several months in a sample of 35 would be reason to stop further trials. A single directly attributable death among 120 patients would presumably lead to instant withdrawal of the new medicine.

It is not suggested that the strict controls applied to clinical pharmacologists by themselves, by governments, and by research committees should or could be imposed on surgeons and confectioners. Everybody cannot be protected from everything. But it is interesting to note a wide divergence of attitudes when in the same issue a case of near-death from sweets is reported without any comment about future safety, 100% iatrogenic morbidity and 4% mortality allows the conclusion that "further careful evaluation of the effects of intestinal bypass operations is required," and 1 in 1000 morbidity makes an intravenous injection "unacceptable."

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¹ Martindale: *The Extra Pharmacopoeia*, ed A Wade, 27th edn, p 603. London, Pharmaceutical Press, 1977.

² Epstein, M T, et al, *British Medical Journal*, 1977, 1, 488.

Prevention of retained throat pack

SIR,—The recent death of a child from a retained throat pack prompts me to suggest that all who apply this useful but dangerous technique must establish a foolproof system in order to avoid a repetition of this tragedy. For example, it is usually possible to leave a length of pack hanging externally or fastened to the tube. In all cases a label should be stuck on the forehead or other prominent site to act as a reminder. The use of a second pack or loose swabs inside the mouth or pharynx must be forbidden. Responsibility for the removal of the pack devolves on the person who inserted it, but all who are present must see it removed at the appropriate time. This is particularly important on occasions when there is a change of anaesthetist.

Only by treating the problem with the same care that is exercised in a laparotomy will tragedies be avoided.

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Ulceration of face associated with trigeminal neuropathy

SIR,—In your leading article on the surgical treatment of trigeminal neuralgia (17 September, p 718) you state that one of the complications of injection of alcohol into the trigeminal ganglion or root and fractional rhizotomy is facial dysaesthesia and you quote its incidence as 10-20%. However, you make no mention of the fact that ulceration of the skin of the face with erosion of the ala nasi is also a well-recognised complication of interruption of the peripheral sensory fibres of trigeminal nerve.

Ulcération en arc of the face and nose was first described in 1933 by McKenzie in Canada and by Loveman in the United States.^{1 2} It may follow the injection of alcohol into the Gasserian ganglion³ or sensory root section of the nerve. In 1959 Spillane and Wells⁴ presented a comprehensive review of the literature and reported this finding in 25 patients, including one of their own. In 1967 Henderson⁵ noted that ulceration of the face

and nostril occurred in 12 (18%) of 66 patients who developed permanent anaesthesia of the cheek and nostril following surgery.⁵ Although he stated that the precise cause was uncertain, he supported my earlier contention⁶ that self-inflicted trauma in response to persistent paraesthesiae may be of importance.

Ulcerative lesions of the face and nostril have also been reported in patients with isolated trigeminal neuropathy.^{1 7} I have also seen quite a number of patients who have developed ulceration of the skin of the forehead and scalp after herpes zoster, and in a previous letter³ I suggested that these lesions involving the analgesic skin may be more often seen by dermatologists than by neurologists and neurosurgeons and that their true incidence is far greater than the paucity of reports in the neurological literature would suggest.

Ulcération en arc may also develop as a complication of involvement of the central sensory pathways of the trigeminal nerve, and I have previously presented clinical details of two such patients with acute vascular disorders of the brainstem.^{5 8} In each patient the neurological findings indicated that the central sensory connections of the trigeminal in the spinal tract and nucleus would have been involved in the neuropathological process. There was dissociated anaesthesia, with loss of pain and temperature sensation but preservation of light touch, over the ipsilateral cheek and nostril and, in one patient, the skin above the eyebrow was also ulcerated (see figure).

Ulceration of skin of face with cartilaginous destruction of nostril in patient with vascular lesion of brainstem.

All these patients with involvement of the peripheral or central sensory pathways of the trigeminal nerve who later developed progressive ulceration of the skin of the face and, in some instances, cartilaginous destruction of the nostril had complained of persistent pain and intense and unpleasant irritation on the affected side of the face where this dissociated anaesthesia was found. The pain was described in such terms as a "deep, gnawing, burning pain" and "as if the whole side of the face was on fire," and the intense irritation was likened to "something crawling under the skin and inside the face" or "being invaded by ants." The patients found themselves picking at this analgesic area of the face and nostril with their finger-nails and often woke up during the night

to find themselves scratching off pieces of skin and tissue involuntarily.

Critical appraisal of these cases led me to the belief that the development and later progression of ulcerative lesions of the face and nostril were not, as hitherto presumed, trophic in origin (by definition, pertaining to nutrition) but were self-inflicted and could thus be preventable. These destructive lesions are the direct result of repeated trauma by the finger-nails to those parts of the face, scalp, and nostril which have been rendered analgesic through involvement of the peripheral or central sensory pathways of the trigeminal nerve, being provoked by persistent and painful paraesthesia.

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¹ McKenzie, K G, *Canadian Medical Association Journal*, 1933, 29, 492.

² Loveman, A B, *Archives of Dermatology and Syphilology*, 1933, 28, 369.

³ Freeman, A G, *British Medical Journal*, 1967, 1, 631.

⁴ Spillane, J D, and Wells, C E C, *Brain*, 1959, 82, 391.

⁵ Henderson, W R, *British Medical Journal*, 1967, 1, 7.

⁶ Freeman, A G, *British Journal of Dermatology*, 1966, 78, 322.

⁷ Spillane, J D, and Urich, H, *Journal of Neurology, Neurosurgery, and Psychiatry*, 1976, 39, 105.

⁸ Freeman, A G, *Journal of Neurology, Neurosurgery, and Psychiatry*, 1976, 39, 821.

Study of doctors' career decisions

SIR,—The imbalance between the posts available in certain specialties and the numbers of doctors wishing to fill them has shown itself as a surplus of applicants for general medicine, nephrology, cardiology, and many surgical specialties while vacancies remain unfilled in community medicine, geriatrics, venereology, anaesthetics, radiology, and some of the psychiatry and pathology groups.

The Institute of Manpower Studies is engaged in a study of qualified doctors' career decisions. These take place over a period of several years and a complex group of factors, including personality, education and experience, career prospects, and working conditions all play a part. Sheer chance is also a factor. We need to know how interest in, or distaste for, a particular specialty arises, what are the critical stages in the decision-making process, and how flexible the process is. The institute's task is to investigate the relative importance of the various factors which determine qualified doctors' specialty decisions and to study the causes of the imbalances between applicants and posts, bearing in mind that these may differ for different specialties.

The research began in October 1976 and the first stage consisted of interviews with 200 doctors all over Great Britain. They included not only doctors inside the NHS but also those in industry, research, the armed Forces, and administration. The interviews helped us to design a questionnaire for the second part of the study—a survey of 7000 doctors.

The doctors we are most interested in are those who have already made their specialty decision and who have done so not too long ago. The sample will concentrate, therefore, on doctors who have qualified between two and 20 years ago; and some older doctors will be included for purposes of comparison. The pilot survey took place in July and the main one is now being sent out.

The questionnaire contains a brief section on personal background and career history and then moves on to the main business of the inquiry—the decision to specialise. It asks