CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Haemophilia centres

SIR,—Haemophilia centres were first established in 1954. The emphasis was on diagnosis and the need to avoid dangerous operations. In 1976 a revised three-tier system was set up with reference centres, ordinary centres, and associate centres. There are now over 150 centres, and the emphasis is on treatment and prophylaxis. As there are about 3300 haemophiliacs in the United Kingdom it follows that the average number of patients attending each centre is 20. Furthermore, as expertise in haematology extends more haematologists feel able to offer diagnosis and treatment. Directors of haemophilia centres have recently been discussing the organisation of haemophilia care, particularly that of supraregional reference centres.

If we are to have haemophilia centres it is sensible to insist on a minimum number of patients to provide a proper service. Twenty seems to me an acceptable minimum. Furthermore, to qualify as a centre, the hospital should provide a comprehensive, 24-hour, clinical and laboratory service. Staff should include a doctor in overall clinical charge, a nurse, a physiotherapist, a social worker, and a secretary. They may not all work full time in the haemophilia centre, but it should be their major commitment.

But do we need this hierarchy of haemophilia centres? Small associate centres provide a service which is no different from that provided by many unrecognised district hospitals. Does recognition serve any useful purpose? Many ordinary haemophilia centres provide the same service as reference centres. Their directors may not wish to refer difficult cases to their local reference centre, but prefer to deal with whichever centre they think is best able to help the particular patient's problem. The present tendency in health service administration is towards devolution at district level, and although there are too few haemophiliacs to justify a centre in every district it is more logical to base haemophilia centres on a regional and not a supraregional basis. I am unaware of any shortcomings in the service for haemophiliacs in the regions which have no supraregional reference centre compared with those which do have one.

Rather than deliberating about reference centres we should be trying to improve the standard of care in ordinary haemophilia centres. Our aim should be to have a network of centres all adequately staffed and all providing a service capable of dealing with most problems. Their size will vary and their expertise will depend on the interests of the staff in each centre. Their relation with local district hospitals can be settled locally and will depend on the interests and abilities of the haematologists together with their colleagues in these hospitals and on the preferences of the patients themselves.

D I K EVANS

Royal Manchester Children's Hospital,
Pendlebury,
Manchester M27 1HA

Benoxaprofen: effect on cutaneous lesions in psoriasis

SIR,—We read with interest the suggestion by Dr B R Allen and Dr S M Littlewood (30 October, p 1241) that benoxaprofen may have an important place in the treatment of psoriasis. They do not mention, however, any change in psoriatic involvement of the nails during treatment. We have seen two patients in whom there has been a considerable improvement in their psoriatic onycholysis during treatment with benoxaprofen for psoriatic arthropathy. At the same time their scalp psoriasis disappeared and cutaneous plaques improved. In one patient the onycholysis returned within a month of discontinuing benoxaprofen. Topical or oral methoxsalen plus ultraviolet-A irradiation has been shown to benefit psoriatic nails.[1 2] The photosensitising property of

benoxaprofen may be responsible for the improvement seen in these patients although, paradoxically, onycholysis is a common side effect of benoxaprofen treatment.

After the chance finding of a dramatic improvement in persistent palmoplantar pustulosis (also known as pustular psoriasis of the hands and feet) in a 70-year-old woman during treatment with benoxaprofen 600 mg daily for osteoarthrosis we carried out a pilot study to assess the effect of benoxaprofen in the treatment of eight patients with recalcitrant palmoplantar pustulosis, all of whom were resistant to other forms of treatment. We treated seven women and one man aged from 56 to 75 years with benoxaprofen 600 mg daily for three months. All topical treatments were discontinued for the duration of the study. All patients improved within the first month of treatment. Four patients were free from pustules after two months' treatment, and all eight were clear after three months. A varying amount of scaling remained in the previously affected areas. All patients relapsed within six weeks of discontinuing treatment. Routine biochemical, haematological, and hepatic function tests were normal throughout the study.

In addition to its inhibitory effect on lipoxygenase activity benoxaprofen specifically regulates the directional movement of monocytes in response to a stimulus. Accumulation of both monocytes and polymorphonuclear leucocytes is implicated in the pathogenesis of palmoplantar pustulosis. We suggest that benoxaprofen is acting on both phases in palmoplantar pustulosis and that this, linked with the improvement seen in psoriasis, warrants further research in this area. We also suggest that a topical formulation of benoxaprofen might be of use in the treatment of psoriasis and palmoplantar pustulosis.

DAVID A FENTON
JOHN D WILKINSON

Department of Dermatology,
Wycombe General Hospital,
High Wycombe, Bucks HP11 2TT

[1] Hofmann C, Plewig C, Braun-Falco O, *et al. International Psoriasis Bulletin* 1977;**4**:3-4.
[2] Marx JL, Scher RK. *Arch Dermatol* 1980;**116**:1023-4.

SIR,—Dr B R Allen and Dr S M Littlewood (30 October, p 1241) describe an interesting study on oral benoxaprofen in treating psoriasis. Their patients all had severe psoriasis (average 63% of total skin affected), and most had failed to respond to cytotoxic drugs. Eight of 13 patients improved, and the rest remained unchanged. Psoriasis characteristically remits and relapses, and with or without treatment there are only two possible outcomes for psoriasis of this severity; either to remain severe or to improve. Thus, their results may simply be following the natural history of the disease. As the authors point out, results with benoxaprofen could have important implications for the pathogenesis and treatment of psoriasis, especially in the light of our recent report[1] of increased concentrations of leukotriene B_4 and other lipoxygenase products in affected psoriatic skin. Controlled trials of benoxaprofen are badly needed, but they are unlikely to be performed in view of the recent ban on its use.

MALCOLM W GREAVES

Institute of Dermatology,
London E9 6BX

[1] Brain SD, Camp RDR, Dowd PM, *et al. Lancet* 1982; ii:762-3.

Confidentiality of patients' records

SIR,—We write in support of the views of Dr David Howe on confidentiality, and we sympathise with him for the negative response his letter evoked. One of our patients also had his application for a job with an insurance company rejected because we would not release information from his records. We are also concerned about the release of information which occurs on a massive scale and in great detail through the personal medical attendants' reports used when people take out life or permanent health insurance. We do not dispute that insurance companies and potential employers have a right to information about an individual's health; we also realise that the most detailed history available is in the hands of his general practitioner and that access to this is therefore desirable to them. What we do dispute very strongly, however, is that this desire for the information gives them the right to obtain it from this source.

A detailed summary of the patient's records provides more information than a medical examination, but it does not follow that it should be made available. A detailed questionnaire and thorough physical examination carried out properly should avoid the risk of an epileptic finding work as a bus driver or pilot or a patient with hypertension getting a job as a steeplejack. It is primarily for the protection of the insurance companies and employers that more detailed information is required not for that of the patient, his workmates, or the public.

Much is said of the needs of the insurance companies, but it is quickly forgotten or swept aside that a general practitioner possesses details about a patient only because he occupies a privileged position in which it is assumed that what he is told or discovers will remain confidential. Confidentiality is not conditional and has no time limit. It is difficult to believe that most general practitioners really feel that it is right to accept information from a patient in the strictest confidence one day and sell it to an insurance company the next simply on the grounds that the patient has given a consent to which he has no option.

We agree wholeheartedly with Dr Howe that the BMA should re-examine its policy in this respect, and we feel that a change is urgently needed. It seems clear, however, that until those who share this view make it known nothing will change.

W P GARSON
G B MAY

Guildford, Surrey

Confidentiality of medicolegal reports

SIR,—Like Mr P J E Wilson and Mr I P Cast (2 October, p 970) I had assumed that medical reports to solicitors were confidential between two professional men and would not be disclosed to any other party except by mutual agreement or by order of a court. This remained my view until about 1974 when a series of events took place which led to the following letter being sent to the Royal Commission on Legal Services in 1976.

"From time to time solicitors write requesting reports and opinions from me as a general medical practitioner about particular patients of mine. It had been my custom to supply as full and frank a report as appeared appropriate including matters which might be either derogatory or distressing to the patient in the belief that this policy would eventually be in his best interests. Such a course of action was of course possible only on the understanding that the correspondence between solicitor and doctor could be regarded as confidential between the two of them. About two years ago a patient brought my own report back from his solicitor in an open envelope and told me that both he and his wife had read it. When I remonstrated with the solicitor concerned he said that the patient had paid for the report, it was therefore his property, and there was no reason why he should not have it regardless of the contents. Since then I have worded my reports in such a constrained fashion that their value to the solicitor must be considerably reduced. Occasionally patients have been sent from their solicitor with a verbal request to supply a medical report. This method is quite unsatisfactory because there is no means of determining the problems requiring particular attention. It also introduces a third party into the mechanism of concourse between the professional men. The purpose of my letter is to suggest a review of such communications with the intention of devising a more satisfactory understanding between the two professions."

To date I have received no answer or recommendations from the august body to which it was addressed, apart from a receipt. The royal commission has long since produced its report; it therefore seems highly unlikely to give any helpful answer now.

R SIMPSON-WHITE

Stonehouse,
Plymouth PL1 3JF

Appendicitis due to Campylobacter jejuni

SIR,—I have spent a good deal of my professional life trying to determine whether one micro-organism or another is a cause of disease. This has never been easy perhaps due to my conservative approach. I see little of this, however, in the contention by Dr F Megraud and others (23 October, p 1165) that the presence of *Campylobacter jejuni* in the appendix of a young adult accounted for her appendicitis. They could be right, but the evidence is flimsy. It seems from what the authors say that *C jejuni* is very rarely found in the inflamed appendix. It must often be close by, however, so that on the rare occasion that it strays there it does not seem reasonable to regard it automatically as the villain. A failure to find these organisms in the appendices of patients without disease and a more striking occurrence than the authors report in patients with appendicitis would be more convincing evidence of a causal relation. I still cannot shed my conservative approach.

D TAYLOR-ROBINSON

Division of Communicable Diseases,
Clinical Research Centre,
Harrow, Middlesex HA1 3UJ

Campylobacter enteritis and erythema nodosum

SIR,—We read with interest the report of erythema nodosum associated with *Campylobacter colitis* by Dr M E Ellis and others (2 October, p 937). Lambert *et al*[1] have described a 48-year-old woman with erythema nodosum and arthralgia associated with *Campylobacter jejuni* enteritis.

In the course of a follow-up to look at the rheumatological problems of patients suffering from *Campylobacter jejuni* enteritis in a single outbreak occurring in Grampian region in