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.

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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.

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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.

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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

England, dieting advice along these lines is my most frequent act of anticipatory care.

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Burkitt, D. P. & Trowell, H. C. (1975). *Refined Carbohydrate Foods and Diseases: Some Implications of Dietary Fibre.* London: Academic Press.

Yellowlees, W. W. (1979). Ill fares the land. *Journal of the Royal College of General Practitioners,* **29**, 7-21.

THE HISTORY OF ANTENATAL CARE IN BRITAIN

Sir,

I am currently researching the history of antenatal care in Britain, and am finding it difficult to obtain information about the development of general practitioner antenatal care. The period I am interested in runs from the beginning of the antenatal care movement (at the end of the First World War) to the present day. Are there any general practitioners who possess records (or good memories) relating to the pre-NHS era who would be willing to supply me with data? I would be very grateful for any help of this kind.

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BOOK REVIEWS

THE PRINCIPLES AND PRACTICE OF MEDICINE. 20th EDITION

A. McGhee Harvey, Richard J. Jones, Victor A. McKusick, Albert H. Owens, Richard S. Ross (Eds.)

Appleton-Century-Crofts
New York (1980)
1569 pages. Price £25.05

Sir William Osler's *Principles and Practice of Medicine* was first published in 1892. Early editions of the book were firmly based on pathology and morbid anatomy, although as a teacher Osler was principally known for attaching great importance to careful clinical observation of the patient: "The student begins with the patient, continues with the patient and ends his studies with the patient, using books and lectures as tools, as a means to an end."

More recent editions of the book have departed from the pathological classification which Osler favoured and which is also followed by other present-day medical tomes. Instead, successive editors have now followed Osler's teachings and concentrated on a patient-centred and problem-centred approach to medicine which gives considerable attention to differential diagnosis and patient management strategies. As a result, it is both easy and profitable to read right through a section and review one's own management strategies against those suggested in the text. It is less easy to use the book as a quick reference.

This edition has been written by a hundred co-authors, all present or recent members of the teaching staff at Johns Hopkins University School of Medicine. Inevitably, present-day American practice of internal medicine dominates the book. Consequently the best sections are those concerning the mainstream of internal medicine, such as the chapters on cardiology and respiratory medicine. The sections dealing with psychiatric and psychosomatic problems are brief and not particularly helpful.

I suspect that general practitioners usually turn to large medical texts for quick reference. For this purpose the competitors—such as Price's textbook or Cecil and Loeb—are probably more useful. However, for more general reading or for problems of differential diagnosis, this text deserves to be considered as a useful but secondary addition to a postgraduate or practice library.

S. A. SMAIL

INCONTINENCE AND ITS MANAGEMENT

Dorothy Mandelstam (Ed.)

Croom Helm
London (1980)
233 pages. Price £9.95

Incontinence is a subject "we dinnae care to talk about", in the words of the old Scots saying. In chapter nine of this book doctors are accused, probably justifiably, of adopting a pessimistic attitude to its management. Yet it is a common and socially devastating problem. A general practitioner will care for about 60 elderly patients suffering from this condition. Even in younger patients there is a high incidence; e.g. Nemir and Middleton, in a study of 1,300 college girls, discovered 52 per cent suffering from stress incontinence. The development of incontinence is probably the most frequent precipitant of hospital admission in the elderly.

The book aims to cover incontinence in the adult population, but naturally the emphasis is on the elderly. The initial chapter deals with normal micturition and its control. It is particularly effective in demonstrating the relationship of different clinical states to abnormal function as shown by urodynamic studies. The following two chapters cover urological and gynaecological aspects of the condition, particularly those concerned with investigation and treatment. The remainder of the book is concerned with management outside hospital. This, of course, requires a multidisciplinary approach with social factors often occupying a more important place than medical ones. There is much repetition of clinical and assessment details in these chapters, which encourages dipping into the pages rather than total immersion. Possibly the attention of different professionals will be concentrated on the section written by a colleague rather than on the whole book; this weakness is inherent in any book aimed at a varied readership. Certainly general practitioners will be amply rewarded by a study of Keith Thompson's chapter on management in the community. His mnemonics for classification of patients are particularly helpful. The appendices covering checklists and guidelines, equipment and further reading are a valuable supplement.

This textbook will find a place on the shelves of the practice library where it