provided additional nursing help, and sometimes medical assistance, to cope with the added load of screening and recruitment and all costs of participation are covered. The workload, once screening is complete, is relatively light and can be largely covered by a competent part-time nurse provided she has ready access to medical advice.

Further details, and a copy of the trial protocol, can be obtained from: The Secretary, M.R.C. Treatment Trial for Mild Hypertension, MRC/DHSS Epidemiology & Medical Care Unit, Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.

W. S. PEART
Chairman.

The Medical Unit,
St. Mary's Hospital,
London, W2 1NY.

W. E. MIALL
Secretary
M.R.C. Working Party on
Mild to Moderate Hypertension.

Epidemiology and Medical Care Unit,
Northwick Park Hospital,
Watford Road,
Harrow, HA1 3UJ.

FINANCIAL DEFICIT FOR THE COLLEGE

Sir,

As you will know from the Honorary Treasurer's Report in the Annual Report, we are now forecasting a deficit of the order of £20,000 in the present financial year (ending 31 March 1976), owing to the effects of inflation. The increase in subscription which was approved at the Annual General Meeting on 15 November will not take effect until 1 July 1976, i.e. after the end of the present financial year when this deficit is expected.

In order therefore to try to balance the books this year, Dr Ian Watson, who is a Past President of the College, proposed at the AGM that all members be asked to make a voluntary contribution to bring the level of their subscriptions for 1 July 1975 up to that approved at the AGM for next year. This means that we are now asking those who paid £25 to contribute a further £10 now, and those who are on reduced subscriptions to contribute whatever they can.

This proposal was unanimously endorsed by the meeting and a considerable sum was collected on the day from those Fellows, Members and Associates who were present. To economise on postage, we do not intend to thank each one individually, but I should like those who have already subscribed to know how much we value their contribution and to ask them to discuss the contents of this letter with their colleagues,, confirming the support given at the Annual General Meeting.

For those who have not already subscribed the additional amount, I ask them now to send their cheque to the Finance Officer at 14 Princes Gate. I should also like to thank those who have responded so generously in support of all the work our College does for general practice.

It would also be very helpful to let the Finance Officer have a variable direct debit form, sent to you with the AGM papers; this method of payment does help us make great economies in administrative expenses.

P. S. BYRNE
President
Royal College of General Practitioners

14 Princes Gate,
Hyde Park,
London SW7 1PU.

ARE REFERENCES REALLY NECESSARY?

Sir,

In your Editorial (December *Journal*), you ask *Are References Really Necessary?*, and then make out a very good case for their retention. I am sure that all would agree that, despite the expense involved, they provide essential information and cannot be omitted. If the purpose of your editorial was to explore the possibility of omitting references as an economy measure, I would not approve such a step. Indeed, I would suggest that, despite any extra cost involved, they should be made even more useful and informative by including the title of each article referred to, in addition to the names of the authors and location, as is now the practice in many scientific journals.

H. W. K. ACHESON
Senior Lecturer in General Practice

Darbishire House Health Centre,
Upper Brook Street,
Manchester, M13 0FW.

REFERENCE

Journal of the Royal College of General Practitioners (1975). Editorial, **25**, 861–2.

Readers' opinions would be much appreciated.—Ed.

SPECIALIST RECOGNITION IN THE EUROPEAN ECONOMIC COMMUNITY

Sir,

The Council for Postgraduate Medical Education in England and Wales has proposed the following paper on the relationship between specialist recognition as determined by the EEC medical directives and accreditation which marks the end point of training as laid down by the Joint Higher Training Committees.

Specialist Recognition in The European Economic Community

An EEC Directive of 16 June 1975 (75/363/EEC) deals *inter alia* with the minimum postgraduate training to be required by Member States before doctors can be recognised as specialists for Community purposes. To facilitate freedom of movement Member States will issue a certificate or other evidence of formal qualifications in

specialised medicine to doctors who have attended a full-time course of theoretical and practical instruction, or an approved part-time course in certain circumstances. The training must be in a university centre, teaching hospital, or approved health establishment for the specified minimum length of time and must involve the personal participation of the doctor training to be a specialist in the activity and in the responsibilities of the establishments concerned.

The Council for Postgraduate Medical Education recommends that:

(1) There should be two types of recognition in the United Kingdom:

(a) *attestation*, being "evidence of formal qualifications in specialised medicine" as set out above, and

(b) *accreditation*, marking the end point of training before a doctor is likely to be appointed as a consultant in the National Health Service.

The difference between attestation and accreditation is sufficiently wide to preclude them being brought together at present.

(2) The General Medical Council, if designated "the competent body" as recommended in the Merrison Report, should issue the certificate of attestation. The certificate would normally be issued to U.K. graduates on notification from the appropriate College or Joint Higher Training Committee that the doctor had met the minimum criteria. The GMC would also have to satisfy itself on the credentials of doctors entering Britain from other Member States.

(3) The introduction of specialist recognition for the EEC should not be allowed to lead to a new grade in the National Health Service.

(4) The programme of training leading to accreditation should remain the responsibility of the Joint Higher Training Committees and Colleges, and it would be appropriate for the GMC to record the names of accredited doctors on its indicative register.

Further information may be obtained from this office.

G. A. MOGEY
Secretary

7 Marylebone Road,
Park Crescent,
London NW1 5HA.

OUTBREAK OF ORF IN NORTH DEVON IN 1975

Sir,

There was a widespread epidemic of animal vesicular disease amongst sheep in North Devon in 1975. Animal vesicular disease ORF—is a virus infection which causes vesicular eruptions on the udders of ewes and during lambing time is transferred to the mucosal surfaces of suckling young lambs. The virus is one of the pox viruses. When the eruptions are severe, the soreness may prevent the lamb suckling properly and cause a failure to thrive and, in severe cases, death.

Farmers traditionally treat the vesicles by applying rock salt which causes scabbing and often the lesion is said to "drop off." There is no veterinary cure though vaccine is available and can be used as a preventive measure. Last year's poor market prices for sheep made the use of such a vaccine much less an economic proposition to a farmer, who in any case usually looks upon the disease as more of an annoyance than a hazard in sheep farming. In North Devon, the local name for the disease in animals is "lure."

Infection of humans by the virus causes an eruption not unlike an infected wart. It is given the name contagious pustular dermatitis; it commonly occurs on the fingers or dorsal surfaces of the hand, sometimes on the wrist. There is nearly always a history of direct contact with infected sheep, though occasionally the absence of a history of direct contact makes it seem likely that the infection may have been transmitted via contaminated structures such as fencing.

The lesion is classically about one centimetre in diameter and has a firm, red base surmounted by a reddish blue capsule, which after a few days may turn into a greyish yellow vesicle, having the appearance of a pustule. This may enlarge and becomes flat topped though the bulla often becomes encrusted and its centre may be umbilicated. If the lesion occurs adjacent to the nail bed and the doctor has not previously seen orf, it can be mistaken for a paronychia. If such a mistaken diagnosis is made and the lesion incised, the absence of pus or exudate should, in itself, be, a clue to the correct diagnosis.

As in animals, there is no effective curative treatment in man. The lesion is best left and, if possible, kept dry. It will resolve spontaneously in three to five weeks. One of the main complications occurs when the lesion is on a particularly exposed part of the hand, where it may be knocked and can become secondarily infected. In this case, a course of an antibiotic should help to clear the secondary infection and allow natural resolution of the vesicle to take place. Sometimes, it is helpful to cover such exposed lesions with a dry dressing.

I have not seen a second lesion occur in a patient and it is thought that one infection confers lifelong immunity.

The worst case seen, a farmer's wife, described her lesion as very painful "because I keep knocking it and keep getting it in water." After a short spell of ten days of dry, hot weather the lesion disappeared and some four or five weeks later she was able to report that "the lambs are all better too."

In a public school of 350 boys, many of them farmers' sons, four other cases were seen, all having a history of direct contact with infected sheep during the Easter vacation. All these cleared spontaneously after an interval of three to five weeks.

As we now approach the 1976 lambing season, I thought this report of a small outbreak of a