Correspondence

Correspondents are asked to be brief.

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Barrier Creams

SIR,—I am more than somewhat disturbed at your report "Was it a Drug?" (*Supplement*, 18 July, p. 64) in relation to the prescription of barrier creams. It was stated that a patient's "chronic dry eczema" was believed to be "aggravated by a substance present on the glass bottles he handled . . . at his job," and that the referees appointed by the Secretary of State for Social Services concluded that "the barrier cream constituted an effective prophylactic, and on the facts of the case (but not without some hesitation) decided that this . . . barrier cream was a drug which the executive council was bound to provide."

Before this report precipitates a rush of prescriptions for such "prophylactic" remedies, may I draw the attention of your readers to a paper published by Robinson and myself¹ entitled "Barrier Creams and Hand Cleansers in Industry"? This may be summarized as follows.

It was at one time considered that employers had a legal responsibility to supply barrier creams for the protection of their workers, and that they could be sued in the courts for negligence if such preparations were not readily available. This no longer applies.

It has been shown by investigative studies that no barrier cream on the market gives the degree of protection claimed by the makers.²

Patch tests to soap-containing barrier

creams (not surprisingly) provide a very high percentage of positive reactions.^{3,4} These suggest that some denaturing of the keratin can result from the long-continued use of such creams. The user may eventually complain of a feeling of slight soreness, which disappears on discontinuing application.

If the normal skin can be thus irritated, there cannot be many dermatologists who would be happy about the use of a "barrier" cream in the presence of "chronic dry eczema." It is admitted that the two preceding points do not apply to the "barrier" creams which do not contain soap, but there are many practical reasons why these are not commonly used.

The main reason for the continued popularity of soap-containing "barrier" creams is their efficiency as skin cleansers. But any of the industrial hand cleansers will do this job just as well, without the risk of irritation from prolonged contact.—I am, etc.,

RONALD SCUTT.

Royal Naval Barracks,
Portsmouth, Hants.

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Prolonged Weightlessness

SIR,—Mr. F. G. St. C. Strange's observations (18 July, p. 162) are hardly in keeping with recent studies on bone demineralization during spaceflight. The more cautious approach of your leading article (4 July, p. 4) is welcome because studies on mineral metabolism in healthy subjects¹⁻⁴ have provided conflicting evidence on the effect of exercise and weightbearing, while obser-

vations during spaceflight have been complicated by varying intakes of calcium. At present, I believe the evidence suggests that limited exercise may prove to be vital in controlling bone reabsorption during prolonged weightlessness.

Using the technique of bone densitometry Mack and her associates⁵ showed reductions in bone mass, based on the x-ray

absorbency of the os calcis of each astronaut, to be 7.8% and 10.3% following the four-day (Gemini IV) and 15.1% and 8.9% following the eight-day (Gemini V) missions. The average calcium intake was 650 mg. per day during Gemini IV and 300 mg. per day during Gemini V. Following the 14-day mission (Gemini VII), in which regular in-flight exercises were undertaken and an average calcium intake of 1,000 mg. per day was maintained, the reductions in bone mass were 2.9% and 2.8% and were within the loss expected following an equivalent period of bed rest. Changes in the density of the middle phalanx of the little finger were, however, as high as 23.2% and 17.0% following Gemini V, and though in-flight exercise and a high calcium diet failed to have such a dramatic effect on these bones, the loss in each astronaut did not exceed 7% and 8% after the 14-day mission. The latter finding would suggest that attention should be given to hand exercises.

These studies emphasize the profound effect of weightlessness on bone metabolism but do not suggest that, in the absence of artificial gravity during spaceflight, severe skeletal pathology is inevitable. On the contrary, there is every possibility that demineralization may be controlled. Nevertheless, the problem is complicated by increased urinary calcium excretion, which may prove to be the more important consideration. Astronauts susceptible to the formation of calculi may have to be excluded from missions to planets beyond the moon.⁶

It is clear that a greater understanding of the control of the mineral content of bone and urine and the role of exercise in skeletal function are needed before extraterrestrial flights of many months' duration are undertaken. It is hoped that studies on bone metabolism in both man and monkey will be carried out aboard orbiting laboratories in the next few years, and the results of these investigations may suggest also a role for agents which impair intestinal absorption of calcium and phosphate and for hormones which may inhibit bone reabsorption.

The 14-day Gemini and 18-day Soyuz missions dispel the dire prophecy that man's bones may fold up after three or four weeks in the weightless state. Artificial gravity may have an important part to play in the exploration of the solar system, particularly with regard to changes in cardiovascular function,⁷ but refrigeration is in the realm of science fiction rather than the logical development of aerospace physiology.—I am, etc.,

A. N. NICHOLSON.

Royal Air Force Institute
of Aviation Medicine,
Farnborough, Hants.

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Problems of Tuberculosis in Immigrants

SIR,—In the report on the Annual Scientific Meeting (18 July, p. 155). Dr. D. K. Stevenson (Bradford) is quoted as follows: "Immigrants had to have a medical check in their own country, but this did not apply to dependants. The facilities on entry were inadequate to deal with these, so that the problem was passed to the local health authorities . . ."

I am aware, as I am sure every practising doctor in Britain is aware, that potential emigrants to Australia and other Commonwealth countries are required to have rather more than a "medical check" before leaving the United Kingdom, and that a normal radiological examination of the chest is obligatory for all intending immigrants to the United States.

In all the political humbug on immigration which appears daily in the lay press my medical colleagues must surely share my disgust at the absence of any reference to the "tuberculosis problem," the "V.D. problem," and even the "trachoma problem." Are we not entitled to know the average cost of diagnosis, hospitalization, and treatment for immigrants admitted to this country with active disease, and the measures which have been or perhaps have yet to be recommended for dealing with the inadequate facilities on entry?

Perhaps a significant clue to this national scandal is to be found in the opening sentence of the report of the Scientific Meeting for Thursday 2 July, which suggests this is a parochial problem since all the speakers were from Bradford. In reality, Bradford is just one of many local authorities faced with the tuberculosis problem. They must all reflect, somewhat ruefully, that the final chapter of this problem was forecast for the early 1970's.—I am, etc.,

J. R. A. HARVEY.

London W.1.

Acute Malaria in Newborn Infants

SIR,—Dr. N. E. Okeke's letter (11 July, p. 108) quoting that "more than one third" of 50 African women who were delivered some five years ago in a medical centre in Eastern Nigeria had "malaria parasites" in their blood is not unduly surprising; this is the common parasite rate in unprotected adult pregnant females in highly endemic areas of Africa.

Far more surprising is the statement that such a high parasite rate was found in women who allegedly were on a prophylactic antimalarial regimen. One would wish to know more about the actual drug given, its dosage, and its regularity. Even more puzzling is the assertion that in all cord bloods from these women, and in the peripheral blood of their newborn, malaria parasites were found.

This observation is contrary not only to that of Blacklock and Gordon¹ quoted by Dr. Okeke, but disagrees also with the views of Covell,² Bruce-Chwatt,³ and Garnham,⁴ and with several other experienced workers in Africa whose concerted opinion is that in women in endemic malarious areas the infections of the placenta may be frequent but the incidence of congenital malaria is exceedingly low (less than 0.1%). It would be of interest if Dr. Okeke's findings could be reported in detail to allow for a proper appraisal of this disclosure of an exceptionally high frequency of congenital malaria in Eastern Nigeria during the period 1965-7. The reference to 0.3-0.5 ml. of intramuscular chloroquine given to infants does not indicate the actual dosage in terms of chloroquine base, and it would be interesting to know something of the results of this treatment.—I am, etc.,

L. J. BRUCE-CHWATT.

London School of Hygiene
and Tropical Medicine,
London W.C.1.

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Acute Malaria in Newborn Infants

SIR,—Dr. N. E. Okeke (11 July, p. 108) asks about the experience of other doctors working in the tropics of the incidence they have noted of acute malaria in newborn infants.

I have described¹ how we found in 700 cases examined in the Fort Hall district of Kenya two infants with subtertian malarial parasites in their blood, which was taken immediately after they were born. In the mothers we observed in specimens of placental blood one benign tertian, 30 subtertian, and 9 quartan malarial parasites.

Also it is of interest to observe that we found in one patient *Microfilaria bancrofti* and in another patient *Spirillum rossi* in the

placental blood. These figures are not as impressive as those of Mackay.²—I am, etc.,

P. G. PRESTON.

Colchester,
Essex.

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Cervico-oculo-acoustic Dysplasia

SIR,—In the reported case of the above syndrome in an adult female by Dr. D. A. A. Primrose (11 July, p. 108) he described the syndrome as rare. This apparent rarity is probably due to the several specialties involved in the management of its features (otologists, oculists, paediatricians, or psychiatrists). To establish a more accurate incidence of the syndrome each specialist would be required to search for the presence of often minimal abnormalities in another system outside his own specialty.

By survey of the school health service, audiology clinics, and area mental deficiency service we found seven cases of cervico-oculo-acoustic syndrome among school-age Glasgow children.¹ There are some 200,000 school children in Glasgow and 17,000 are surveyed by the School Health Service audiometricians annually. We did not, however, survey orthopaedic or ophthalmic clinics, and it is likely that additional cases are referred to one or other of these disciplines without cross-referral to audiology or mental deficiency.

We note that the case described by Dr. Primrose had an occipital meningocele. Two further adult females found by us similarly show occipital meningocele, and indeed Wildervanck^{2,3} in his original description includes rachischisis as a salient feature of the dysplasia.—We are, etc.,

W. I. FRASER.

Lynebank Hospital,
Dunfermline.

R. C. MACGILLIVRAY.

Lennox Castle,
Lennoxtown.

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Police Drug Searches

SIR,—The licence given to police to search citizens for illegal possession of drugs is open to much abuse.

Recently I have seen young people searched in the middle of Piccadilly Circus in a way that could hardly help to solve the drug problem, and seemed devoid of all human dignity. Also in the past few months I have had two patients, both with a psychiatric history, seized by the police and kept in a police station till I informed the police that the possession of tablets or a prescription for tablets was medically authorized.