This patient, a woman 20 years old, presented at this Department on 20 July 1964 with a lesion on the left cheek below the left eye. This was erythematous, slightly scaly, somewhat raised, and circumscribed by a ring of vesicles. It measured 4.25 cm. in diameter, and was of six weeks' duration. The patient's history was not contributory. Scrapings from the lesion revealed mycelium, and on culture yielded *T. megninii*. The macroscopical and microscopical morphology was typical of the species. Furthermore, this strain demonstrated clearly, in two successive cultural tests, its absolute requirement for histidine on the synthetic basal medium devised by Georg for this purpose.² On this medium it is unable to produce any growth in the absence of histidine, whereas *T. rubrum*, which in many other respects it resembles, is able to grow well on this medium, irrespective of the presence or absence of histidine. This strain of *T. megninii* was sensitive *in vitro* at 27° C. to 10 µg./ml. of griseofulvin in Sabouraud glucose broth. For comparison with this strain, one of the isolates of *T. megninii* obtained by Dr. I. Sarkany and his colleagues at the Royal Free Hospital, London, was used in parallel series in these tests, and they were found to be similar in all respects.

Treatment of the patient was begun with fine-particle griseofulvin, in the dosage of 125 mg. four times daily. The lesion responded well at first to this drug, which was stopped only when the erythematous reaction had almost cleared, and scrapings were microscopically negative. Instead, ung. betnovate was prescribed. One week later, on 11 August 1964, the patient returned with three discrete circumscribed lesions within the area of the initial lesion (see Fig.) and scrapings from them were not only positive microscopically, but also on culture yielded *T. megninii* for the second time. Accordingly, fearing that the ung. betnovate had been responsible for its exacerbation, this drug was promptly withdrawn and griseofulvin prescribed again twice daily. However, despite these measures, the lesion remained active for another 22 weeks, during which period *T. megninii* was isolated from it for the third, fourth, and fifth times, respectively on 29 September and 30 November 1964, and on 26 January 1965. Then at three subsequent examinations, the last on 16 March 1965, scrapings were negative microscopically and on culture. By this date also, about eight months after the patient's first visit to this clinic, the lesion had completely cleared and she was accordingly discharged.

We are indebted to Dr. S. T. Anning for his permission to publish this report, to Dr. I. Sarkany for a culture of one of his isolates, and to Mr. R. A. Forster for technical assistance.

—We are, etc.,

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C. J. LATOUCHE.

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- Sarkany, I., Clayton, Yvonne M., and Beck, G. A., *Brit. J. Derm.*, 1963, 75, 388.
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Varicose Veins in Pregnancy

SIR,—In your editorial entitled "Varicose Veins in Pregnancy" (3 July, p. 3) you quote K. Sigg as stating that varicose veins are three to four times commoner in multiparous women than in males and nulliparous women. I believe that the difference between the incidence in multiparous and nulliparous women is very much lower.

In a personal survey in general practice of 4,983 patients (2,222 male and 2,761 female), I found that 338 patients had either attended a doctor for varicose veins or had been found to have them on routine examination. The age at first complaint of these patients was sought and produced figures of some interest. The sex distribution of sufferers was 223 females to 115 males, a ratio nearer 2:1 than the 3 or 4:1 that you quote. The reason for this discrepancy may be that the males in this series were much less enthusiastic about seeking treatment than the females—possibly on cosmetic grounds. The distribution of nulliparous and multiparous females was as follows:

Age at first complaint in years	Nulliparous females	Parous females
15-20	1 (2.5%)	13 (7.1%)
20-30	3 (7.3%)	34 (18.7%)
30-40	15 (36.6%)	67 (36.8%)
40-50	10 (24.4%)	58 (34.6%)
50-60	6 (14.6%)	6 (3.3%)
60-70	5 (12.2%)	3 (1.6%)
70+	1 (2.5%)	1 (0.5%)

Thus 182 (81.1%) of the female sufferers were multiparous. But of the total series of 2,761 females 1,573 (74%) had borne children, and thus the likelihood of 182 suffering from varicose veins was no higher than might have been expected.

The explanation of the discrepancy noted seems to lie partly in the very different ages at which the two groups make their first complaint—for most of the patients attending out-patients for treatment do so before the age of 50 and this weighs the incidence in favour of the multipara—and partly in a failure to relate out-patient attendances to the actual incidence of the condition in the population at risk.

It may well be that pregnancy is not such an important aetiological factor as is thought, but is an accelerating factor in the development of symptoms.—I am, etc.,

Bromsgrove, Worcs.

M. DRURY.

SIR,—With regard to the leader (3 July, p. 3) on varicose veins in pregnancy the aetiological factors you quote are common to all pregnant women irrespective of race. You omit a later reference¹ that I submit qualifies those you give. Concerning their basic cause, in 1963 I visited the C. Johnson Memorial Hospital of 600 beds at Nqutu, Natal, to verify the reported absence of varicose veins, including those in pregnancy, in Africans living tribally. I saw no varicose veins, and was given figures from the hospital registers. These included 3,141 cases of pregnancy with no varicose veins of the legs, but 4 of vulval varicosities, and 1 of haemorrhoids. Later the Superintendent, Mr. A. Barker, F.R.C.S.,² produced records showing 5 cases of varicose veins in over 14,000 consecutive admissions. This must constitute a challenge to your leader with an incidence of around 10% in British women.^{3,4,5} I presented two supporting facts.¹ The first is that in U.S.A., whether in the Cook County

Hospital, Chicago, of the industrial north, or the Charity Hospital, New Orleans, in the agricultural south, varicose veins are as common in the coloured as in the whites. Surgeons tell me that they are also starting in the black residents of Durban and Port Elizabeth. The second is that the food of the tribal Africans in Natal consists mainly of cooked unrefined maize, which eliminates many factors that might be advanced as important. Their diet is so exclusively one of maize that deficiency diseases like kwashi-orkor are common. The unrefined diet gives a twice-daily stool which is soft and narrow in diameter, and is described locally as the tooth-paste stool.

In my article I considered that colonic stasis arising from a diet containing excessive purified carbohydrates—e.g., white flour and white sugar—leads to pressure on the iliac veins, and is the essential cause of the plague that varicose veins have come to be in westernized peoples. This applies to varicose veins in pregnancy which appear in the first three months, when constipation is often worse and the uterus is not an obstructive factor. In a letter to the *Lancet*⁶ I answered objections that were raised to this thesis. To those interested in varicose veins in pregnancy I suggest they will find the prescription of unprocessed bran, one to four tablespoonfuls daily, will correct the bowel stasis. I have advised it with advantage for years.

The treatment you seem to advocate has obtained from time immemorial—i.e., rest, elevation, and elastic stockings—these in spite of it having been shown that operation or Fegan's injections give worth-while results. A fundamental of varicose veins is that the reverse flow in them operates in the standing and recumbent position (at 1,000 operations, the bleed-back flow was observed in over 800, even though patients were anaesthetized and the table was tilted head down). The rest and elevation of the legs in these days of "do it yourself" is at best but a placebo, and is usually impracticable. Any patient who has varicose veins before or after pregnancy should have them treated, for they are a steadily increasing burden, and the process never "burns itself out." Patients and their practitioners are hesitant to seek treatment because the results are still disappointing. They will continue to be until a full and accurate diagnosis is made and the leak or leaks of high pressure from the deep into the superficial veins are stopped at their source, and stripping, which is fashionable, is relegated to the limbo of irrational operations. In pregnancy the conditions for operation are applied more stringently, but when a leak is clear cut and really troublesome the strategic ligature is done.—I am, etc.,

London W.1.

HAROLD DODD.

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Lung Cancer Among White South Africans

SIR,—Dr. Geoffrey Dean's figures for lung-cancer mortality rates of various categories of smokers among the white South

African rural population (10 July, p. 111) will come as a shock to those who may have changed from moderate cigarette smoking to pipe smoking as a preventive measure. Contrasting the relative lung-cancer death rates for (1) smokers of up to 20 cigarettes a day and (2) pipe smokers in his survey and that of Hammond and Horn¹ in America gives the following results:

	Lung-cancer Mortality Compared with that of Non-smokers		Lung-cancer Mortality Compared with that of the Total Average	
	Cigarettes 1-20 a Day	Pipe Only	Cigarettes 1-20 a Day	Pipe Only
Hammond and Horn's study of white Americans aged 50-69 (1952-5) ¹ ..	793%	301%	149%	57%
Dean's study of white South Africans aged 45-64 (1947-60)	186%	486%	43%	113%

The South African pipe smoker's risk works out at 261% of that of the moderate cigarette smoker, whereas in America it is only 38%. Incidentally, Dr. Dean's figures only show mortalities of smokers of up to 20 cigarettes a day and of smokers of 25 or more. Unless this is a misprint it leaves an astonishing loophole.

In view of this and many other contradictions in the published statistics of the relationship between smoking and lung cancer may I renew my urgent plea for a fresh retrospective investigation of all the possible factors involved in every recorded case of lung cancer in this country? This can only be carried out by a programme of research under official auspices, and should record not only the smoking habits but details of residence and occupation so as to provide a means of estimating the patient's exposure to diesel fumes and other forms of air pollution as well as to various types of tobacco smoke. Carcinogens in urban atmosphere must be analysed and traced quantitatively to their sources.

The present controversy over the cause of the increase in lung cancer is based on speculative evidence, and one can prove almost anything by selecting the right set of figures. The only reliable conclusion that can be drawn at the moment is that those who breathe air unpolluted by either tobacco smoke, diesel fumes, or other forms of atmospheric contamination seem to have a relative immunity from the disease, and the only justifiable recommendation to the public would be to avoid them all as far as possible. Propaganda against the cigarette has been on a gigantic scale—with very little result—whereas warnings about the dangers of diesel exhaust have been suppressed or ignored. The death rate from lung cancer is still rising inexorably, and the responsibility of those in control of our national public health policy cannot be evaded.—I am, etc.,

GEOFFREY MYDDELTON.

Henley on Thames, Oxon.

REFERENCE

- ¹ Hammond, E. C. and Horn, D., *J. Amer. med. Ass.*, 1958, **166**, 1294.

Phenindione Toxicity

SIR,—An eczematous reaction to drug therapy is unusual but probably is seen most often with gold, penicillin, and streptomycin. From Dr. E. K. M. Smith's report (3 July, p. 24) and from my own recent observations it might seem that phenindione should be added to this list—although other skin manifestations of toxicity, including pruritus without rash, urticaria, purpura, and necrotic lesions, are better known.¹

I have seen three women in-patients aged 32, 45, and 60 who had an itchy eczema of sudden onset with obvious erythema and scaling that affected predominantly the scalp, ears, eyelids, axillae, groins, and natal cleft. None had a past or family history of eczema. In spite of stopping phenindione in two of them, the eruption persisted and was only partly suppressed by topical corticosteroids.

Eczema may be an important early sign of phenindione toxicity, because the rash may precede other toxic manifestations, such as those due to damage to kidney, liver, and bone-marrow. For example, the woman aged 45 had had the rash for a week in hospital before the "drug fever" appeared. The drug was stopped a few days later. After a further week oliguric renal failure was diagnosed.—I am, etc.,

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REFERENCE

- ¹ Perkins, J., *Lancet*, 1962, **1**, 125, 127.

Africa's Needs

SIR,—Dr. S. McClatchie (10 July, p. 109) is right to stress the need for doctors of any specialty or in general practice to do basic work under difficult conditions; re-orientation of training of African students to their special needs and increasing supply of technicians are beyond dispute.

The need for medical care is so great that it may never be met, but there must surely be room for any doctor or specialist for any reasonable time, doing any type of medicine, sent by any organization; and any one, particularly the young, helping in this manner will benefit and mature from meeting Africa's challenge, however humble his efforts.—I am, etc.,

Windsor, Berks.

ROY MAUDSLEY.

SIR,—As one who has spent the whole of his professional life in Africa, I have with some interest read the contributions in the *B.M.J.* on Africa's needs.

First may I endorse the practical approach of Dr. S. McClatchie (10 July, p. 109), especially his plea that the flying visits of experts be replaced by more practical visits. As one who has benefited from overseas visitors may I say how very useful their visits are, but only if the expert is willing to stay a while. Much of "Africa's medicine" is carried on in small rural hospitals, often under almost primitive conditions—it is to these places that experts should come and show in a practical way how their skills can be used and applied.

Having said this, it must, of course, be added that "the short-term doctor," be it even

for a year or two, is not the real answer to Africa's needs—we need men and women who will devote their professional life to the service of Africa. The spirit of service, sacrifice, and adventure has always been one that has been associated with the British way of life and its expression more particularly in Christian service. There is unlimited opportunity in the medical field in Africa now, as there has always been, if we can match it with the men and women to respond to the challenge.

There are no branches of medical skill that cannot be used to the full and there are many fascinating medical problems that are waiting to be investigated. Burkitt in his classical studies on lymphoma has shown the way, and there are many other similar problems which need only the application of a ready mind to be brought to light.

The standards of medical practice are going to be set in Africa in the next 10 years, and the lead of devoted men is needed to see that what has been begun by men of the past is not lost now that the reaping time has come.

The Government and mission medical services in Africa realize that perhaps the most urgent needs are those of training, and here, too, are needed men of talent, skill, and devotion. We have many fine institutions in Africa, but the training of medical, nursing, and technical personnel may well fall below standard if we fail to supply the teachers of highest quality that are so urgently needed.—I am, etc.,

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JOSEPH TAYLOR.

"Medical Directory"

SIR,—The posting of the annual schedule for the *Medical Directory* 1966 has now been completed.

It is desired to include in the book the names of all fully and provisionally registered medical practitioners living or working in the British Isles, and also the names of British-qualified doctors living or working abroad. All such practitioners who have not received the annual schedule are asked to communicate at once with the Editor, the *Medical Directory*, 104 Gloucester Place, London W.1, stating full name and year of qualification.—I am, etc.,

Medical Directory,
London W.1.

B. STANTON.

Points from Letters

"Wriggling Reflex"

Dr. J. LIEBER (London W.1) writes: I was interested in the article "Query Appendix" (17 July, p. 124) and particularly concerning young women where there might be an emotional cause. The late Mr. Ewart, of St. George's Hospital, often demonstrated that in young women where there was an emotional cause, when the abdomen was first palpated, they wriggled. He gave it the name "Ewart's wriggling reflex."

Charges for Patients

Dr. S. SHUBSACHS (Manchester 16) writes: Can anyone tell me why a dentist claiming a N.H.S. fee for treating a tooth with a root abscess, or an N.H.S. optician for glasses, is more in keeping with all the principles of "social justice" than is charging a fee for a boil or a sprained ankle? Does the longer period of shortage of dentists justify the barrier?