which may well be detrimental to that person's overall well-being.

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¹ *National U* (Canberra), 30 April, 1975.

² Grinker, R R, et al, *Archives of General Psychiatry*, 1962, 6, 405.

³ Eissler, K R, in *The Psychoanalytic Study of Society*, ed W Muenster-Burger and S Axelrod. New York, IUP, 1960.

⁴ Goldney, R D, *Australian and New Zealand Journal of Psychiatry*, 1974, 8, 199.

Shingles: a belt of roses from Hell

SIR,—Your leading article on shingles (6 January, p 5) gives an excellent account of the pathology, clinical picture, and early treatment of this common disease. Unfortunately there are many patients who continue to have severe, long-term discomfort and I believe there is much more to offer than "analgesics, sympathy, and a liberal helping of hope." For example, in pain relief clinics throughout the country many of these individuals have been helped, though seldom completely relieved, by transcutaneous nerve stimulation and similar methods of recruitment of large-fibre pain-inhibitory systems.^{1 2} It is disappointing also to find no reference to drug regimens incorporating anticonvulsants with tricyclic antidepressants. There is much clinical evidence to support the use of fluphenazine with amitriptyline³ and sodium valproate with amitriptyline.⁴ Peripheral nerve blocks are of limited value except for those with superficial burning dysaesthesia.

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¹ Nathan, P W, and Wall, P D, *British Medical Journal*, 1974, 3, 645.

² Mehta, M, *Anaesthesia*, 1978, 33, 258.

³ Taub, A, and Collins, W F, in *Advances in Neurology*, vol 4, ed J Bonica, p 309. New York, Raven Press, 1974.

⁴ Raftery, H, communication to Second World Congress on pain, Montreal, September 1978.

SIR,—Despite much interesting information about herpes zoster in your leading article (6 January, p 5), some of your statements must not go unchallenged. It is our contention that there is no reliable information suggesting that treatment of zoster with systemic steroids causes dissemination of the disease *except in the immunosuppressed patient*. Such immunosuppression does not occur during a short course of steroid therapy. But let us assume that dissemination does occur, and what do we have—chickenpox. Disseminated zoster is potentially lethal only in the immunosuppressed. It is interesting that, of the references quoted, No 20, an article by Juel-Jensen,¹ quotes as the main evidence for the dangers of dissemination of steroid-treated zoster a notoriously bad article by Merselis *et al*. This was reviewed in the *Year Book of Dermatology*,² with the comment that "Avoidance of corticosteroids . . . is not justified on the basis of the material presented. . . . It should be mentioned that systemic steroids are now an accepted approach to the treatment of herpes zoster, especially when ophthalmic involvement is a feature." Indeed, you state that early treatment with systemic steroids reduces the incidence of postherpetic neuralgia.

Now to the question of cost. Even if 33%

idoxuridine were available in general practice, its cost to this hospital is £102 for 30 ml. Although we have not yet decided how this could be applied "constantly to the whole dermatome for four days" (a continuous recycling spray inside an oxygen tent?), the cost—since C4, for example, has a rough surface area of 258 cm²—would run to possibly £1000 or more per patient.

This department, with its general practitioner assistants, has treated many hundreds of cases of zoster with prednisolone over 20 years and with excellent therapeutic effect, and will continue to do so—at a rough cost of less than 100p per patient.

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¹ Juel-Jensen, B E, *British Medical Journal*, 1970, 4, 776.

² Baer, R L, and Kopf, A W (editors), *Year Book of Dermatology for 1964-65*, p 386. Chicago, Year Book Medical Publishers, 1964-5.

Computers and confidentiality

SIR,—Your leading article "Computers and confidentiality" (16 December, p 1663) criticises the Report of the Committee on Data Protection (HMSO Cmnd 7341) for its failure to ensure the inviolability of the doctor's "right" to keep his records from his patients. Had you explained our proposals even briefly your readers might have been able to judge for themselves whether our conclusions were unreasonable.

We suggested that the Act should lay down the duties of a data protection authority (DPA) and the principles by which it should be guided. But our witnesses made it clear that a single set of rules built into the statute would lead to unnecessary costs being placed on the users of personal data whose activities posed little threat to privacy, and we knew that changes taking place in computer hardware might rapidly outdate the provisions of a statute. To meet these and other problems we proposed that the DPA should prepare subsidiary legislation in the form of codes of practice for different applications, including codes for medical records, for medical research, for social service records, and so on. We envisaged that about 50 codes would be needed for all applications. We specifically urged that the codes should be worked out bilaterally between the DPA and representatives of the users, a point you unfortunately missed. The medical profession would thus have a full voice in determining whether patients should have the right of access to their files (and, at the moment, this refers only to computer files). The weight of the arguments presented by our witnesses was against right of access, so we accepted that the code for medical records should stipulate an exemption from the general rule that a data subject should be able to see his record. It should be clear that an exception to the general rule was being made for medical records. But should there ever be public pressure to remove this exception the profession would be able to play a part in determining the outcome through their consultations with the DPA.

Your suggestion that this exception be in the statute is contrary to the whole philosophy of the report. It is extremely cumbersome to change an Act, whereas the codes of practice, as subsidiary legislation, could be relatively easily altered as circumstances changed. If at

some later date the consensus were that patients should have the right of access, there would be few procedural obstacles to overcome.

The advantages to medicine of a Data Protection Act should be substantial. You mention the success of the Oxford Record Linkage Study, without explaining that some doctors refuse to co-operate with it because they cannot in good conscience supply identifiable medical data to a computer system which is not regulated by law. If the system were regulated, the Aylesbury doctors would probably lift their ban. This could equally apply to other computer projects in the health field which have run into trouble because of lack of firm safeguards. Thus, rather than stultifying computer developments in medicine, the Data Protection Act should remove much of the basis for opposition and apprehension.

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Safety in clinical laboratories

SIR,—It has recently been claimed by Mr D C Jenkins, general secretary of the Association of Scientific, Technical and Managerial Staffs, that no action has been taken for more than three years to improve the standards of safety in NHS laboratories.¹ It was also implied that Crown immunity of such Government-controlled departments has been used as a means of avoiding the institution of improvements.

The facts are that there has been a great deal of activity in the study and publicising of laboratory hazards, highlighted by the Howie Report and by your leading article on it (8 April 1978, p 871). Despite financial stringency definite improvements have been made, particularly in relation to hepatitis, the annual incidence of which in 1975-6 fell to only one-quarter of what it was in 1970-4.² There is still room for improvement in the prevention of infection, especially in relation to tuberculosis in post-mortem room staff; but the potential for major disaster in recent years has arisen in laboratories outside the NHS.

The control of non-infective hazards—chemical poisons, radioactivity, fire, explosion, electrical dangers, noise, and faulty centrifuges—is improving: for example, in relation to radioisotopes there are stringent regulations which are enforced as much in Crown establishments as elsewhere.

Finally, it is surprising to us that Mr Jenkins is apparently unaware of all these activities designed to improve the safety of his members in NHS laboratories, in which his members are active participants and have contributed to the drawing up of safety codes which have been used for some years in hospital laboratories. The emotions raised by the recent occurrence in Birmingham are understandable, but outbursts unrelated to the facts do not help.

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¹ Loshak, D, *Sunday Telegraph*, 7 January, 1979.

² Grist, N R, *Journal of Clinical Pathology*, 1978, 31, 415.