dramatic cures are in warts that are recent in their appearance and have not been treated by a multitude of other methods. This observation would support Lyell's thesis (referred to in the leading article) that inadequate treatment is worse than no treatment at all.

Anyone contemplating using liquid nitrogen for warts is advised first to read the article on "Cryosurgery of benign and premalignant cutaneous lesions," in Zacarian's textbook.¹

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¹ Zacarian, S A, *Cryosurgical Advances in Dermatology and Tumours of the Head and Neck*. Springfield, Illinois, Thomas, 1977.

SIR,—I was delighted with your leading article "Throwing off warts" (19 August, p 521) and I would like to add two points.

I suspect that the efficiency or otherwise of many dermatology departments in peripheral hospitals is balanced on the number of patients referred with warts. Individually they are time-consuming and demanding of treatments which are expensive in manpower. If the "wart list" is completely ignored there is always the risk of a significant disease being missed. It would be valuable if the Department of Health and Social Security were to organise a survey, including epidemiology, treatment evaluation, and public education, aimed to reduce the demand for treatment of warts at hospitals.

Secondly, I have the impression that many patients with persistent warts are atopic. Of four adults with warts seen by me last week, one was a known case of sarcoidosis, two gave a history of asthma in one parent, and only one had no relevant personal or family history. Perhaps atopy is one reason why some apparently healthy people "differ immunologically from the rest of the population" in relation to the wart virus.

RODERICK HOWELL

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Rubella immunisation

SIR,—A sad consequence of the present rubella epidemic is the increase in the number of cases during pregnancy (12 August, p 504) and the tragic termination of originally wanted pregnancies. The detection and immunisation of non-immune women of child-bearing age and the personnel who care for them (8 July, p 127; 12 August, p 504) undoubtedly should continue. However, could it not be avoided in future years if all children, both boys and girls, were to be offered the vaccine in their early teens? In this way perhaps a more effective level of immunity in the community could be obtained. There may be sound medical and ethical reasons for the present DHSS recommendation to immunise girls only, but in the light of recent events are they still tenable?

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Tardive dyskinesia treatment with DEA

SIR,—Recent interest in tardive dyskinesia and encouraging results in Canada¹ on treatment with dihydrogenated ergot alkaloids (DEA, Hydergine), prompted a pilot study on six patients who had been on long-term phenothiazines. They were each given DEA 4.5 mg daily and observed over six weeks.

We found that all responded within two to four weeks, and by six weeks one had lost all symptoms of tardive dyskinesia and the others had mild symptoms only. We are proceeding with a placebo phase after active treatment and will go on to a more extended study. There have been suggestions that tardive dyskinesia is associated with disturbed dopamine activity in the striatum, and DEA may work either by correcting this directly or by improving the metabolism of cells in the area by increased oxygenation.

J HAJIOFF

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¹ Gomez, E, *Psychiatric Journal of the University of Ottawa*, 1971, 2, 67.

Preinjection skin swabbing

SIR,—I was very sorry to read (15 July, p 191) that your expert still recommends swabbing of the skin before injection. As is pointed out in his reply, sterilisation is impossible and even were it practicable it is of doubtful consequence.

Unfortunately, your expert does not seem to be aware of the demonstration of the lack of need for routine skin preparation before injection which I have now made in three different medical journals.¹⁻³ Many doctors already forego skin preparation as a routine in their patients whether they are diabetic or not. In fact, it used to be well known that Dr R D Lawrence, the leading diabetic specialist, used to inject himself through his trouser leg without any untoward effect. It really is high time that the profession gave up this obsolete procedure. Incidentally, should any doctor be brought before the courts for neglecting skin preparation before injection I should be delighted to come to his defence and to help rid the medical and nursing professions of an outmoded bogey.

T C DANN

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¹ Dann, T C, *Practitioner*, 1966, 192, 546.
² Dann, T C, *British Medical Journal*, 1968, 3, 250.
³ Dann, T C, *Lancet*, 1969, 2, 96.

New consultant contract

SIR,—I write to thank Dr F Hampson for his letter (19 August, p 573) referring to the possible adverse effects the new contract could have on the relative position of consultant pathologists. The fears he expresses have been voiced by many others and the Consulting Pathologists' Group Committee is well aware of them and has been in constant contact with Mr David Bolt on the subject.

As we see the matter at the moment, theoretically if the basic 10 sessions are properly priced then pathologists will retain parity. We understand that the contract will not be recommended to the profession unless this basic pricing is acceptable. It is therefore only in the matter of additional sessions that there could be a cause for worry. It is obviously essential that the cost of the additional sessions in general should not adversely affect the pricing of the basic contract and we hope we can leave this to the good sense of our negotiating subcommittee. Given this situation, pathologists should be able to put forward claims for extra sessions on the basis of extra administrative responsibility, holiday

cover, excessive work load, and on-call duties, and with regard to the latter pathologists have been advised to organise themselves into regular rotas for on-call duties if they are at the moment undertaking duties of this type.

There are, however, far more worrying aspects which could well affect the functioning of the new contract, and the profession should be made aware of this and take action to oppose them. For instance, it would appear from recent legislation that possibly not only may pathologists have their entitlement to category II fees drastically reduced but they may also find their services sold by health authorities to local nursing homes and thus their participation in private pathology work pre-empted. In such circumstances the new contract will have little meaning for pathologists and the principle that the Government can dispose of the work of consultants for gain by selling their professional opinions to a third party needs to be totally rejected.

We hope that the profession will remain united and that any action the BMA takes will be based only on the sure knowledge that it will be beneficial to all members. It would be too easy to allow small groups to fall behind in attempts to improve the position, at least temporarily, of the majority. However, we can state categorically that, certainly since 1973, so far as pathologists are concerned there has been no evidence of this whatsoever. Our proposals have always been most carefully and sympathetically considered and the BMA negotiators have always striven valiantly on our behalf. I am sure they will do this in the future.

G S ANDREWS

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Consulting Pathologists' Group,
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Administrative NHDs

SIR,—The proposed new consultant contract allows for the payment of additional administrative notional half-days (NHDs) to the one incorporated in the standard contract. These might, for example, be appropriate in the larger psychiatric hospitals.

The consultant who undertakes not to engage in private practice, however, may well have time to bring more to these sessions; would it not therefore be better if they were normally reserved for the fourth or fifth optional additional NHDs?

T L PILKINGTON

Stockton on Tees,
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Honorary retirement contracts

SIR,—I should like to comment on some of the points made by Dr S T H Jenkins (12 August, p 505) as they affect Gwynedd.

My authority, with the support (not the opposition) of its medical advisory committees, has recently reaffirmed its policy of granting consultants, on retirement, the title of consultant emeritus, the term "emeritus" being defined in the *Concise Oxford Dictionary* as "honourably discharged from service." In order that the person concerned may retain links with the hospitals and other institutions in which he has worked