Computed tomogram in case of perforating injury to right eye.

superotemporal quadrantanopia. There was no sympathetic ophthalmia.

All stab wounds and similar injuries to the eye and orbit should alert the examining doctor to the possibility of intracranial damage. A normal level of consciousness does not exclude intracranial damage—symptoms may not arise for up to two months after the initial event.¹⁻³ Examination must include visual field testing; skull x ray and computed tomography may confirm clinical suspicion.

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- 1 Bard LA, Jarrett WH. Intracranial complications of penetrating orbital injuries. *Arch Ophthalmol* 1964;71:332-43.
- 2 Duffy GP, Bhandari YS. Intracranial complications following transorbital penetrating injuries. *Br J Surg* 1969;56:685-8.
- 3 Guthkelch AN. Apparently trivial wounds of the eyelids with intracranial damage. *Br Med J* 1960;ii:842-4.

Leg ulcers

SIR,—Professor H A F Dudley (2 January, p 65), in his criticism of Dr P K Buxton's article (12 December, p 1542), suggests that in up to a quarter of patients with venous ulceration this is the result of isolated saphenofemoral incompetence and that permanent cure of the ulcer can be achieved by saphenofemoral ligation.

This has been well recognised for many years, and true "varicose ulceration" responds well to saphenofemoral ligation and stripping. It was the frequently poor results of this operation that led Cockett and Elgan Jones in 1953¹ to investigate the contribution of perforating vein incompetence to venous ulceration and to coin the term "ankle blow-out syndrome." In limiting the surgery of venous ulceration to patients with isolated saphenofemoral incompetence, Professor Dudley denies the possibility of permanent ulcer healing to those many patients, three quarters of the total in his view, with other venous disorders. Although both Professor Dudley and Dr Buxton fail to mention the lower calf and ankle perforating veins, Dr Buxton does describe the ankle vascular "flare." The importance of this preulcer venous flare was first recognised by Cockett and Elgan Jones, who pointed out that it is a network of thin walled fine venules, not varicose veins, which communicate with one or more perforating veins and dilate when these become incompetent. Professor Dudley

quotes Sethia's and Darke's finding that 17 of their ulcerated legs had primary long saphenous incompetence²; it is also relevant that perforating vein incompetence was shown in 59 of these 60 legs. A lower incidence (14/23; 61%) was found in the study of which Professor Dudley is a coauthor,³ but this is perhaps a result of inadequate investigation, Doppler ultrasound having been used only to investigate saphenofemoral and popliteal incompetence in this study.

In a study of 77 patients with venous ulceration⁴ we used Doppler ultrasound to detect calf and ankle perforating vein incompetence, and this was found in 108 of 109 ulcerated legs, an incidence remarkably similar to that reported by Sethia and Darke. Saphenous incompetence was found in 47% of these patients and deep vein incompetence, as indicated by popliteal reflux detected by Doppler ultrasound, in 41%. All these patients underwent subfascial perforating vein ligation with saphenofemoral ligation and stripping where this was incompetent. Those with evidence of deep vein incompetence wore knee length elastic compression stockings after operation. Early results have been encouraging, over 80% of ulcers remaining healed between three and six years after surgery. A 10 year follow up study is now being organised. Doubtless some of the initially healed legs will have reulcerated, but it seems likely that permanent healing will be achieved in many more than the 25% with isolated saphenofemoral incompetence which Professor Dudley considers suitable for surgery.

The dismal long term results of conservative management by dressings and elastic compression are too well recognised to need repetition. Apart from perforating vein ligation, popliteal reflux can now sometimes be corrected by axillary vein transposition, and surgery offers the possibility of long term ulcer healing to many more patients than those with isolated saphenofemoral incompetence.

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- 1 Cockett FB, Jones DEE. The ankle blow-out syndrome. A new approach to the varicose ulcer problem. *Lancet* 1953;ii:17-23.
- 2 Sethia KK, Darke SG. Long saphenous incompetence as a cause of venous ulceration. *Br J Surg* 1984;71:754-5.
- 3 Hoare MC, Nicolaides AN, Miles CR, *et al*. The role of primary varicose veins in venous ulceration. *Surgery* 1982;92:450-3.
- 4 Negus D, Friedgood A. The effective management of venous ulceration. *Br J Surg* 1983;70:623-7.

SIR,—Professor H A F Dudley (2 January, p 65) suggests that surgical treatment of long saphenous incompetence might relieve varicosities leading to leg ulcers in about 25% of patients. If so I am sure this would be welcomed by both the sufferers from venous ulcers and those who care for them.

Sethia and Darke give the average age of the patients studied as 55.4¹ but most patients in the dermatology clinic with leg ulcers are considerably older than this.² I was unable to find the article by Hoare *et al* as the reference was incorrectly printed. It would seem, however, that the results were basically the same.

Other authors suggest that primary saphenous insufficiency is relatively rarely associated with venous ulcers.³⁻⁵

Another problem is determining the relative roles of long saphenous incompetence and incompetent perforating veins lower in the leg, but the techniques mentioned by Professor Dudley should help to elucidate this.

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- 1 Sethia KK, Darke SG. Long saphenous incompetence as a cause of venous ulceration. *Br J Surg* 1984;71:754-5.

- 2 Callam MJ, Ruckley CV, Harper DR, Dale JJ. Chronic ulceration of the leg: extent of the problem and provision of care. *Br Med J* 1985;290:1855-6.
- 3 Anning ST. *Leg ulcers, their causes and treatment*. London: Churchill, 1954.
- 4 Andersen MN, McDonald KE. Results of surgical therapy of severe stasis ulceration of the legs. *Ann Surg* 1963;157:281-6.
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Vitamins and neural tube defects

SIR,—Professor Rodney Harris (9 January, p 80) omitted to mention the study conducted on behalf of the Committee on Safety of Medicines by Winship *et al*.¹

Babies born with neural tube defects were identified by the Office of Population Censuses and Surveys. Prescription data for the three months before the last menstrual period and for the first trimester of pregnancy were obtained for 764 mothers whose children had a defect of the central nervous system and for an equal number of mothers of control babies born from the same doctors' practices.

There was a statistically significant difference overall between the numbers of mothers who were prescribed drugs in the study and control groups during the three months before the last menstrual period but no such difference was found for the first trimester of pregnancy, nor was there a significant difference for any specific group of drugs. For a composite group of non-steroidal anti-inflammatory drugs, salicylates, and sulphasalazine there was a significant difference for the trimester before the last menstrual period. There are arguments against such an artificial grouping, however, and when the individual drugs were considered the comparisons were no longer significant. The odds ratios for all medicines containing folic acid taken in the trimester before the last menstrual period were considerably less than unity, in contrast with nearly all other comparisons. This supports a suggested protective effect against neural tube defects of folic acid supplements begun before the onset of pregnancy.

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- 1 Winship KA, Cahal DA, Weber JCP, Griffin JP. Maternal drug histories and central nervous system anomalies. *Arch Dis Child* 1984;59:1052-60.

Sexism and the plural in medical writing

SIR,—Consistent use of the plural, Sue Burkhardt's solution to continuing male arrogance in medical writing (19-26 December, p 1585), would achieve more than this.

How deceptively easy and usually irrelevant it is for the doctor to attain clinical and ethical "excellence" for the patient; how difficult and relevant it is for all doctors to do their best for all the people they serve. Doctors who carelessly omit half the human race because they are women would write more accurately by using the plural, but they might also begin to see many others in their catchment area who "realistically" must be forgotten. By thinking in group terms medical authors will be encouraged to accept more generally the real test of quality and relevance in work they describe, the relation of their acts and observations as numerators over at least an implied population denominator; not only that such and such can now be done but whether or not it is actually being done on more than a token scale.

We may not be personally responsible for the increasing non-application of advances in medical