LETTERS TO THE EDITOR

OUTBREAK OF ORF IN NORTH DEVON

Sir,

Dr Hall in his interesting letter (March *Journal*) states: 'As in animals, there is no effective curative treatment in man.' This is not true. Orf vanishes like magic if it is treated with idoxuridine dissolved in DMSO. Orf is due to a DNA virus which is inhibited by idoxuridine. If orf is treated like herpetic whitlows, that is by soaking a piece of lint the size of the lesion in preferably 35 per cent idoxuridine in DMSO, and the lint is rewetted daily for four to five days, the lesion heals very quickly and after a few days the virus can no longer be found on electronmicroscopy. The only readily available preparation is a five per cent solution of idoxuridine in DMSO (Herpid) and until a stronger solution becomes generally available this can be used.

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Reference

Hall, M. S. (1976). *Journal of the Royal College of General Practitioners,* **26**, 203-204.

DEEP VEIN THROMBOSIS AFTER AIR TRAVEL

Sir,

We recently saw an acutely ill patient (a well-built, previously physically fit, Australian man, aged 46) who had a pulmonary embolism following a deep vein thrombosis (DVT) eventually diagnosed by venography. There were no supporting clinical signs of DVT. The patient had travelled from Australia on a global business tour and had stopped at many centres. He had come to us from New York.

We have since been informed that deep vein thrombosis occurred during the last war in people who sat for long periods in air-raid shelters. However, it has not been reported as a complication in other similar situations involving sitting for long periods.

If we believe that factors of stress, pressure-point obstruction, temperature variation, lack of exercise, and long periods of immobility contribute to the aetiology of deep vein thrombosis, should we, in fact, pay more attention to the risk of its occurrence in commercial airline crews and passengers?

We would be interested to hear if this possibility has been recognized or investigated, or of other cases of DVT seen in general practice, with a recent history of long-distance travel.

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URINARY TRACT INFECTION

Sir,

During a recent visit to my native Prague, I attended the Second Congress of the European Association of Urology, which took place from 24 to 26 September. I had been asked by Dr Whewell of Middlesbrough to look at the section on urinary infection with reference to general practice, but unfortunately most of the papers were on urinary tract malignancy and tuberculosis.

However, I felt that one paper, given by V. Prat of the Institute of Clinical Experimental Medicine and of the Urological Clinic, Prague, was of some interest to general practitioners, and I quote from the résumé: 'In recent years diagnostic efforts have concentrated on localizing the infection site in patients with significant bacteruria. The knowledge of these data is of value for diagnosis, prognosis, and for the therapeutic regimen in an individual patient. Besides older methods based on evaluation of quantitative bacteriological findings in the bladder urine and washout method, new methods have been developed.' Bacterial excretion rates can be easier to demonstrate after saline loading or after diuretics, and there are new methods of demonstrating antibody-coated bacteria in urinary sediment.

After the Congress I went to the urological clinic to establish if these new methods of investigation were already being practised. They were not, and the mid-stream specimen of urine (MSU) is still the routine procedure.

However, they saw no reason why single-dose diuretics after a negative MSU should not be used by primary care doctors to help establish the presence of continued infection. If infection was demonstrable after provocation with a diurectic would it not point to the upper urinary tract?

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GENTAMICIN VERSUS WARTS

Sir,

It is my misfortune to have gained a local reputation for treating warts, which I normally do by curettage and galvanocautery under local anaesthesia. However, I am always reluctant to perform this painful operation on children; and occasionally plantar warts are so extensive that surgical treatment would cause an unacceptably large wound and scar.

In the latter I have been in the habit of prescribing gentamicin cream to be applied daily after bathing, and the results seem to be substantially better than those obtained with the usual chemical applications.

Perhaps some of your more scientifically-minded readers might care to conduct a controlled trial of this remedy which, after research, may prove to be no better than dandelion juice; but, nevertheless, it seems to me to be worth trying?

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LEAD AND MULTIPLE SCLEROSIS

Sir,

The article 'Lead and Multiple Sclerosis' (August *Journal*), represents a welcome addition to knowledge on this subject. Many investigators have realized that lead is not the cause of multiple sclerosis. Many blood lead concentrations and urine lead concentrations on patients with MS and controls have been carried out in Vancouver and the results are in complete agreement with the findings expressed in this article.