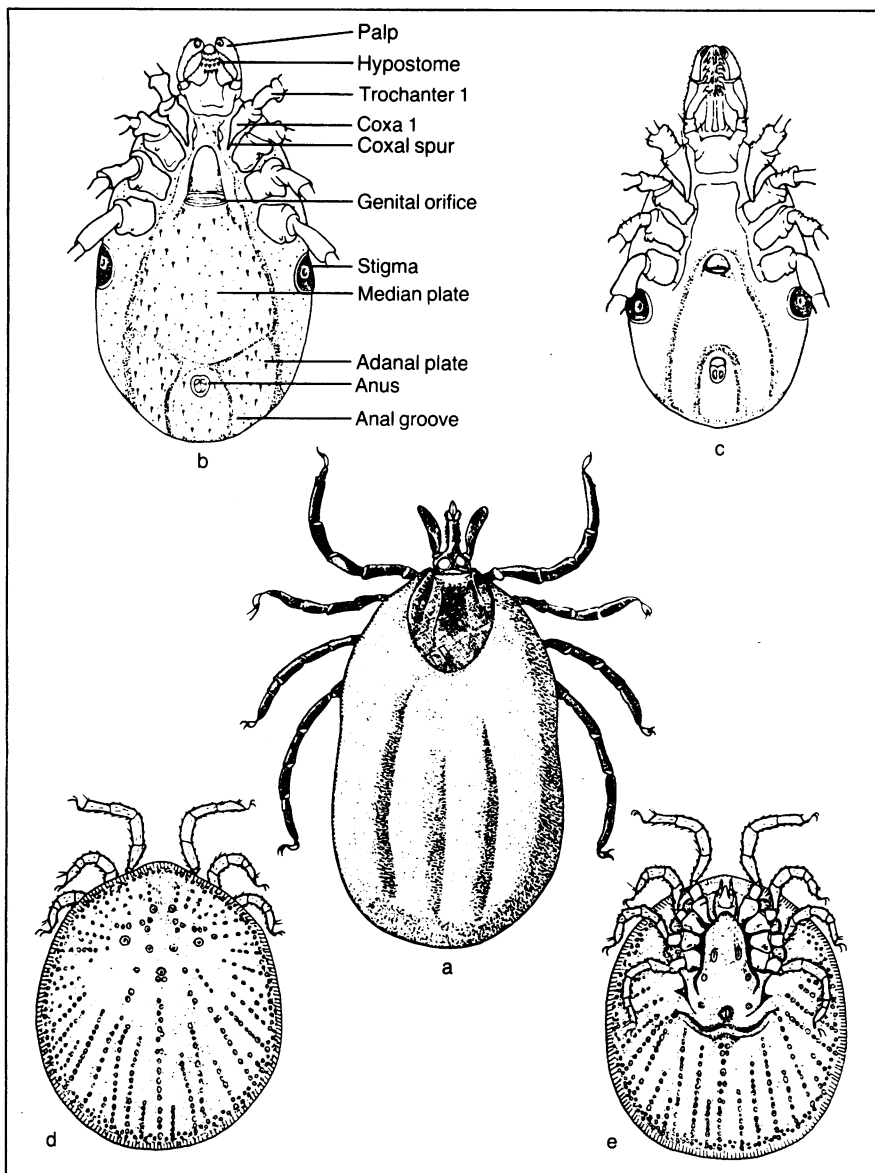


# LETTERS TO THE EDITOR



The sheep tick, *Ixodes ricinus*. a) Dorsum of an engorged female; b) venter of male; c) venter of female; d) *Argas vespertilionis*, dorsum of female; e) *Argas vespertilionis*, venter of female (after Moogstraal, 1958). Source: Smith (1973). Reproduced by permission of the Trustees of the British Museum.

## AN URBAN SHEEP TICK

Sir,  
Six year old Sharon said she had a worm sticking out of her head. To the doctors' disbelief, there was a white object about a centimetre long embedded in her scalp. It took some force to remove it, after which it was sent to the laboratory at our local hospital. Later the same day, an excited phone call from the

Public Health Laboratory, Whipps Cross Hospital, told us that we had removed a female sheep tick—*Ixodes ricinus* (Smith, 1973), minus its head.

*Ixodes* infestation not being the staff of life in our city practice, we quickly found out a few facts about this insect (*British Medical Journal*, 1977). It is a common parasite of sheep in this country and is known to transmit various arbovirus and rickettsial infections

to man. In Britain this risk is considered to be remote. The best way of removal is to apply a glowing cigarette or match end to its back.

Unfortunately the site of Sharon's bite became infected, and later had to be incised. She was also given a course of erythromycin. After four weeks there was complete healing, with no adverse after-effects.

Where did this tick come from? The family has no pets, and Sharon herself had not handled any sheep. The only possible source was her younger brother who had stroked some sheep on a recent farm visit.

We have found no other reports of urban sheep tick infestation in the British literature.

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## References

- British Medical Journal* (1977). Human tick infestation in Britain. Four letters to the editor. 2, 1288-1289.  
Smith, K. G. V. (1973). *Insects and other Arthropods of Medical Importance*. London: The Trustees of the British Museum (Natural History).

## PRIMARY CARE FOR CHILDREN

Sir,  
I read with interest the article "Paediatric primary care in Inner London" (September *Journal*, p. 520), and the suggestion that there was no evidence of movement away from primary general practitioner care.

Two years ago we found that many children were brought to a paediatric casualty department for minor childhood illnesses such as otitis media and wheezy bronchitis (Cooper and Lynch, 1979). Their parents tended to have diffuse social problems, and regarded minor acute paediatric illnesses as life-threatening emergencies. Although these families sought urgent medical advice at a casualty department they failed to seek long-term health care for their children. A few families attended child health clinics, but failed to use either hospital outpatients or their family doctors regularly.

In order to prevent movement away from primary general practitioner care