decreased greatly once military action began. This reduction was attributed to the change in food supplies; fresh local produce was widely used during the early phase, but pre-packed western supplies were used once the military action escalated.[2]

In our view, the use of single-dose ciprofloxacin for travellers' diarrhoea is encouraging. However, careful evaluation is needed of the impact of this disease on operational effectiveness before widespread use can be recommended in a military setting.

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1 Elliot J, Connor MP, Green AD. Gastrointestinal disease amongst RAF personnel in Belize. *Trans R Soc Trop Med Hyg* 1994; **88:** 373.
2 Kilpatrick ME. Diarrhoeal disease: a military perspective. *Trans R Soc Trop Med Hyg* 1993; **87** (suppl 3): 47–48.

SIR—We are concerned about the consequences of Salam and colleagues' conclusions.

First, the study is confined to a very specific population—namely, professional soldiers. These men will be very fit, perhaps used to travelling to different parts of the world, and are thus a very different population from the average traveller abroad. Second, the numbers are small and the results could have arisen by chance. More importantly, the small numbers considerably reduce the chances of seeing any complications of therapy. Pseudomembranous colitis, thrombocytopenia, and Stevens-Johnson syndrome, though rare, are well-recognised and dangerous complications of ciprofloxacin therapy.[1] It is not sufficient to conclude that the small dose used will be cost-effective, free of side-effects, and unlikely to produce resistance, when one considers the potential numbers of patients who will probably use such a treatment if it is widely introduced. UK residents undertake more than 30 million overseas journeys each year, and 30–50% might develop diarrhoea.[2] Such vast numbers of people seeing their general practitioner for tablets before going on holiday would swamp an already overburdened service. Third, the follow-up period does not allow for the detection of possible rebound diarrhoea.

We feel that Salam's study has drawn attention to an important issue, but larger randomised controlled trials are needed in a more representative population, and guidelines should be developed for the most appropriate usage.

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1 British National Formulary. London: British Medical Association Pharmaceutical Press, September, 1994.
2 Health advice for travellers 1994. Department of Health. London: HM Stationery Office 5/94.

SIR—Although Salam and colleagues suggest that "short-term therapy may also be less likely to promote emergence of drug resistance", they ignore the wider issues of drug resistance.

Indiscriminate use of antibiotics for benign, self-limiting infections fuels the rapid evolution of resistance, which limits the duration of their effectiveness. In developing countries the availability of antibiotics to which enteric pathogens remain susceptible is an increasing problem.[1] Individuals with severe enteric infections such as cholera, dysentery, or invasive salmonellosis may die because an effective antibiotic is not available. Visitors' use of new antibiotics such as ciprofloxacin promotes resistance in enteric pathogens and could deprive the local population of one of a few remaining effective drugs.

Perhaps it would have been better for the wider good had the soldiers foregone ciprofloxacin and run the risk of so-called Belize belly.

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1 Murray BE, Alvarado T, Kim K-H. Increasing resistance to trimethoprim-sulfamethoxazole among isolates of *Escherichia coli* in developing countries. *J Infect Dis* 1985; **152:** 1107–13.

Topical treatment for Dupuytren's contracture

SIR—Since Shelley and Shelley's report[1] of success with topical 0·05% clobetasol propionate cream (Dermovate) twice daily and 0·05% tretinoin cream (Retin-A) once daily in Dupuytren's contracture, I have faithfully used this treatment. These workers did not indicate how many patients were thus treated but state that in one who had had a painful fibrous cord extending up the fourth finger for 9 months, after 3 months the pain resolved and by 9 months the contracture was no longer present and the skin was normal.

At my age, wishing to avoid surgery under general anaesthesia for what must be regarded as a minor disability, I have now continued with this topical therapy for 17 months. Sad to say during this period my condition has regressed. I have increasing difficulty in typing and cutting my finger-nails and toe-nails and can no longer wear a glove on my right hand.

Long-term assessment of any therapeutic regimen must be subjected to constant review. Because I personally have failed to respond to this therapy as advocated is not a criticism of such advice given. Nevertheless, can Shelley and Shelley verify that they are still having success as presented and what percentage of patients completely respond as described in their letter? I wonder if any of your readers who are fellow-sufferers have benefited from topical therapy and if any further clinical trials support its efficacy?

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1 Shelley WB, Shelley ED. Response of Dupuytren's contracture to high potency topical steroid. *Lancet* 1993; **342:** 366.

Subcutaneous gammaglobulin for patients with secondary hypogammaglobulinaemia

SIR—Patients with secondary humoral immunodeficiencies such as hypogammaglobulinaemia resulting from haematological malignancies frequently get bacterial infections which are associated with substantial mortality. Prophylaxis with intravenous gammaglobulin was shown to be effective in preventing bacterial infections in a blinded multicentre study,[1] and it is currently recommended that patients with low-grade B-cell tumours, such as chronic lymphocytic leukaemia (CLL) or lymphoma,[2] who have had a severe infection and display low concentrations of total IgG or of antibodies against pneumococcal capsular polysaccharides,[3] should be treated with intravenously administered gammaglobulin. However, because of the costs involved, this recommendation has not been widely accepted. Rapid subcutaneous infusion of gammaglobulin