emphasised. It is hoped that guidance along these lines will soon be issued as a booklet on "Water Supply Hygiene" for water authorities.

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J A RYCROFT

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¹ Brodie, J, *Journal of Hygiene*, 1977, **79**, 161 and 181.
² Ministry of Housing and Local Government, *Safe-
guards to be Adopted in the Operation and Management
of Waterworks*. London, HMSO, 1967.

³ Public Health Laboratory Service, *Journal of Hygiene*.
In press.

⁴ Department of Health and Social Security. *Health
Service Catering. II: Hygiene in Catering and Food
Service Areas*. London, HMSO, 1974.

⁵ Rahman, A F M S, and Cowan, M E, *British Medical
Journal*, 1974, **11**, 121.

IgE, T cells and transfer factor in mycosis fungoides

SIR,—We have studied with great interest the article of Dr P L Amlot and Mr L A Green (11 February, p 327) on atopy and IgE concentrations in Hodgkin's disease (HD) and other lymphomas. The authors state that with one exception no valid study so far has shown any differences in serum IgE concentrations between people with malignant diseases and those without, the one exception being HD. We should like to point out that Tan *et al*¹ in 1974 found an elevated serum IgE in patients with mycosis fungoides (MF), another malignant lymphoma. We would also like to add that we in 1975,² although we were not able to confirm an increased mean IgE value for our patients with MF, found highly elevated values in 4 out of 22 cases. None of these 4 patients were atopic. This clearly indicates that high serum IgE values may also be found in other types of lymphoma.

The distribution of B cells in the peripheral blood of our patients was normal, while the mean percentage of T cells was significantly lower than in controls. We have recently completed a preliminary investigation on transfer factor (TF) as an additional therapeutic agent in MF. Twelve patients in a state of progressive disease were investigated. All but one had previously been in remission induced by topical whole-body treatment with nitrogen mustard. All continued their previous treatment in unchanged dosages but also received monthly injections of TF. Following this combined treatment seven patients improved significantly and two of these went into complete remission. Treatment was followed by an increase in T lymphocytes and a decrease in serum IgE. This decrease in IgE had no relationship to atopy. The differences between the original and latest values were significant ($P < 0.05$).

We believe that the reverse relation between T cells and serum IgE following therapy adds support to the idea of a deficiency of suppressor T cells accounting for the increased IgE levels in some lymphomas, a suggestion dismissed by Dr Amlot and Mr Green. This, however, cannot be proved until an evaluation of the distribution of the various subpopulations of T lymphocytes has been performed. We believe that our own as well as Dr Amlot and

Mr Green's findings may have a bearing on treatment.

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¹ Tan, R S H, *et al*, *British Journal of Dermatology*,
1974, **91**, suppl 10, p 35.

² Zachariae, H, *et al*, *Acta Dermatovenereologica*, 1975,
55, 466.

Needle tracheostomy for acute upper airway obstruction

SIR,—Dr T H Lee (4 February, p 281) described a case in which needle tracheostomy for acute upper airway obstruction led to a successful outcome. A number of points in his case report, however, give rise to disquiet.

From his description the patient concerned was probably suffering from partial rather than total airway obstruction so that the Medicut intravenous cannula contributed to the airway rather than replaced it. While I agree that a needle through the trachea (the cricothyroid membrane is preferable) is a "simple, quick, and relatively atraumatic procedure," the extrapolation of its use from the case described to patients with "pharyngeal foreign bodies, trauma from road traffic accidents, or angio-neurotic oedema" must be viewed with some caution.

The experiments quoted¹ as having shown that the 12G Medicut can sustain ventilation were laboratory experiments and were related to flow rates at quoted pressures. In some preliminary studies we asked volunteers to breathe through a 12G Medicut cannula attached to a pneumotachograph and with a pressure transducer measuring airway pressures. Two minutes was the most any volunteer could manage, although this was extended to three minutes when the Medicut was halved in length. Tidal volumes recorded were from 100 to 150 ml but rapidly became less as the respiratory rate increased.

These were only preliminary findings and should not be regarded as conclusive, but I believe that the place of needle tracheostomy must be viewed with some caution. A 12G Medicut cannula does not provide an airway. It may buy a few extra minutes in patients with total obstruction and was clearly a great help in Dr Lee's patient with partial obstruction. It can also be used for insufflating oxygen when appropriate apparatus is available. Nevertheless, severe upper airway obstruction needs more than such temporary management and, in the present state of knowledge of needle tracheostomy, this can be provided only by endotracheal intubation, emergency laryngostomy, or emergency tracheostomy. To delay the institution of one of these remedies in favour of needle tracheostomy is to court disaster.

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¹ Clarke, S W, and Cochrane, G M, *Practitioner*, 1975,
215, 340.

SIR,—May I give my support to Mrs Rosemary H M Adams and Dr R H Hardy (4 March, p 576) in their advocacy of laryng-

ostomy or cricothyrotomy in preference to emergency tracheostomy or the insertion of a needle-borne cannula through the cricothyroid membrane as described by Dr T H Lee (4 February, p 281)? Mrs Adams mentions the Abelson cricothyrotomy cannula as "the instrument available," but I would suggest that a better choice might be the British-made Penlon Tracheotome Mark II, which, despite its misleading name, is a thoughtfully designed, autoclavable instrument for penetration and cannulation of the cricothyroid membrane, combining piercing blade, trocar, and dilator all in one. In addition, it incorporates an adjustable "swing-stop" rest and a fixed penetration guard. It is thus more positive during initial placement and is unlikely to wander from the piercing location during complete introduction. The metal-boxed set includes a 7.5-mm cuffed tracheostomy tube and connector, a Mitchell cuff inflator, and even a small tube of lubricant jelly.

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All doctors great and small

SIR,—It is heartening to those workers in the animal health and public health fields to see zoonoses again featured in your leading article (25 February, p 464). Heartening but not surprising, for the effect of zoonotic diseases on human health merits a good deal of your time and space. Your call for greater collaboration between the medical and veterinary professions is justified, for there is so much to do and we can all do better.

However, in praising the work the Scottish doctors and veterinarians who have operated liaison meetings for a number of years and who have excellent collaborative work to show for it you do less than justice to the English scene when you say that no such local group exists in England.

It can safely be said that the initiating group was that involving the Public Health Laboratory Service and the State Veterinary Service in England, which has been in operation for some 16 years. More recently it has included representatives from the Department of Health and Social Security and is known as the Zoonoses Group. This group has always been a valuable forum for developments in meat hygiene and salmonella control and it conceived the Zoonoses Order. Since that order was promulgated in 1975 attempts have been made to replicate the group at local level throughout Great Britain so that the beneficial collaboration in the central group could be developed by officers faced with the practical problems. They are not decision-making bodies concerned with case work but regular gatherings of medical officers of environmental health, representatives of the Public Health Laboratory Service, environmental health officers, and state veterinarians discussing matters of common interest. Because 80% of food poisoning cases are caused by salmonellae and the vast majority of these have an animal source it would seem obvious that consultation with the veterinarian with public health responsibilities would be beneficial, indeed essential, to the investigation and control of food poisoning occurrences. So it is that most of the local groups are operating successfully with enthusiastic support from all disciplines

and none more so than those in Scotland. There are still a few areas in England and Wales in which local officials have not been fully convinced of the benefits of liaison and collaboration, but enlightenment continues to spread and needs to be nurtured.

The Zoonoses Order has been effective in bringing attention to bear on a number of problems, identifying sources of infection and means of spread which have been followed by successful control measures. However, it lacks its companion order, the proposed Protein Processing Order, which is held up by administrative problems. When that is available it can be expected to reduce markedly the recycling of salmonellae in animal feeds and, that achieved, the livestock industries will be able to tackle more easily the vertical perpetuation of infections in their animals.

The State Veterinary Service is pleased to see the development of the Communicable Disease Surveillance Centre in the Public Health Laboratory Service, and excellent liaison exists between that centre and the epidemiology unit at the Central Veterinary Laboratory and the headquarters of the SVS. The scope for collaborative efforts is immense and the most satisfying aspect is that it is well recognised by the heads of services concerned. The same can be said of the Scottish counterparts. There has been a small amount of secondment of staff between the disciplines to the mutual benefit of both, and more exchanges of this kind are likely in the future. Thus at central medicoveterinary level the problems of the food-borne zoonoses are well understood and collaboration is good.

The position with regard to the zoonoses of companion animals is not so well advanced, and, as you rightly point out, there is much need for co-operation between the two professions. Nevertheless, the veterinary profession is very conscious of the part it has to play in furthering responsible pet ownership and we feel sure that it will be receptive to any proposals for a joint campaign.

E LOWES

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Alcoholism treatment centres

SIR,—Dr Julius Merry performs a useful service (21 January, p 161) in describing the detailed workings of an alcoholism treatment centre (ATC). However, the crying need in the specialist treatment unit field today is to evaluate properly the effectiveness of these expensive units. For example, the costly coronary care units are now coming under scrutiny, as it is realised from controlled trials that they may make no difference to mortality.¹ Likewise ATC beds are much more costly than mental hospital beds, but randomised comparisons are practically non-existent. Yet Dr Merry fails even to mention controls in his section on treatment evaluation: his figures for improvement, based on a highly selected patient intake, are not appreciably better than have been quoted for spontaneous remission in some studies.²

Again, he does not define the criteria for gauging improvement: how objective were these? Did he use blind assessors of change in clinical status or did his therapists judge the value of their own work? If such preconditions

for adequate monitoring have not been observed we are no farther forward than Glatt's 1955 uncontrolled study³ which gave the impetus to the development of the ATC concept. This is surely not an area in which it is satisfactory to use the patient as his own control.

What evidence there is—for example, the recent work from the Institute of Psychiatry⁴ or the Rand Corporation study⁵—suggests that inpatient treatment in an ATC is not really any better than no treatment at all. Indeed, why should it be, when the typical psychotherapeutic approach, whether applied on an individual, group, or family basis, is not of proved scientific value in any other sphere in psychiatry?⁶

Dr Merry asserts, without providing evidence, that psychotropic medication would be antitherapeutic in his programme. His proscription of organic treatment may well be doing a disservice⁷ to the vulnerable patients under his care, whom he acknowledges may have other psychiatric illnesses.

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¹ Mather, H G, *et al*, *British Medical Journal*, 1971, **3**, 334.

² Emrick, C D, *Journal of Studies in Alcohol*, 1975, **36**, 88.

³ Glatt, M M, *British Journal of Addiction*, 1955, **52**, 55.

⁴ Edwards, G, *et al*, *Journal of Studies in Alcohol*, 1977, **38**, 1004.

⁵ Armor, D J, Polich, J M, and Stambul, H B, *Alcoholism and Treatment*. National Institute of Alcohol Abuse and Alcoholism, Santa Monica, California, Rand Corporation, 1976.

⁶ Rachman, S, *The Effects of Psychotherapy*. Oxford, Pergamon, 1971.

⁷ Kinnell, H G, *British Medical Journal*, 1977, **2**, 1479.

* * * We sent a copy of this letter to Dr Merry, whose reply is printed below.—ED, *BMJ*.

SIR,—I like Dr Kinnell's style. In his opening sentence he says that my paper "performs a useful service" and then spends the rest of his letter in wholesale condemnation.

In fact, the primary purpose of the paper was to describe the treatment programme. There was no scientific pretension about the evaluation because I am very conscious of the great difficulty or even impossibility of constructing an evaluation design to satisfy strictly scientific criteria. There is the problem of definition of alcoholism. There is the problem of underlying psychiatric conditions and of numerous other variables impossible or difficult to match.

Since he is so intent on the scientific method Dr Kinnell surprises me with statements for which he has no evidence. He asserts that my patients are "highly selected," whereas in fact we reject less than 2% of patients seen for assessment. He accuses me of doing a disservice to patients by proscribing organic treatment. What we proscribe are tranquillisers and hypnotics (for reasons stated), but we do in fact use electric convulsion therapy, antidepressant drugs, and lithium in appropriate cases because there is some evidence of therapeutic advantage. I did state, "We do recognise that there will be patients who cannot cope without tranquillisers, hypnotics, and alcohol," but this is a situation of compromise and probably therapeutic defeat.

I am amused by Dr Kinnell's unscientific comments about evidence which he approves and which "suggests that inpatient treatment in an ATC is not really any better than no treatment at all" (his scientific words and my italics). With regard to cost, ATC beds are

more costly than mental hospital beds. But they are no more costly than the other psychiatric beds in a district general hospital.

Finally, Dr Kinnell and I are really discussing philosophies of treatment. Our treatment is designed to help patients in the community. For example, we are not only treating the patients in the unit, but we are helping the long- and medium-stay patients in the psychiatric hospital through the service provided by our patients. Through this approach we are also giving relief to the overburdened nurses caring for the long- and medium-stay patients. We also relieve and support partners and families of the inpatients. Thus we are not concerned only with mortality and morbidity, but we recognise that sooner or later patients will suffer from chronic and relapsing illnesses. I believe that as well as being concerned with mortality and morbidity a very important role for the doctor is to limit suffering and probably more importantly to help the patient and his family cope with his illness. This is what we are attempting with our alcoholism service.

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Topical glucocorticosteroids for psoriasis

SIR,—For some years publicity has been given to the side effects of strong topical glucocorticosteroids.^{1,2} In particular, efforts have been made to discourage their prescription in psoriasis, where the chronic nature of the disease is especially likely to lead to prolonged usage and hence skin atrophy. In any case corticosteroids are not particularly effective and there are effective alternative remedies.³ Despite this you have published a colour advertisement promoting the use for psoriasis of one of the strongest topical glucocorticosteroids (3 December, facing p 1479). Not only does this advertisement promote a therapy which we know to be generally unacceptable, it also makes claims which are to our knowledge totally without justification (that it is safe if less than 50 g per week are used and that it induces prolonged remissions). This advertisement does a great disservice and should be withdrawn.

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¹ *Lancet*, 1977, **2**, 487.

² *British Medical Journal*, 1977, **1**, 988.

³ Seville, R H, *Practitioner*, 1977, **219**, 833.

* * * The authors sent a copy of this letter to the medical department of the company whose advertisement they criticise. Their reply is printed below.—ED, *BMJ*.

SIR,—In their criticism of the three-month-old advertisement for Dermovate (clobetasol propionate), Dr Finlay¹ and his colleagues have misrepresented the tenor of its text by