In addition, a recent study⁴ of testicular morphology in boys treated for acute lymphoblastic leukaemia (ALL) with combination chemotherapy found no evidence of a relationship between the degree of tubular damage and the age at which the subject first received cytotoxic therapy. Therefore the prepubertal testis would appear to be just as vulnerable to cytotoxic damage as the pubertal testis.

Finally, it is true that we observed⁵ depressed ovarian function in a proportion of girls previously treated for ALL with combination chemotherapy. However, the evidence indicated direct damage to the ovaries due to the chemotherapy rather than as a consequence of radiation-induced hypothalamic-pituitary damage.

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¹ Pennisi, A J, Grushkin, C M, and Lieberman, E, *American Journal of Diseases of Children*, 1975, **129**, 315.

² Sherins, R J, Olweny, C L M, and Ziegler, J L, *New England Journal of Medicine*, 1978, **299**, 12.

³ Shalet, S M, et al, *Clinical Endocrinology*. In press.

⁴ Lendon, M, et al, *Lancet*, 1978, **2**, 439.

⁵ Shalet, S M, et al, *Journal of Pediatrics*, 1977, **90**, 920.

Normality and abnormality in psychiatry

SIR,—Professor Geoffrey Rose and Dr D J P Barker (23 September, p 873) have reminded us of a major difficulty in medicine—the differentiation of abnormality from normality. The operational definition of abnormality mostly adopted by psychiatrists embraces its statistical, clinical, and prognostic aspects. There are no tables of “normal” ranges of the quality, severity, and duration of psychic reactions, but each psychiatrist acquires a measure of these by experience. This is necessarily a subjective process. It is influenced by our concepts of mental illness, themselves dependent on our culture, subculture, personal experiences, and training. Those who treat the whole spectrum of illness become more tolerant of milder psychic reactions, and may regard them as normal. In keeping with this, it was shown that medical doctors rate psychiatric patients as less sick than do other professional groups.¹

We may also be influenced by the country where we receive our psychiatric training. Psychiatrists trained in Britain, for instance, see less pathology than those trained in the United States.² Similar Anglo-American differences in measures of psychiatric morbidity were also shown during the course of an epidemiological study in New York.³ The degree of subjectivity that enters our recognition of abnormality can be minimised by standardising the criteria for its recognition, being aware of those factors that influence our measures, and training. High levels of agreement on the recognition of specific abnormalities, such as schizophrenia,⁴ and high levels of inter-rater reliability in the use of rating scales can be achieved.

Not all those who react abnormally in the statistical sense have psychiatric disorders. Clinical and prognostic factors also have to be considered. These include the suffering caused to the individual and society. Because of our medical training we attach considerable importance to organic abnormalities and the

response to treatment. The debate as to whether antisocial personality disorders should be treated by psychiatrists would come to an abrupt end if in psychopaths a consistent physical abnormality were discovered or if a new drug capable of converting them into well-adjusted citizens were synthesised. The bandwagon would be filled with all disciplines making their territorial claims and curing as many psychopaths as possible. At present only a handful of devoted doctors treat these individuals and we all pass the buck in their direction.

As psychiatrists we should give more thought to the concepts of normality and abnormality for clinical reasons as well as research. Unless we do this some abnormal people may be neglected medically, while others will only have to enter our office and they will become converted from people to patients. As a result, medical treatment may be prescribed for non-medical conditions, and people will be exposed to the unnecessary risk of iatrogenic disease.

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¹ Copeland, J R M, et al, *Psychological Medicine*, 1975, **5**, 89.

² Katz, M M, et al, *American Journal of Psychiatry*, 1969, **125**, 937.

³ Edwards, J G, *Mental Health and Society*, 1977, **4**, 126.

⁴ Wing, J K, et al, *British Journal of Psychiatry*, 1967, **113**, 499.

Drug treatment of psychiatric patients in general practice

SIR,—The article by Dr P Tyrer on the drug treatment of psychiatric patients in general practice (7 October, p 1008) arrives at conclusions which cannot be justified by the study.

It is always difficult to perform research of this nature when the observer is also a participant in the consultative process. Dr Tyrer's observations took place over a period of four years and in that time he must have had patients referred to him by general practitioners whose knowledge of pharmacology had been found wanting on the evidence of a previous referral. Did Dr Tyrer seek, ever so diplomatically, to remedy that defect in his correspondence arising from the first consultation, as one would expect from a specialist whose advice had been sought, or did he allow the general practitioner to labour on in ignorance so that the scientific validity of the study was unimpaired?

There are several statements in the article which will not meet with universal agreement. For example, he defines a regular daily dose of 50 mg amitriptyline as being too low, yet I have under my care a patient on this dose and the laboratory reports a therapeutic blood level of nortriptyline. The major flaw, however, is that he attempts to generalise on psychiatric prescribing in the world of general practice, not by going into that world but by surveying it from the narrow keyhole in the door of his outpatient clinic. Two hundred and eighty-seven patients in four years represents only a fraction of the psychiatric morbidity in a population of 120 000. He has no idea how many patients in Southampton have received excellent treatment from their general practitioners for psychiatric illness and achieved a complete cure without coming near him. He makes the assumption that he is seeing a representative sample, but it is an equally

tenable assumption that the patients he sees are referred because they are not getting better because their treatment is inadequate. His sample is highly biased towards providing the sort of statistics he obviously set out to achieve when he embarked on the study. General practice research should be done in general practice or not at all.

In his discussion of the results Dr Tyrer suggests that the seductive advertising of the pharmaceutical companies is partially to blame for bad prescribing. General practitioners are used to the pressure of advertising and I would be surprised if it is as influential as he thinks. We are very susceptible to the views of our academic specialist colleagues and I find it disturbing that at least one eminent consultant has been associated with the advertising campaigns of three separate psychotropic drugs.

IAN H MCKEE

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SIR,—Dr Peter Tyrer (7 October, p 1008) criticises GPs for misuse of psychotropic drugs in the patients they refer to his psychiatric outpatients. He bases his criticism on his own diagnosis of the patients referred and his knowledge of the pharmacology of the drugs used by the GP. But pharmacology is only one part, and on occasions a small part, of the effect a drug has on a patient. One needs to know who first prescribed it, what the patient thought it was for, what he now thinks it is doing, and above all in what climate of transaction it is being prescribed.

Often patients cling on to various drugs as a token of the doctor's concern, and this concern may be more potent than the pharmacological effects of (for example) a small dose of amitriptyline which we may give them. It is, of course, our duty to try to cut this down and to be aware of the pharmacology of the drugs we use, but Dr Tyrer should understand that general practice involves frequent brief encounters between doctor and patient. With luck we may be able to develop a relationship which is useful. Until this happens, and often it never is, it is common for prescriptions to be given as a token of our wish to do something better for them in time. To dismiss this as useless placebo prescribing is to ignore the subtle and strong individual associations which patients have with their chosen drug, of whatever colour, shape, or size, often prescribed by a previous psychiatrist who has failed to help them.

It is disturbing that a psychiatrist should write an article which so completely ignores the human factors in medicine, and all the tensions between doctor and patient which surround their transaction. Perhaps he should spend a little time in general practice to see why patients really take drugs. He might learn a few healthy self-doubts about his own prescribing, instead of criticising his GP colleagues from afar.

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Preventing deaths from malaria

SIR,—In their letter (21 October, p 1158), Drs W D Mackenzie and P J C Chapman rightly take credit on behalf of British Airways and British Caledonian Airways respectively for their in-flight announcements concerning malarial risk. Better late than never, but a

recent personal experience casts doubt on the effectiveness of such belated advice.

When the usual—and commendably accurate—announcement was made on a BA flight approaching Colombo, the young couple sitting alongside me expressed fleeting concern, followed by incredulity. After all, they reassured each other, their (package deal) travel agents had assured them that there was no malaria in Sri Lanka and no need to take any precautions. I did not mince my words of urgent advice, and felt more than justified only a few days later when I joined a seminar at the bedside of a man in the terminal stages of cerebral malaria contracted in the very area to which my travelling companions were proceeding.

In this case the anonymous travel agent had not only failed to provide information; he had given serious misinformation. Perhaps the responsible travel agents require protection from negligent competitors? Surely there is no alternative to requiring all booking agents by law to give adequate and timely advice to their customers.

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Trouble with children's feet

SIR,—I was most interested to read the views of Dr Julian Verbov (30 September, p 962) on atopic dermatitis of the forefoot in children and have also seen cases since the 'sixties or even earlier. It seems to be getting commoner, but awareness of a disease does, of course, send up the incidence by leaps and bounds. I did not see, or at any rate did not recognise, the condition in infancy and my patients were aged between 5 and 12. At this time of life wear and tear on the feet are prodigious and the feet are growing so that the shoe never has a chance to mould itself to the foot. I came to the conclusion that this was probably one of many causes of dermatitis of the feet in children and that it did not persist after the feet had stopped growing.

Since I retired I have been able to confirm that for strenuous walking one needs shoes or boots that are well run in and preferably those at least 10 years old.

H T H WILSON

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SIR,—I have followed with interest the recent article and correspondence on ingrowing toenails (9 September, p 737; 14 October, p 1087) and atopic dermatitis of the forefoot (30 September, p 962) in infants and believe I know the cause of this.

It has become increasingly fashionable to encase babies in a garment of the "Baby-Gro" type which is open at neck and wrists and continues down into closed channels which enclose and constrict the infant's feet. Some 15 years ago manufacturers of baby clothes did realise that there is not a British Standard baby and trousers were left open at the ankle to allow for different leg lengths, the feet being covered with booties—this is not the case now. The current garments are advertised as being able "to grow with your baby." Babies are expensive, so it is natural that this represents an appealing economy to many mothers.

I submit that this argument is wrong. I have never seen ingrowing toenails in persons of an age to wear shoes (and socks) who can actively

adduct their great toes. For a time I (who can adduct my big toes) wore support tights and often put them on wrongly—that is, stretching them up over my legs with my feet plantar-flexed when they should be put on with the foot held firmly at right angles to the leg. As a result I couldn't move my toes as I used to and I started to develop ingrowing toenails.

Babies kick—but this is a movement more associated with cycling than football. Seeing a baby trying to stretch its legs and feet in a constricting (though admittedly stretching) garment such as I have described will be self-explanatory. Some pedal with the ball of their foot—these may well develop atopic dermatitis of the forefoot; some point their toes—these run a risk of getting ingrowing toenails.

Prevention is simple: a pair of scissors to cut the "feet" off the constricting garment and insistence that baby's clothes are washed in either Persil or soap flakes.

SHONA BIRD

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SIR,—I agree with the statement of Mr F B Bailie and Mr D M Evans that ingrowing toenails are uncommon in infancy (9 September, p 737). However, I would question their implication that paronychia in this age group requires avulsion of the nail in the first instance as a conservative step. I recently saw a patient with similar features to their first case.

A 6-week-old boy was referred with inflammation of the lateral nail fold of the left big toe but without suppuration. The nails of both big toes were flat, with the lateral borders covered by the nailfold as seen with typical ingrowing toenails. Nystatin cream was applied twice a day for 10 days with complete resolution.

Commonly low-grade non-suppurating paronychia is due to fungal infections and can be treated by appropriate topical preparations. I would encourage such an approach initially before resorting to the "conservative" operation of avulsion of the nail.

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SIR,—In growing toe nails in infant boys are not uncommon (9 September, p 737; 14 October, p 1087). Occasionally, infants of either sex are born with ingrowing toe nails. At this hospital Miss I Irving and Dr A Pierce have taught me that affected infants frequently have chronic monilial paronychia, and these cases usually respond to the application of nystatin cream. However, surgery does have a role to play in persistent cases.

During the last two years I have operated on three boys, two with ingrowing nails of both great toes. At the time of surgery one infant was aged 5 months and had had symptoms for over three months, another was 2 years old and had had granulation tissue about all four nail folds since the age of 2 months, and the third was aged 3 years and had had symptoms for over two years. These cases respond to simple excision of the granulation tissue along with a margin of healthy skin, the nail remaining intact and the wound being left to heal without sutures. The raw area epithelialises within three weeks at most. I performed this "operation" in one older girl, and to my astonishment the wound was healed the follow-

ing morning, the dressing having been removed in error. I have performed this simple procedure in 22 cases and symptoms were relieved in all but one. The cosmetic result is highly satisfactory, but it is important that the parents and older children should be taught the correct method for trimming the toenails.¹

Except perhaps for onychogryphosis, avulsion of the toenail is an illogical and obsolete operation with a very high recurrence rate. Indeed, the new nail frequently "ingrows" on both sides, whereas the original nail often "ingrew" on only one side of the toe. The abandonment of this ridiculous procedure is long overdue.

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¹ Bailey, H, *Demonstrations of Physical Signs in Clinical Surgery*, 13th edn, p 774. Bristol, John Wright and Sons, 1960.

SIR,—We were interested in the short report on ingrowing toe nails in infancy (9 September, p 737) by Mr F B Bailie and Mr D M Evans. The accident and emergency department in the Nottingham General Hospital, in close liaison with the chiropody department, has undertaken a prospective and retrospective study in the aetiology, pathology, and management of ingrowing toe nails, which it is hoped will be published shortly.

In the year 1977 we have seen 12 children at ages up to 5 years. The youngest was a 10-day-old boy, whose brother at the age of 2 months also suffered from ingrowing toe nails. We do agree that there must be a factor of inheritance in these cases—probably in all cases, no matter at what age they present to us. We will be able to comment on the factor of inheritance in a later report, once we have completed our studies. We believe that a conservative line of management¹ is more satisfactory in younger patients and phenolisation in older patients.

The convex cutting of nail as the cause² does not seem to be the factor in any one of these cases. We have specifically asked parents in our follow-up clinics. It seems that inherited architecture, as suggested by Lathrop,³ may be playing an important part in the causation of the condition. The shape of the toe and the curvature of the nail are probably determined by inheritance and made worse by acquired factors like shoes, socks, and nail-cutting habits. The children we have seen did not wear high heels or narrow shoes for any length of time.

I am grateful to Mr E R Dumble, sector chiropodist, for his help in this study.

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¹ Lloyd-Davies, R W, and Brill, G C, *British Journal of Surgery*, 1963, **50**, 592.

² Orr, C M S, and Photin, S, *Hospital Update*, 1977, **3**, 465.

³ Lathrop, R G, *Cutis*, 1977, **20**, 119.

"Run for fun"

SIR,—We would like to report on the "medical run" held recently in Birmingham, particularly since there has been another disturbing report (21 October, p 1158) of casualties occurring in such runs. The Birmingham run attracted 131 starters, of whom over 80 completed the full 10 000-metre course. Many of those failing to