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Recurrent Herpetic whitlow

Sir

Herpetic whitlow is usually a benign but painful nuisance. It can however cause more serious problems for patients and doctors than is generally realized as outlined below.

A thirty-nine year old D.I.Y. shop manager presented to the Accident and Emergency Department at this hospital with a two year history of recurrent painful blister on the tip of his left middle finger. There had been ten episodes in all. It had been treated on different occasions by both general practitioner and local A&E department with incision, antibiotics and poultices. It always resolved slowly, over a period of 2 to 3 weeks. It impaired some aspects of his work but did not require him to take sick leave.

At presentation he had a blister with surrounding erythema. Incision of the roof produced a clear discharge which grew Herpes Simplex virus type 2, Tzanck smear was negative. Culture also grew a coliform sensitive to Trimethoprim. He was treated with simple analgesia. Acyclovir 200 mg five times per day and trimethoprim 200 mg bd for 5 days. There was a poor clinical response but the whitlow healed gradually over the next 3 weeks. He was advized about future drug prophylaxis (see below).

Treatment of recurrent herpetic whitlow is not well documented and the only series—eight patients—found Acyclovir 800 mg bd for 5 days at the onset of prodromal symptoms prevented cutaneous manifestations (Gill *et al.*, 1956). Treatment during the acute phase is generally ineffective.

It is important for doctors to be aware of the danger of incorrect diagnosis and management as seen in this case. Misdiagnosis may lead to cross-infection and serious illness in immunocompromized, surgery can cause prolonged healing and pain, secondary infection and encephalitis (Carter, 1979; Louis *et al.*, 1979). Health care workers may best avoid infection by wearing rubber gloves (the virus is found in 2.5% of normal adult saliva and 6.5% of bronchial secretions of hospital patients with tracheostomies (Schwandt *et al.*, 1987).

It can be a significant problem for doctors as in the case of the surgical resident who had to stop direct patient care for 10 days per month over a 4 year period because of recurrent whitlow (Laskin, 1985).

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The hanging head method for the treatment of acute wry neck

Sir

The hanging head method is a simple but effective method for treating acute painful wry neck of spontaneous onset. This method appears not to have been described before in the literature.

Patients with wry neck frequently attend accident and emergency departments seeking relief from a distressing but self-limiting condition. Examination reveals unilateral sternomastoid muscle spasm with torticollis and head tilt to the opposite side.

In the absence of a history of preceding trauma X-rays are not necessary. It is, however, essential to exclude a dystonic reaction to phenothiazines or related drugs. In children, a coexisting sore throat may suggest atlanto-axial rotary fixation, which needs radiographic confirmation.

All other patients can be treated satisfactorily by the hanging head method.

A trolley, stretcher or couch with head-down tilt facility is necessary. The patient is explained that this procedure aims to release spasm of the involved neck muscles.

The patient lies supine and a head-down tilt of about 20° is provided. The head is brought to the edge of the couch and an assistant supports the pelvis to prevent the patient from sliding down. A period of suspension of between 5-10 min is necessary. The dependent head provides a weight to allow traction on the neck. Supplemental manual axial traction to the head and neck may be applied but is not usually necessary. The procedure is terminated if the patient feels unwell in this position.

At the end of the procedure a pain-free patient with a straight neck is obtained. No subsequent immobilization of the neck is necessary, nor are analgesics provided. The author has not encountered any recurrences with this method.

During the period 1 January to 1 June 1988, 23 patients with acute wry neck attended accident and emergency departments in Slough and Ascot. Of these, 10 were submitted to this procedure. None had any recurrent or persistent symptoms. Of the other 13, 4 returned within 24 h with persistent symptoms. Although these numbers are small, patient satisfaction with this method was universal and the immediate relief of symptoms highly evident to both patient and operator.

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