two days. The initial satisfactory response probably resulted in healed meninges, which prevented the penicillin from diffusing into the cerebrospinal fluid before the organisms were eradicated; substitution of chloramphenicol gave a dramatic response.

Cefuroxime and other expensive β lactams are active on β lactamase producers but have little advantage over ampicillin on sensitive organisms. We were aware of the possible toxicity of chloramphenicol and were constantly on guard. I have not come across a single case of toxicity in my experience in Africa. The inordinate fear of using chloramphenicol is often due to use of a faulty logic by doctors on decisions "involving small likelihoods of extremely serious consequences. They frequently perceive the probability of rare events to be many times greater than the data actually demonstrate it to be."[4]

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Genital herpes: hype or hope?

SIR,—The leading article on genital herpes by Professor Michael Adler and Dr Adrian Mindel (4 June, p 1767) was timely, particularly because the media have inaccurately highlighted the horrors and raised the hope of a cure in herpes sufferers with the new antiviral drug acyclovir. It is unlikely that the true incidence of primary or recurrent herpes will be known unless the form SB60 is modified in the immediate future.

The media have not only raised the hope of a cure with acyclovir but have also paradoxically created panic, which was made so evident to us by the number of patients with recurrent herpes attending this department soon after the programme. The women's magazines did not lose time either to frighten their readers. All the patients came expecting to receive acyclovir and to be cured of herpes. We would like to caution the unwary that acyclovir has its limitations. To be effective it has to be taken in the early stage, preferably in the prodromal stage, of the disease, and it is costly, particularly considering the marginal benefit it confers on patients with recurrent herpes. If acyclovir is prescribed widely and for milder forms of the disease in an attempt to alter the recurrence rate, drug resistant mutants may emerge. Indeed, herpes simplex virus resistant to acyclovir has already been isolated from treated patients.[1 2] We believe that for established recurrent herpes a simple saline bath and talcum powder are as effective and much cheaper than any available antiviral drugs, particularly since recurrent attacks are much milder and of shorter duration and heal more quickly, and in most cases the intervals between attacks are longer.

Finally, Barton *et al*[3] have also emphasised the underestimation of the role of herpes simplex virus 1 in the possible aetiology of carcinoma of the cervix. In this department, since 1973, all patients with positive cervical herpes have been advised to have annual cervical smears, and we are pleased to confirm to date not a single case of carcinoma of the cervix has been reported in those followed up.

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Non-hormonal treatment of osteoporosis

SIR,—It is unfortunate that in the study of osteoporosis and its prevention and treatment doctors generally neglect the use of exercise (26 March, p 999). The prevention of bone loss by calcium supplementation or by hormone replacement treatment in women is paralleled by a similar preventive effect of regular exercise.[1 2]

Smith[2] examined 30 elderly women with a mean age of 84 years, and placed them into two groups, which were matched on the basis of age, weight, and walking ability. The experimental group participated in a 30 minute exercise programme, three days a week, for three years. At the end of this period there was a 5·6% difference in bone mineral content, consisting of a 2·3% gain in the experimental group and a 3·3% loss in the control group. The results support the previous study of Aloia,[1] which indicated a substantial increase in total body calcium in women who exercised regularly for one year. In addition to the effects of exercise on bone mineral content, its effects on muscle strength and neuromuscular coordination may further reduce the incidence of fracture in the elderly.[3]

While admitting the usefulness of adequate amounts of dietary calcium, we would suggest that in addition changes in life style with regular exercise would certainly be more beneficial and place the subjects at less risk than hormone replacement treatment.

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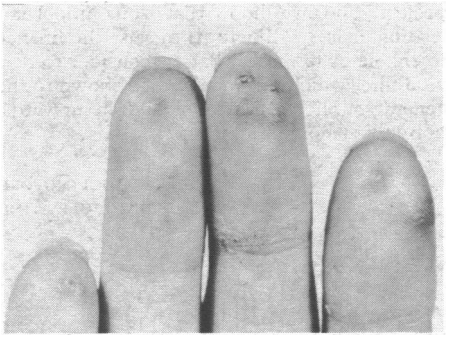
Finger sepsis

SIR,—Dr J S Skyler and others (21 May, p 1614) describe two cases of finger sepsis, presumably of bacterial origin, as a complication of self monitoring of blood glucose. We have not encountered any cases of bacterial finger sepsis in our diabetic clinic but wish to report a case of presumed viral infection of the fingers in a self monitoring pregnant diabetic patient.

A 28 year old, newly diagnosed, pregnant insulin dependent diabetic developed multiple pustular lesions on the fingertips of both hands six days after starting self blood glucose monitoring (figure). These lesions coincided with the sites of



Viral infection on the fingers of a diabetic patient.

previous finger pricks. At this time she had vulvulovaginitis from which herpes simplex was subsequently cultured. Although the pustular fluid from the fingers was not examined for the presence of herpes virus, we presume that the patient transferred the virus from her genitalia to her fingertips and inoculated herself when she used the stylet.

Until now, apart from washing hands, no special precautions with regard to sterility have been suggested to our patients who perform home blood glucose monitoring. This case indicates that particular care with regard to antiseptic precautions should be taken in patients with existing viral or bacterial skin, mucous membrane, or serum infections. Indeed, we have recently taught a patient with Australia antigen to monitor his own glucose, and we emphasised his infectivity, and the importance of after care and isolation of his self monitoring kit.

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Deaths in the first 10 minutes

SIR,—We were interested in your leading article on deaths in the first 10 minutes (4 June, p 1768). Seven years ago we in Pulborough set up a registered charity called Arun Cardiac Emergency, which was established to equip the community ambulances in the Pulborough and surrounding area with resuscitation equipment in the form of defibrillators, monitors, and drug boxes containing equipment not only for cardiopulmonary resuscitation but also for use at road traffic accidents and other acute emergencies. The ambulance personnel are trained to use the defibrillators, and the equipment and drug boxes are available for doctors attending any of the above incidents.

As a result of statistics available from Seattle and Brighton, we have also recognised the need for public education in cardiopulmonary resuscitation to try to sustain life before the arrival of the ambulance. Living in a rural community, instruction of the public by lectures, as performed in Brighton, is not really feasible, and this is borne out by the