but in whom a diagnosis of pyelonephritis is subsequently established. It has also been shown that to examine the urinary deposit for white cells in the way they describe may be misleading.² And it is well known that the urine may be infected even if there is no increase in the number of white cells present.^{3 4}

The difficulties of quantitative pour-plate cultures have perhaps been over-emphasized by those less experienced in this technique. We have found that a competent technician can perform up to 20 such cultures in an hour.—We are, etc.,

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Herpes Zoster and Steroid Therapy

SIR,—Since herpes zoster is a fairly common disease and since steroid therapy is now widely used in the treatment of many unrelated diseases, it is worth while to assess whether steroids have any effect in herpes zoster by noting the occurrence of severity of zoster. Duke-Elder¹ reported improvement in cases of zoster iridocyclitis treated with cortisone. Carter and Royds² were more guarded in their conclusions regarding their own results with prednisone treatment in 15 cases of ophthalmic herpes zoster.

Such consideration justifies the report of a case in which it would appear that steroids did not affect favourably the progress of herpes zoster—on the contrary, its course appeared to be more severe.

A woman aged 54 developed a papular rash on both arms, legs, and abdomen in July, 1961. There was subsequently considerable itching and exfoliation. No cause could be found. The patient gradually became more and more disturbed because of it. Local treatment had no effect. Only oral steroids controlled the symptoms and lesions. Prednisolone, 10 mg. per day, was the first preparation used. Betamethasone, 0.5 mg. per day, was used subsequently. Within a week of stopping the steroids the lesions and itching recurred, and soon disappeared after taking steroids again.

On April 19, 1963, she developed right intercostal herpes zoster with a D₅-D₆ distribution. In less than a week the zoster lesions became gangrenous, and a carbuncle 1½ in. (3.7 cm.) in diameter developed on the back in the zoster area. There was very deep tissue destruction in all the affected areas. There was no glycosuria. The carbuncle healed within a week with parenteral penicillin. The zoster lesions healed within four weeks with considerable scarring and deep pigmentation.

More than 200 patients with herpes zoster were seen during the last 30 years in practice—this one being the most severe, and the only one who had been on continuous steroid therapy.

It appears that steroids will not suppress or ameliorate the course and progress of herpes zoster. This was also seen in the case described by Creighton and Dewar.³—I am, etc.,

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A. FRY.

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Westergren E.S.R. and Plastic Containers

SIR,—The inference in the letter published in the *Journal* by Dr. R. J. Weir and Dr. J. M. Jackson (May 25, p. 1414) is that polystyrene is the causative factor for the difference in results.

I have recently carried out a series of investigations into the causation of the inhibition of fall in Westergren E.S.R.s using plastic containers, and a short paper on this subject is now in the press. My findings show that the added preservatives, a mixture of hydroxybenzoates, are the direct causative factors in this inhibition and that the polystyrene has little or no effect on the fall of the red cells.—I am, etc.,

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Accident Services

SIR,—Mr. H. Osmond-Clarke (May 25, p. 1410) deplures, with some justification, the failure of the Minister of Health to take up the recommendation of the Interim Report of the Accident Services Review Committee to create a third tier in the Central Accident Units. Equally deplorable and disappointing is the lack of consideration given to the organization of the first tier proposed by Mr. Osmond-Clarke's Committee—a peripheral casualty service. "The main purpose of this service will be to provide treatment for minor injuries . . . for every major injury there occur at least a hundred minor injuries and the potential morbidity of these is high."¹

The sheer volume of work connected with minor conditions at present carried out at hospital casualty departments is indicated by the analysis made by the Accident and Emergency Services Subcommittee²—no less than 65% of new cases coming under the headings bruises, sprains, wounds, sepsis, and foreign bodies, while Fry³ and Crombie⁴ have estimated the incidence of the "general practice type of case" at casualty departments at between 40% and 60%. With the increasing awareness of the medico-legal, if not clinical, importance of obtaining radiographs in cases of sprains and bruises it is fair to assume that a large proportion of the increase in "casualty" work—24.5% new cases in the Birmingham region between 1951 and 1961⁵—is accounted for by these minor injuries.

However, to expect general practitioners to treat these cases on their own premises, with their own equipment, and, dare one mention it, without proper remuneration, is quite unrealistic. Even where facilities are available, as at the S.E. London G.P. Centre, the figures—128 minor operations during the course of a full year⁶—show that a peripheral casualty service could only become effective if "organized at a cottage hospital or general practitioner diagnostic and treatment centre and staffed by a rota of general practitioners."¹

Recent discussions between a group of general practitioners in Birmingham and representatives of both sides of industry have shown that these "consumer bodies" are well aware of the inefficiency of the present arrangements, necessitating long journeys to hospital and endless hours of waiting for the most trivial of injuries. If the lead given by the Accident Services Review Committee had been followed by the Minister of Health there is no doubt that, in its own interest, industry would have been prepared to contribute to the establishment of peripheral casualty services, forming the backbone