causing symptoms which are worse than the side-effects of the drugs used to treat them.

For a free copy, write (with a stamped envelope at least 8 inches by 5 inches) to Ms Julie Stone, British Heart Foundation, 57 Gloucester Place, London W1H 4DH.

THE VOLVO PRIZE

The Swedish motor car firm awards an annual prize for a clinical report on investigation and management of back pain. One of the authors of the latest prize-winning entry is a general practitioner, Dr Ray Million, of Eccles, who wrote, with colleagues from the Rheumatic Diseases Centre, Hope Hospital, Salford, on the assessment of the progress of the back pain patients.

HEALTH VISITING IN THE 80s

The Health Visitors Association has prepared a small booklet defining what health visiting is about and what its priorities should be. General practitioners will be interested in the long section about what kind of management structure there should be, and how health visitors can work with doctors. It is made plain in the document what a very different philosophy health visitors have from community nurses, social workers and doctors.

Health Visiting in the 80s is available, price 40p, from HVA, 36 Eccleston Square, London SW1V 1PF.

IRISH TRAINEES

The second annual general meeting of Irish trainees in general practice was held in Galway in October 1980, and the secretary of the National Trainee Organization of the Republic of Ireland has sent us a report of it. Education, business and entertainment were provided in a mixture that attracted 35 trainees, as well as teachers and interested general practitioners—the professional life of Irish and the UK trainees obviously has many similarities. No doubt we will be even better informed after the Spring Meeting in Dublin next year.

MEETINGS AND COURSES

The Mental Health Foundation

Conference on psychiatric disorders in general practice, Oxford 12-13 September 1981. For further details contact Dr Richard Thompson, Assistant Director, The Mental Health Foundation, 8 Wimpole Street, London W1M 8HY.

Preventing disablement

International seminar sponsored by the DHSS, Leeds Castle, 8-12 November 1981. Further information from the DHSS press office, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

Stroke patients

'Are we Meeting the Needs of Stroke Patients?', The Chest, Heart and Stroke Association, 24 June, Bloomsbury Centre Hotel, Coram Street, London WC1. For further details contact the Association at Tavistock House North, Tavistock Square, London WC1H 9JE.

LETTERS TO THE EDITOR

PREVENTION

Sir,

It is a sad reflection of our College and the profession that the only recommendation to be put in bold type in the College's report on health and prevention in primary care on page 14 states (I paraphrase) "Additional incentives will have to be offered to general practitioners". While I concede that extra staff and computers cost money, we could do a lot more in every consultation if we just asked ourselves as we end a consultation if we have discussed preventive measures.

DONALD GAU
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Reference

Royal College of General Practitioners. (1981). *Health and Prevention in Primary Care. Report from General Practice 17.* London: RCGP.

VAGINAL DISCHARGE

Sir,

During 1979 the *Journal* carried a series of letters discussing the management of vaginal discharge in general practice, in particular the problem of diagnosing gonococcal infection in young women in the practice situation. A letter from Moss and Patman (November 1979 *Journal*) pointed out that most regimes advocated for investigating vaginal discharge in the primary care situation would miss several pathogens. It has become a cause of concern to us that, in the absence of readily identifiable vaginal pathogens, practitioners may move into the area of psychosexual diagnosis before physical pathology has been fully excluded.

One common symptomatic genital sexual pathogen in women is *Haemophilus vaginalis.* This is a small gram-negative micro-aerophilic rod, the clinical implication of which has often been ignored in practice. Several studies have identified this organism as the causative pathogen in large numbers of women with previously unexplained vaginal discharge. The organism produces characteristic clinical features, and there is a thin homogeneous discharge, usually grey or white. This may or may not be profuse but is usually offensive in smell and may be described as 'fishy'. It is associated with a high vaginal pH of 5.0 to 5.5 compared with the normal 4.0 to 4.7. It is not uncommon for the presenting complaint to be that of offensive vaginal odour. This may have been commented on by the sexual partner and is a considerable cause of distress to the patient. Many patients have had repeated courses of anticandida therapy without success.

We wish to report that, as a result of repeated diagnosis of this condition in the Department of Genito-Urinary Medicine in Doncaster, attempts were made to make a specific microbiological diagnosis of this condition in general practice. In a period of two months, four cases have been identified in the practice and these have been confirmed with smear and culture examination. In addition to the endocervical charcoal swabs to exclude Neisseria, swabs were sent in Stuart's medium from the posterior vaginal vault for culture for *Haemophilus vaginalis.* In addition, air

dried slides were prepared for gram staining to identify gram-negative coccobacilli, to look for the relative absence of Döderleins bacilli and the presence of diagnostic 'clue cells'—these are the altered vaginal epithelial cells due to cell surface adherence of *H. vaginalis*.

The degree of symptomatic relief using treatment with 'Flagyl' 400 mg b.d. for seven days has been very marked. Similar results in the clinic have been obtained, using erythromycin 500 mg b.d. Even more noticeable in these patients has been the degree of psychological relief resulting from the acceptance, accurate diagnosis, treatment and effective management of a condition which causes a great deal of distress.

In the management of *H. vaginalis* vaginitis it is felt that simultaneous examination and treatment of the sexual partner is indicated.

J. L. HAWORTH
Balby Health Centre
Doncaster.

T. R. MOSS
Consultant
Department of Genito-Urinary Medicine
Doncaster Royal Infirmary
Doncaster.

URBAN SHEEP TICK

Sir,

I was interested to read of the discovery of a sheep tick on the head of a six-year-old child in London (January *Journal*, p. 55).

In western Canada, as in most parts of North America, ticks are quite common and are particularly a seasonal hazard in early summer. They do not transfer directly from one animal to another, but usually rest in long grass between blood meals awaiting the passage of a new host. They move quite slowly and their bite is entirely painless. In spite of this, the mouth parts are buried deeply in the skin where the tick remains attached for several days. Folk medicine recommends touching the tick with a hot match or cigarette, perforating it or applying kerosene to it. I have found that none of these methods will cause the tick to release its bite, and even crushing the body of a tick between forceps does not discourage it. It is important to remove the complete mouth parts because, when they are left embedded, inflammation and infection of the bite commonly occur. My treatment is to grasp the tick firmly in forceps and apply gentle traction and, with a No. 18 needle, chisel the epidermis immediately around the attached mouth parts until the complete tick can be lifted off with a small fragment of skin still held in its mouth. This procedure is painless, probably because the mouth parts secrete some local anaesthetic into the skin.

In addition to viral and rickettsial infections spread by ticks, the bite of many ticks can cause an ascending paralysis. This occurs four to six days after the tick has been acquired and progresses from difficulty in walking, through complete locomotor paralysis within 24 hours, to difficulties in speech and respiration and finally to death. The bites of female ticks appear to be more dangerous in this respect than the bites of male ticks, and in humans the victim is most commonly a female child. Once all ticks are found and removed, recovery is spontaneous, but the child may need respiratory assistance for a while. This condition has been caused by *Ixodes ricinus*, mentioned in the letter referred to above from Dr Bloomfield and Dr Samuel; in England and France it has also been caused by *Ixodes hexagonus*.

Although this condition is rare, it would be a pity for any child to die of an ascending paralysis simply because none of the attending doctors had heard of the condition and diligently searched for the ticks.

L. C. ROSE
Department of Family Medicine
University of Manitoba
Winnipeg
Canada.

DRUG ABUSE AND THE FAMILY DOCTOR

Sir,

Human nature being what it is, many of the problems of contemporary society are mirrored on both sides of the Atlantic. Drug abuse is as common in Canada as it is in the United Kingdom; only the drug being abused is different. Marked regional preferences are apparent to those of us who have practised medicine in both jurisdictions.

Mandrax, barbiturates, amphetamines and narcotics such as pethidine were the favourite drugs of abuse when I was in practice in Glasgow, and nowadays in Canada the popular choices are amphetamines, narcotics such as pethidine (known here as Demerol) and any and all preparations containing codeine (here available on prescription only).

Then, as now, I was amazed at the large quantities of drugs which an addict or abuser could obtain quite legally on prescription from physicians whom I considered to be overgullible and careless, but might be more kindly referred to as naive and overtrusting.

Recent articles in the Canadian popular press and a special report by the College of Physicians and Surgeons of Ontario (1980) make it plain that it is the easiest thing in the world to obtain drugs with abuse potential from the average doctor.

The following simple rules are suggested in an effort to help eliminate at least a small part of what is a generally recognized dangerous habit:

1. Do not prescribe drugs with abuse potential to persons whom you do not know without substantial objective evidence of their need.

2. Beware of the patient who requests a prescription for a suspect drug by name, even if small quantities only are involved. You are probably sixth or seventh on his list for the day.

3. Do not be afraid to say 'No'. If your suspicions are correct, this is a patient you can do without. If your suspicions are wrong, the reasonable patient will appreciate your concern and will not take offence.

J. A. MCSHERRY
Carruthers Clinic
1150 Pontiac Drive
Sarnia
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Canada.

Reference

College of Physicians and Surgeons of Ontario. (1980). Ad hoc committee to look into problems of physicians prescribing narcotic and controlled drugs under questionable circumstances. Interim Report.

PREVENTION AND DIET

Sir,

Having worked in a West African community health programme, I read with particular interest the stimulating reports *Health and Prevention in Primary Care* and *Prevention of Arterial Disease in General Practice* (Royal College of General Practitioners, 1981).

One opportunity for prevention which is omitted is advice to eat less refined carbohydrates and more bran or other roughage. I believe there is now firm evidence that this advice helps to prevent constipation, diverticulitis and other colonic disorders (Burkitt and Trowell, 1975), and circumstantial evidence that it may reduce the incidence and/or severity of diabetes and ischaemic heart disease (Yellowlees, 1978).

Having read this evidence and witnessed the profound differences in diet and disease patterns between Africa and