been unsuccessful. It is usually possible to tail off corticosteroid dosage after three months." It is not suggested by the writer that desensitization may have occurred meanwhile.

In fact desensitization to streptomycin and P.A.S. is regularly obtained when steroids in adequate dosage are added to the drug regimen, there being no need to interrupt full chemotherapy with the offending drugs, because hypersensitive reactions are suppressed. Hepatitis or exfoliative dermatitis is not a contraindication.¹ The risk of drug resistance is not incurred. The patient under this regimen is rapidly, and apparently permanently, desensitized. Some writers have found that desensitization is achieved in ten days by this technique.² Moreover, the patient so treated has the significant advantage of receiving steroids as an adjuvant to chemotherapy. It is probable that just as Type IV allergy to drugs is overcome under steroid cover so is Type IV allergy to the tuberculous antigen. It has been shown repeatedly in Britain and elsewhere in many controlled trials that there are statistically significant advantages in using steroids in cases of active and extensive pulmonary tuberculosis, in that clinical recovery and radiological clearing are much more rapid and the degree of residual fibrosis is less. Your contributor speaks of the necessity for continuing chemotherapy for two or three years in cases of advanced pulmonary tuberculosis. This is presumably because viable tubercle bacilli may have become sequestered in fibrous tissue, a situation which would be avoided if corticosteroids were introduced at an early stage of treatment. Although the elimination of tubercle bacilli is a prime motive for treatment with antituberculous drugs, there are other factors which are worthy of consideration, such as the patient's reactions to the tubercle antigen, the duration of his illness under treatment, and the extent of lung damage which is incurred when inflammatory processes are allowed to continue unnecessarily.

Your contributor also dismisses the use of steroids in all forms of tuberculosis, including meningitis, but it is not difficult to recall cases such as the following. A child suffering from miliary tuberculosis and meningitis developed severe drug reactions to streptomycin and P.A.S., which at the time were the only drugs available, and the prognosis was therefore virtually hopeless. Under steroid cover the drugs were continued and recovery was swift and uneventful.

Support for the view that doctors in this country are perhaps misinformed about the value of corticosteroids in pulmonary tuberculosis is given in an annotation in another journal.³ Giving a comprehensive review of world publications on this subject ("a Cinderella-story"), the writer concludes as follows: "Those who . . . spoke for it [hormone therapy] in the difficult early stages can be satisfied that they have contributed to the most significant development in the treatment of tuberculosis since the introduction of chemotherapy itself." It is a pity that your contributor, in his otherwise authoritative review of drugs for tuberculosis, should have dismissed corticosteroids in six lines.—I am, etc.,

London W.1.

L. E. HOUGHTON.

REFERENCES

- Houghton, L. E., *Lancet*, 1954, 1, 595.
- Francis, R. S., and Gupta, S. K., *Tubercle (Lond.)*, 1958, 39, 236.
- Lancet*, 1966, 1, 192.

Bacteria in Urine

SIR,—I find it puzzling that articles on urinary tract infections (7 September, p. 600) never seem to mention that organisms can be clearly seen in the unstained urine under the 4th objective.

The interpretation of this finding is not necessarily easy, but the presence of visible organisms seems to me to be a useful observation comparable to the presence or absence of pus cells.—I am, etc.,

Oxtd,
Surrey.

J. H. LANKESTER.

Pain in the Face

SIR,—As a neurosurgeon whose life is crowded with patients suffering from pain in the face, I approached Professor Henry Miller's oration (8 June, p. 577) with more than passing interest. I have long counted myself among his admirers, and found myself increasingly dismayed as I discovered how much I disagreed with almost everything he said.

It is true that Tegretol (carbamazepine) has transformed the management of this common malady. A significant proportion of the many patients who respond to the drug cease to do so, however, after a period of time which may vary from six months to six years. These folk, added to those who are intolerant or unresponsive, constitute a hard core of cases which will always require some form of surgical treatment. Professor Miller misleads when he says "alcohol injection of the Gasserian ganglion has lost its vogue . . . the technique is difficult and the result unpredictable." The truth of the matter is that—properly done—alcohol injection of the sensory root is the only safe, certain, once and for all, permanent cure, having a small morbidity and no mortality. No other form of treatment qualifies for such a description, and the recurrence rate after limited root section is not "small" but on the contrary considerable.

The great problem indeed lies in the difficulty of injecting the sensory root properly; the technique "has lost its vogue" because few neurologists or neurosurgeons (and I am not myself one such) have trained themselves to do it. To play the violin well is difficult, too, but it has not lost its vogue.

Nerve division operations for malignant pain in the head, face, throat, and neck are among the most satisfying and gratifying in the surgery of advanced malignant disease. They are not in the least mutilating, usually confer total relief from pain, have a surprisingly small mortality, and are infinitely to be preferred to a drugged, befuddled, agonized process of dying.—I am, etc.,

JULIEN C. TAYLOR.

Derbyshire Royal Infirmary,
Derby.

SIR,—Giant-cell arteritis is often overlooked, although a common condition and one frequently causing blindness in one or both eyes in old age. Mr. Martin Joyce (24 August, p. 498) has pointed this out, in response to the view of Dr. R. W. Barter (27 July, p. 251) that arteritis is a self-limiting disease, but the need for urgent treat-

ment is not stressed. The second eye may become blind within hours of the first being affected, and while it is justifiable to await the result of an E.S.R. estimation, which takes an hour, it is certainly not right to wait for an arterial biopsy to be arranged. This procedure may be undertaken as confirmation in doubtful cases, and many are atypical with little or no pain. Prednisolone should be given at once in dosage of 60 mg. a day, and gradually reduced as symptoms and the E.S.R. respond, but should be continued for six months and often for longer.

Treatment is very effective in preventing further loss of sight, but almost useless in recovering that which has been lost, so time is of prime importance.—I am, etc.,

R. A. D. CRAWFORD.

Kent and Canterbury Hospital,
Canterbury.

Antibiotics in the Treatment of E.N.T. Infections

SIR,—In this interesting article (24 August, p. 480) your expert notes that most boils are due to *Staphylococcus pyogenes*, and that "the chances of a resistant organism are not great," so he recommends penicillin as the drug of choice. Recently I examined the figures of the numbers of throat and nasal swabs taken during 1964 from patients on admission to the infectious diseases wards of this hospital, which yielded *Staph. pyogenes*, and also the antibiotic sensitivity patterns of these organisms. Overall, out of 534 patients from whom *Staph. pyogenes* was isolated) only 169 (31.7%) yielded penicillin-sensitive strains. Among children under 5 years of age, some of whom probably carried staphylococci acquired in maternity hospitals, only 57 (20%) of 285 carriers yielded penicillin-sensitive strains. In case the situation had changed over the last few years I examined the figures for throat and nasal swabs taken in July and the first three weeks of August this year, and found that only 11 (16.9%) of the strains of *Staph. pyogenes* from 65 carriers were sensitive to penicillin. As these swabs were taken on admission of the patients to hospital, apart from a few instances where patients may have been transferred from other hospitals, they must reflect the state of carriage of penicillin-resistant strains in the local population.

It would appear, therefore, that in Glasgow at least the chances of meeting a resistant organism are, in fact, quite high, and this raises the question as to whether penicillin should ever be used to treat presumptive staphylococcal infections. In this connexion the observations of Mr. Price and his colleagues (17 August, p. 407) on the similarity of response of superficial sepsis due to penicillin-resistant *Staph. pyogenes* to treatment with phenoxymethyl-penicillin, phenethicillin, and lincomycin are relevant and intriguing, and there is certainly room for further observations on this problem. An acutely painful lesion such as a furuncle in the external auditory meatus may form a suitable subject for such a study.—I am, etc.,

R. J. FALLON.

Department of Pathology,
Ruchill Hospital,
Glasgow N.W.