either did not take the material they were supposed to be taking or did not respond. Actually we already have evidence that patients who have been on tartrazine-Ponceau-R-free capsules for nine months or so do show the expected and not the anomalous PGE₂ reaction.

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¹ Field, E J, and Joyce, G, *European Neurology*, 1978, **17**, 67.

² Field, E J, *Lancet*, 1978, **1**, 780.

³ Mertin, J, et al, *Klinische Wochenschrift*, 1974, **52**, 248.

⁴ Caspary, E A, in *Immunological Techniques for Detection of Cancer*, ed B Bjorklund, p 74. Stockholm, Bonniers, 1973.

⁵ Millar, J H D, et al, *British Medical Journal*, 1973, **1**, 765.

"Trench foot" caused by the cold

SIR,—With reference to the letter (3 March, p 622) from Dr Paul Marcus, we have read it with interest and he does make some valid points, particularly in respect of the wind chill factor, which was without doubt of significance in the injury we described in our letter (10 February, p 414).

It was difficult to decide, when our case presented some six days after the initial injury, whether it was or was not one of frostbite; but on balance, because of the rather diffuse and ill-defined area of circulatory disturbance and the lack of tissue necrosis other than the two small blisters referred to, we considered that it was a case of "exposure foot," which might be a better title than trench or immersion foot.

Interestingly, some four months after the initial injury, there is still a sluggish capillary response of the upper surface of the affected foot from 2.5 cm proximal to the digital webs, and a reduction in the dorsalis pedis pulse on that foot. There is no evidence of any sensory loss or other neurological involvement. The patient himself is unaware of any difference in the two feet, other than that the affected foot still gets a little "puffy" by evening. On balance we think our original diagnosis was correct, although we cannot be certain.

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Unnecessary skiing injuries

SIR,—We have to report the disturbing fact that school skiing parties do not always take precautions which would reduce the number of serious leg injuries.

Several days ago we admitted to our orthopaedic department two 16-year-old girls who had been taking part in the same skiing holiday in the Italian Dolomites. The skiing experience of both of them was limited to six hours of training on a fibre-glass slope, arranged by the PE department of their school. While in Italy they had professional coaching supervision and used equipment hired locally. Not once, however, was the efficacy of the ski bindings checked, nor did the instructor make sure that the boots were capable of disengaging from the skis in prescribed conditions.

In consequence, while suffering minor falls when skiing both girls sustained injuries to the knee; significantly, the boot failed to disengage from the bindings on the affected side. The first of the girls was subsequently tobogganed to the local hospital, her knee was x-rayed, and a diagnosis of minor sprain was made. She was advised to walk on the

affected leg in protective knee dressing, which she did for almost a week. The second girl, who had a similar experience, would not be bothered to follow the first girl's example and walked on the affected leg for four days.

Both of them presented in our hospital with locked knee. The x-rays revealed in both cases avulsion of the anterior tibial spine from the intercondylar tibial eminence. Both girls underwent emergency explorative surgery. The avulsed bone was reduced and fixed with a lag screw; the cruciate ligament attached to it was found to be intact.

We consider that school teachers in charge of skiing groups should be appropriately trained in safety checks, including checks of ski bindings, in order to eliminate the risk of such injuries.

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Alopecia areata

SIR,—Your leading article (24 February, p 505) refers to dinitrochlorobenzene (DNCB) as a new form of therapy for alopecia areata, and doctors who are confronted by patients with this distressing condition will be tempted to try any new treatment which might promote hair growth. I would, however, like to present my experience with this agent and suggest a cautious approach to its use. Seventeen patients were successfully sensitised to 2% DNCB in acetone. They then applied a 0.1% solution to the right side of the scalp for two months and to both sides for three months. After five months regrowth of hair had occurred in eight patients, but could only be definitely attributed to DNCB in five. In those five patients growth started on the right side and then followed on the left. In the other three growth was simultaneous on both sides and eyelashes reappeared in two. While this may reflect a general immunological stimulation by DNCB, it could have been a chance occurrence.

It is essential to induce an allergic contact dermatitis to promote hair growth and all 17 patients complained of irritation. Five patients experienced marked vesiculation and four of these developed postauricular and occipital lymphadenopathy. Two developed oedema of the eyelids, one requiring admission to hospital. Two patients, in spite of wearing PVC gloves for application, developed dermatitis of the hands. One patient was unable to go to work on two occasions on the day following application. The spouses of two patients developed a rash on the face.

This high incidence of side effects, the possibility of cross-sensitisation of DNCB with other nitrobenzene compounds and chloramphenicol, and the unknown sequelae of such potent antigenic stimulation calls for reservation in the use of DNCB in alopecia areata.

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Differences between Leeds fractures and London fractures?

SIR,—The short report by Dr M R Baker and others of a study of the 25-hydroxy vitamin D (25-OHD) concentrations in elderly women with fractured neck of femur in Leeds (3

March, p 589) reveals a lower mean plasma concentration in the fracture group than in age-matched controls. This contrasts with our own findings, which have already been reported to the Medical Research Society¹ and which are shortly to be published in full.² It would be reassuring to know that the apparent difference in 25-OHD concentration in these women remains statistically significant after suitable steps have been taken to allow for the grossly non-normal distribution of the concentrations.

In a cohort of 70- to 80-year-old patients with fractured neck of femur drawn from the catchment area of this hospital we found a mean 25-OHD concentration of 17.7 nmol/l (708 ng/100 ml) in comparison with 20.3 nmol/l (812 ng/100 ml) for age-matched patients admitted for routine orthopaedic surgery. This difference was not significant, the 95% ranges being 4.2-73.8 (168-2952) and 10.0-84.7 nmol/l (400-3388 ng/100 ml) respectively (a logarithmic transformation was necessary to correct the skewed distribution of the data). The interview-assessed dietary intakes of vitamin D were not different (mean values of 78 and 71 IU), nor were the histories of exposure to sunlight (6.5 and 6.7 arbitrary units in patients with fractures and controls respectively). We agree, however, that the vitamin D status of these elderly people is more strongly correlated with sunlight exposure than with dietary vitamin D intake.³

The Leeds data appear to be compatible with the hypothesis that vitamin D deficiency may contribute to fractured neck of femur in the elderly in Leeds. But we have found no evidence to implicate vitamin D deficiency in the aetiology of this fracture in outer London.

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¹ Wootton, R, et al, *Clinical Science and Molecular Medicine*, 1978, **54**, 28P.

² Wootton, R, et al, *Clinical Science*. In press.

³ Hodkinson, H M, et al, *Journal of Clinical and Experimental Gerontology*. In press.

Hypnosis

SIR,—I would like to take issue with Dr H G Kinnell on his remarks on hypnosis (17 March, p 751).

He says that hypnosis may on occasion be harmful and quotes Dr David Waxman in support of this statement. Dr Waxman is, in fact, one of the leading exponents of hypnotherapy in this country and the fact that he recognises the dangers of the technique simply means that he uses it responsibly, as may be said of any other method of treatment.

Dr Kinnell disparages what he calls clinical anecdotal accounts in support of hypnosis and seems to imply that without controlled trials it is impossible to come to hard-and-fast conclusions about the usefulness of any method of treatment. I submit that if I see a patient, as I have done recently, who has been smoking 50 cigarettes a day for 30 years and who has severe chronic bronchitis and emphysema and if this patient has only consulted me in desperation after all other attempts to give up smoking have failed and if, further, after three short sessions of hypnosis he neither smokes nor wants to smoke, nor suffers any withdrawal symptoms, substitution symptoms, or other ill effect from the treatment, I do not

have to conduct a controlled trial to deduce that I have helped this man to retain what is left of his health. In any case it is untrue to say that properly controlled trials have never shown the value of hypnosis in treatment. The work of Dr Maher-Loughnan has proved the effectiveness of hypnosis in the treatment of asthma.

Lastly, Dr Kinnell states that natural childbirth patients in one study did not differ from untrained patients in estimates of pain intensity. I fail to see what this statement has to do with this thesis as natural childbirth can in no way be equated with hypnosis.

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SIR,—That curious hostility shown by some members of our profession towards hypnosis as a therapeutic tool received its most recent expression in the letter from Dr H G Kinnell (17 March, p 751). Whether he has himself any direct experience in the subject is unclear—at least, no spark of original thought was allowed to break through the solemn procession of old shibboleths derived from work having, presumably, “scientific value” (whatever that may mean).

This old, old route was once traversed by the BMA itself—but that was in the last century, and the overwhelming weight of evidence since that hypnosis offers a method of treatment both unique and effective is today generally accepted. The logical outcome has been a demand, rightly supported by you (7 October, p 978), for instruction and training which (pace Dr Kinnell) is simple, safe, and infinitely rewarding.

I have found (and I am in good company) that hypnosis has a strictly limited role to play in psychotherapy. But there are certain conditions where it is, in my view, the method of choice. The deconditioning of phobic states, some sexual difficulties, and abreactive relief all come to mind.

General practice offers, probably, the widest scope for the deployment of hypnotherapy. Many of the psychosomatic illnesses are particularly susceptible and I have seen excellent results in certain forms of asthma, essential hypertension, and some skin disorders. Again, midwifery with a hypnotically trained mother is a most rewarding experience.

I am only too well aware that the shortage of time poses problems for the busy GP and it cannot be denied that the induction of hypnosis, at least initially, requires an unhurried approach. Still, our dental colleagues seem to manage as they have been quick to realise the benefit to the conscious patient and, above all, children that this technique provides. I am doubtful if time could be better spent than in adding this method of treatment to our therapeutic skills.

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Restrictions on NHS prescribing in Australia

SIR,—Dr Tony Smith's description of the Australian pharmaceutical benefits scheme in “Restrictions on NHS prescribing in Australia” (13 January, p 99) is misleading in several details.

The primary aim of the pharmaceutical benefits scheme is not to keep down costs but

to provide an extensive range of drugs and medicinal preparations on a subsidised basis to all persons being treated by a medical practitioner in Australia. Due regard is given to the quality of the drugs, comparative efficacy and toxicity, and continuity of supply. At the same time the Government does endeavour to achieve maximum value for the taxpayers' money spent under the scheme.

The availability of phenoxymethylpenicillin as a benefit item is not restricted to the prophylaxis of rheumatic fever. Phenoxymethylpenicillin may be prescribed for any appropriate disease or purpose. However, when prescribed for the prophylaxis of recurrent streptococcal infections (including rheumatic fever) larger quantities may be supplied as a benefit than for other purposes.

The Pharmaceutical Benefits Advisory Committee, which recommends the drugs to be available as benefits, bases its deliberations primarily on medical considerations. The committee, when assessing drugs of comparable efficacy and toxicity, may take cognisance of price; but where price is considered it is merely as a secondary consideration.

The committee does not publish the *Australian Prescriber*, which is an independently edited publication financed by the Commonwealth Department of Health.

D DE SOUZA

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SIR,—I refer to the article “Restrictions on NHS prescribing in Australia” (13 January, p 99), in which you refer to *Australian Prescriber* as being published by the Pharmaceutical Benefits Advisory Committee.

The journal is in fact independently edited, and it is the executive editorial board which commissions and approves all material that appears in the journal. Members of the board are chosen for their particular expertise and interest in therapeutic education at the practice level, one member being a general practitioner. Although the journal is financed by the Commonwealth Department of Health and the board is chaired by an officer of the Department, the senior adviser in clinical pharmacology, the board is genuinely independent of the Department and must continue to be so if the journal is to be accepted by the medical profession. An advisory editorial panel also provides an avenue by which the comments, views, and suggestions of all specialist colleges and societies, which are represented on the panel, can reach the executive editorial board.

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Detecting and managing hypertension

SIR,—I read with great interest the paper by Dr D G Beevers and others (17 March, p 715) on the detection and management of hypertension. I was somewhat dismayed to find that there was a difference in the wording used in question 5 of the questionnaire and in the legend to table II. The former read “At what level of diastolic blood pressure would you begin to treat an asymptomatic 50-year-old man for hypertension?” The latter states “Levels . . . at which clinicians said they would begin drug treatment.” I am sure that

the authors do not regard “treatment” and “drug treatment” as synonymous.

In this context it is difficult to better a recent commentary by Ball¹: “A mild hypertensive who stops smoking, reduces dietary fats and total calories, cuts down his salt intake and takes regular physical exercise is likely to improve his outlook much more than if he merely takes a drug to lower his blood pressure. He will certainly feel much better and avoid any side effects. These measures often lead to a fall in blood pressure and the need for drugs disappears.”

I am sure that Dr Beevers and his colleagues need no conversion, but their article has important propaganda points to make for non-specialists in the field. If, as stated in their discussion, there is lack of evidence of benefit from “treatment” of mild hypertension then perhaps the method of treatment is wrong?

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¹ Ball, K P, *Cardiovascular Forum*, 1979, 1, 7.

Neglected indexes

SIR,—During the period between 6 January and 17 March of this year no mention is made in your book reviews of the indexes. On the assumption that your reviewers read the complete work from beginning to end and expect the same from their readers, why is the subject neglected? Furthermore the topic was not mentioned in any of the contributions based on the meeting of the Society of Medical Authors published on 3 February (p 309).

In this no-man's land between publishers and authors where each party often thinks the other should pay for the service, is this an expression of the frequently expressed view that indexes do not sell books?

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Action on alcohol

SIR,—I have been catching up on some back numbers of the *BMJ* and wish to comment on your leader (10 February, p 361) entitled “Action on alcohol.”

Is it not time to admit that our whole approach to the problem of dangerous drugs is little short of insane? Alcohol is probably in truth far more dangerous a drug than heroin, possibly than any other drug of abuse. Apart from the appalling consequences to individual drinkers and the families of alcoholics, the social costs are almost beyond computation. Yet we allow advertising entirely freely. Even worse than the public commercial advertising is the implication which is so general in public entertainments, broadcast plays, and so on that drinking is a normal, acceptable part of life. We have even heard foolish suggestions that the increase of wine consumption in this country is to be approved despite the tragic experience in European countries. We ensure that most of our children will believe the drinking of alcohol to be a desirable part of maturity by tantalising them with alcohol, which is supposed to be kept just out of their reach until they are 18. If our society really did care at all about the appalling damage done by alcohol and the anguish to so many individuals it would utterly prohibit all kinds of advertis-