Further investigation has shown that the incorrect Reflomat result may have resulted from inserting the Reflomat strip into the machine upside down, which can give spurious readings up to 4.0 mmol/l. Incorrect insertion of the strip is, of course, more likely when testing for hypoglycaemia since the test surface fails to show significant colour change in this situation. This problem does not appear to be significant with the more recently available Reflotest-Hypoglycémie strips, though false results may occur if either of the strips is not fully inserted into the machine.

Although all laboratory results should be interpreted in the context of the clinical findings, we should like to alert your readers to this potential cause of error and suggest that the manufacturers alter the colour of the blank reverse side of the strip to obviate this risk.

We should like to emphasise, however, that provided that the instructions are followed and the strips used correctly the Reflomat method has proved reproducible, accurate, and reliable.

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*The authors sent a copy of this letter to the Boehringer Corporation, whose reply is printed below.—Ed, *BMJ*.

SIR,—The Reflomat and Reflotest system was designed to be simple and reliable to operate both in the laboratory and in the hands of the appropriate staff throughout the hospital, and thus Boehringer Mannheim and the Boehringer Corporation (London) regret that this mishap has occurred.

We have not been able to reproduce the results reported since using the standard Reflotest strip upside down in the instrument gives a low (virtually zero) reading on the scale and not a higher result as indicated in the letter. Thus inserting the strip upside down cannot lead to overlooking a possible hypoglycaemia. The only way that we feel this result could have occurred is by inadvertently reading a Reflotest-Hypoglycémie strip by means of the normal black Reflotest scale instead of the correct Reflotest-Hypoglycémie scale, which is coloured grey. Our tests showed that if this occurred with a sample containing 0.6 mmol/l a result of 4.2 mmol/l (75.7 mg/100 ml) could be erroneously obtained.

At present normal Reflotest scales are coloured black and Reflotest-Hypoglycémie scales are grey with a corresponding grey marking on the Reflotest-Hypoglycémie strips. Reflotest-Glucose strips do not at present have any colouring on the reverse side. While we are sure that even the best possible system cannot exclude human error, we are always eager to improve the safety and quality of our products and therefore take this letter seriously. Accordingly, future batches will be redesigned so that the labels of both types of strip are different and the possibility of producing a coloured reverse side to the Reflotest-Glucose strip will be investigated.

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Erythema chronicum migrans in Britain

SIR,—Further to your recent leading article "Ticks, tourists, and encephalitis" (26 August, p 587), we would like to report six cases of erythema chronicum migrans (ECM) seen in that area of East Anglia served by the Cambridge department of dermatology in the past three years. ECM is a clinically distinctive variant of the rather heterogeneous group of annular erythemas but its aetiology remains obscure, although it is generally considered to be due to a tick-borne non-bacterial infectious agent. Until recently cases of ECM originating outside Scandinavia and certain other parts of Europe were rare and most European reports incriminate the tick *Ixodes ricinus* as vector.

All the patients, four of whom were male adults, gave similar histories. An irritable primary reaction would be followed by the appearance of an erythematous, slightly indurated ring which slowly extended with central clearing over successive months until they sought treatment. The width of the erythematous band at the time of examination was approximately 2 cm and the diameter of the largest of the rings was about 75 cm. Clearance occurred within a few days of starting a course of oral penicillin. Little or no systemic upset was reported by our patients, although one had a penicillin reaction. Routine blood counts were normal and no elevation of Weil-Felix titres was detected. Biopsy was performed on one lesion and a mild perivascular lymphocytic infiltrate was seen in the mid-dermis.

Rickettsiae, spirochaetes, and viruses have all at times been incriminated as infecting organisms and perhaps the speed of resolution following treatment with penicillin, erythromycin, or tetracycline might favour a rickettsial infection.

While most of our patients felt they had been bitten by an insect, none considered it had been a tick. Four cases came from the region of the Thetford Forest, where ticks reputedly exist, and one patient was bitten by something while walking in the forest. Another case has been reported from south-east Scotland.¹

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¹ Obasi, O E, *British Journal of Dermatology*, 1977, 97, 459.

Ingrowing toenails in infancy

SIR,—I agree with Mr F B Bailie and Mr D M Evans (9 September, p 737) that ingrowing toenail certainly occurs in infants but is uncommon. In my experience the usual cause in an infant is unduly prominent skin at the extreme tip of the big toe forming an anterior nail fold which encourages ingrowing and prevents the free end of the big toe nail growing normally; the condition may sometimes be genetically determined. I wonder, in fact, whether this was the cause in the first of the cases reported by Mr Bailie and Mr Evans.

The figure shown illustrates the right big toe nail ingrowing and the anterior nail fold in a boy aged 9 months. The condition was asymptomatic until he started wearing shoes around the age of 18 months, when the lateral and medial nail folds became inflamed. However, he is now 2 years 8 months old and, although the nail remains ingrown, he is not troubled at all because he wears wide-toed shoes. In addition, over the past six months or

Right big toe with prominent anterior nail fold in male infant aged 9 months.

so the skin at the toe tip has ceased to overhang and looks normal. In this particular infant the big toe nail has never required trimming because it grows very slowly. The left big toe and nail are normal. The boy's father has had long-standing trouble with an ingrowing big toe nail which has occurred despite avulsion of the toe nail on two occasions in his teens.

As a general rule, surgery should be avoided both because of the likelihood of recurrence and because some cases do improve spontaneously. Pressure trauma to the skin around the nail must be minimised and topical antiseptics/antibiotics may be required for paronychia.

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Health of King Henry VIII

SIR,—May we acknowledge the reply of Dr R J Hetherington (30 September, p 956) which, in part, indicates the reports in *The Complete Peerage* of the hearsay evidence of an illegitimate son, Henry Carey, not recognised by the King during his lifetime? Notwithstanding the retrospective reports of the hearsay evidence, one illegitimate birth, where fathering, putative or not, is attributed to the King, does not significantly affect the total of surviving births (two females and two males after multiple partners) over the long period of 38 years (2 September, p 700). Against which matters of undoubted fact we may now balance and weigh by other criteria the evidence of a contemporary, independent informant who secretly communicates for posterity at the risk of his life on dangerous matters without possibility of any benefit or reward during his lifetime.¹ May we offer an opinion that Hans Holbein, the informant, appears to have made his point on the underlying "genetic impediment" of the King? The artist's comment is relevant.

We hope that Dr Hetherington will consider