

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

### Bioterrorism

In his editorial (October 2002 *JRSM*<sup>1</sup>) Dr Beale proposes an incomplete solution. The universal vaccination idea is based on the view that the current conflict is caused by a few 'rotten apples' ('rogue states', etc.) bent on upsetting an otherwise perfect world. Is it not more 'scientific' and morally less repugnant to use some of the money which will be dedicated to rendering the good apples biologically immune, to sociological, psychological, political, linguistic, religious and conceptual research so that the reasons why people have become 'careless with their lives' can be understood? Have the human sciences also been thrown overboard?

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### REFERENCE

- 1 Beale AJ. Bioterrorism: what can we do? *J R Soc Med* 2002;95:479-80

### Michelangelo and medicine

Dr Strauss and Dr Marzo-Ortega (October 2002 *JRSM*<sup>1</sup>) and indeed the other authors they cite, do not refer to two other aspects of medical interest in Michelangelo's David. The first is the very large right hand which is quite disproportionate to the size of the rest of the statue, although, as far as I am aware, anatomically normal. The second feature is the depiction of David with his sling over his left shoulder with a stone in his right hand. This strongly implies that the subject was left-handed. The only commentary I have found on this point is that the stone from which the statue was carved was difficult to work, and indeed it had already been worked on by others before Michelangelo used it. While this may have affected the way the sculpture was made it does not seem entirely convincing that it necessitated making a left-handed subject.

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### REFERENCE

- 1 Strauss RM, Marzo-Ortega H. Michelangelo and medicine. *J R Soc Med* 2002;95:514-15

Dr Strauss and Dr Marzo-Ortega (October 2002 *JRSM*<sup>1</sup>) remind us that interpretation of art is subjective. The force that inspired Michelangelo Buonarroti, a sculptor and reluctant painter, has also been much discussed over the centuries. However, surely there can be no debate over Goethe's words that 'unless one has seen the Sistine Chapel

it is impossible to form an intuitive concept of what one person is capable of doing'. When I visit these treasures again, the authors' comments will throw a fascinating new light on them.

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### REFERENCE

- 1 Strauss RM, Marzo-Ortega H. Michelangelo and medicine. *J R Soc Med* 2002;95:514-15

### Wet combing to eradicate head lice

Dr Vander Stichele and his colleagues (July 2002 *JRSM*<sup>1</sup>) make a welcome contribution to the debate on the merits of wet combing for the detection and treatment of head lice. The comb they have tested is the Bug Buster comb<sup>2</sup>. This forms part of the kit now available in the UK on NHS prescription to assist parents who are encouraged to remedy head lice at home. However, the Belgian researchers do not seem to have tested the full Bug Busting method. In our experience, dry and damp lice move swiftly away from disturbance created by combing, thus evading detection. We find that it is important to shampoo and rinse the hair before applying conditioner. This takes moisture (which temporarily immobilizes lice) to the hair roots, their main habitat. The omission of shampooing in the Belgian study produces a protocol which is easier for school screening, but not the most effective.

Moreover, the Bug Busting wet combing method consists of combing sessions on days 1, 5, 9 and 13. At each session the hatched lice on the head are removed, leaving the eggs, which take a maximum of 10 days to hatch. It is therefore expected that lice which hatched on day 10 will be found during the fourth session. The cure rate should be measured at a further, fifth, session; by doing this at the fourth session, Vander Stichele and colleagues may have counted possible successes as failures.

We suggest that the Belgian protocol of wetting the hair is an improvement on spraying only where hair-washing cannot be carried out. It is definitely an advance on applying conditioner to dry hair. Wetting the hair may prove to be the most sensitive protocol that is feasible in mass screening. It should be tested against the full Bug Busting method.

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## REFERENCES

- 1 Vander Stichele RH, Gyssels L, Bracke C, *et al*. Wet combing for head lice: feasibility in mass screening, treatment preference and outcome. *J R Soc Med* 2002;**95**:348-52
- 2 Lapeere H. *International Congress on Phthiraptera (Lice)*. University of Queensland, July 2002 [Presentation]

**Immunotherapy for cancer**

The correspondence on immunotherapy for cancer<sup>1,2</sup> revives ideas first put forward in your own pages by Richards in 1988<sup>3</sup>. The methods outlined regarded as unorthodox at the time, included immunotherapy and local debulking surgery—these being followed by a highly supportive regimen. In twenty years of its use I have not seen this regime improved upon. It remains now only for the enzyme components and one or two others to be added to current thinking. At the time, I gather, Richards' discussion paper drew only two responses. Remarkable? Perhaps—but now well worth another read.

R Bryant

## REFERENCES

- 1 Johnson AE. Immunotherapy for cancer. *J R Soc Med* 2002;**95**:427
- 2 Grange J, Sumbford J, Stanford C. Immunotherapy for cancer. *J R Soc Med* 2002;**95**:525
- 3 Richards BA. The enzyme knife—a renewed direction for cancer therapy? *J R Soc Med* 1988;**81**:284-5

**Drug-facilitated sexual assault**

Jason Payne-James and Deborah Rogers (July 2002 *JRSM*<sup>1</sup>) draw wider attention to a report<sup>2</sup> identifying that many complainants of sexual assault have high concentrations of alcohol in their blood. In a Home Office report it was recommended that, when psychoactive drugs are involved, a clinical psychologist should testify as to the effects of the drug and that a toxicologist would be able to give evidence as to the complainant's behaviour against that of typical reactions to the drugs in question<sup>3</sup>. In the UK clinical psychologists are not necessarily trained in substance misuse and may never have seen an acutely intoxicated patient in a forensic setting as part of their practice. Thus clinical psychologists who are not specialists in addiction may not be able to advise investigators or provide evidence in court on the effects of drugs. Most toxicologists, except for a few who are medically qualified, cannot comment expertly on the clinical effects of drugs on an individual, although they may give helpful general advice on the effects of drug metabolites and level of toxicity.

In many cases the forensic physician who has attended the complainant shortly after the incident and who has taken a detailed history and performed a full examination will be the person in the best position to assist the court with an

informed opinion, based on the objective results of an appropriate clinical examination, as to whether or not the complainant is intoxicated at the time of presentation. Furthermore his/her clinical findings will inform the analytical toxicologist's approach to the samples submitted to the laboratory. The opinion of a competent forensic physician as to which substances may have caused the signs exhibited and symptoms described by the complainant may be invaluable to the investigators and to the court, before the laboratory results have become available or in those cases where the complainant has presented too late for useful toxicological results to be obtained.

Clear recommendations have been issued to forensic physicians when called to examine complainants of sexual assault<sup>4</sup> as well as for the toxicological investigation of such assaults<sup>5,6</sup>.

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## REFERENCES

- 1 Payne-James J, Rogers D. Drug facilitated sexual assault, "ladettes" and alcohol. *J R Soc Med* 2002;**95**:326-7
- 2 Hindmarch I, ElSohly M, Gambles J, Salamone S. Forensic analysis of drug use in cases of alleged sexual assault. *J Clin Forens Med* 2001;**8**:197-205
- 3 Sturman P. *Drug Assisted Sexual Assault. A Study for the Home Office under The Police Research Award Scheme*. London: Home Office, 2000
- 4 Stark MM, Wells D. Drug mediated sexual assault. *J Clin Forens Med* 1999;**6**:53-5
- 5 Le Beau M, Andollo W, Hearn WL, *et al*. Recommendations for toxicological investigations of drug-facilitated sexual assault. *J Forens Sci* 1999;**44**:1:227-30
- 6 Rogers D. Forensic samples (guideline 14). In: Stark MM, Rogers DJ, Norfolk GA, eds. *Good Practice Guidelines*. London: Metropolitan Police, 2001

**HIV/AIDS in developing countries**

The personal views of Mr Loeffler (October 2002 *JRSM*<sup>1</sup>) are at odds with those of the WHO and *inter alia* the last two International AIDS Conferences where the rolling out of treatment for HIV/AIDS in developing countries was high on the agenda. The issue is not only one of a basic human right for the recipient, whether they be in developed or developing countries, but also of helping prevent the spread of HIV/AIDS. His experiences in Nairobi, Kenya, do not necessarily speak for the rest of Africa or possibly elsewhere outside his domain in Kenya.