeated intravenous boluses of propranolol were given in an attempt to control the episodes of tachycardia and hypertension. The next day an intravenous infusion of labetalol (1 mg/min) was begun but paroxysms of tachycardia continued. Four hours later she became hypotensive and oliguric but these features resolved when the labetalol was

stopped. The following day she had a sustained supraventricular tachycardia and hypertension, which persisted for four hours after labetalol infusion was recommenced. The infusion was continued for 10 days, during which time there were no episodes of tachycardia lasting more than 30 seconds. In the 10 days after labetalol was stopped the paroxysms of supraventricular tachycardia recurred, on average two or three times each day; but this period coincided with the time when the patient was being weaned off the ventilator and was receiving less sedation. These episodes were treated with intravenous boluses, initially of propranolol and later of verapamil, which appeared to be more effective than the propranolol.

The rapid fluctuations in arrhythmias and blood pressure which occur in tetanus make it difficult to assess the effects of sympathetic blocking drugs in this disease, because an apparent therapeutic response to an intravenous bolus may reflect spontaneous resolution. In this case, however, the episodes of supraventricular tachycardia were less frequent and less severe during labetalol infusion and recurred when the drug was stopped, although sedation was also decreased at this time. We conclude that labetalol infusion (1 mg/min) is unlikely to correct an established arrhythmia but may be useful in prophylaxis in severe tetanus. It is not, however, a substitute for adequate sedation and may cause hypotension initially.

H CONNOR

IAN P HINE

D G HART

County Hospital,
Hereford HR1 2ER

Emphyseus

SIR,—By chance, I came across the word emphyteusis in the *Shorter Oxford English Dictionary*. It has been known since 1618 and its literal meaning is implanting, the word in a legal term denoting "a perpetual right in a piece of another's land." I see no reason why this melodious word should not be adopted by cardiologists with reference to pacemakers. Only recently, after all, neurologists have appropriated the banking term deficit. The Greek equivalents of implant and implantee must be left to Hellenists.

I must declare my interest: I carry a pacemaker between my right pectoral muscles and the superficial integument. I would much prefer to be known by a soft Greek expression than by the ugly neologism implantee.

LÉON SHIRLAW

Gidea Park, Essex RM2 5AT

Makerere University Medical School

SIR,—Many doctors throughout the world are concerned with the fate of this famous African medical school. My wife and I have just returned from a four-day visit to Makerere, where we were able to assess the present situation. Contrary to some rumours, the medical school has never ceased to function and has sustained its large student intake and heavy teaching programme. At the time of our visit some final examinations were being conducted with scrupulous attention to their organisation.

The enormous problems which have faced the medical school are by no means over, but this would seem to be an opportune time to

pay tribute to the university and hospital staff who have remained in Uganda, often at personal sacrifice, and have maintained high standards in such difficult conditions.

M S R HUTT

Department of Morbid Anatomy,
St Thomas's Hospital Medical School,
London SE1 7EH

Minor operations in general practice

SIR,—May I add to the correspondence that has followed Dr J S Brown's article (16 June, p 1609)? The problem I should like to highlight is the provision of the services of the central sterile supply department (CSSD).

I am denied free use of the CSSD for my minor surgery service because, according to my district administrator, it is DHSS policy that GPs will not be provided with sterile supplies. I can, however, be supplied with the CSSD facilities I require if I pay a recurring sterilisation charge for each pack. Therefore my partners and I are expected to pay for the privilege of reducing the surgical waiting list at our local hospital.

As Dr Brown's article has shown the cost-effectiveness of minor surgery within general practice, surely we should now be given some active help and encouragement to provide a service which benefits both the patient and the over-stretched hospital service.

BRIAN ROBERTSON

Church Crookham, Hants GU13 0AJ

Functional budgeting

SIR,—I have only recently had brought to my attention the letter from Mr P J E Wilson (2 June, p 1485) on functional budgeting. Although you have published a reply to this from Messrs Todd and Worsley (21 July, p 213), I feel that as so many of Mr Wilson's arguments are inaccurate I should write to you as an officer at the "sharp end" who has a very satisfactory budgeting system in operation.

It grieves me to see that some consultants are still very suspicious of the concept of budgeting. I feel that this suspicion stems from an ignorance of why we must have this kind of system; the benefits that can accrue from it, both from the viewpoint of the budget holder and also from that of the management team; and the part that all staff can, and should, play in the control of expenditure—even medical staff. Mr Todd and Mr Worsley pointed out the salient argument that medical staff have it in their power to commit considerable resources—they put it at least 60%, but I would venture to suggest that the figure is much higher when we look at the total effects of patients being admitted to hospital, including catering, laundry, etc. Medical staff have through the ages felt that they should not be controlled over their expenditure and that they should have the divine right to spend whatever they wish.

We have had such a budgeting system in this district for over three years now. All managers are involved, including the medical staff. This involvement has been largely at their own request and I am sure that they would bear testimony to the fairness of the system and the benefits that they reap. As well as the service-providing specialties such