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HEAT SPOTS

Papular urticaria (lichen urticatus, strophulus, prurigo infantum, etc.), popularly known as heat spots or teething rash (*feux de dents, zahnpocken*), is one of the commonest and most distressing diseases of infants and young children. The disease usually manifests itself in attacks lasting a few weeks to a month or two, but occasionally persists without complete remission. It begins in infancy and generally ceases to recur by the time the child is 5 years old, but may last longer in minor degree.

In an attack the rash appears in crops so that the established eruption shows a variety of lesions at all stages of development. The fresh lesion is a little round or oval, red urticarial wheal which resembles an insect bite. This may disappear in a day or two or subside to a papule, become vesicular or bullous, and eventually be covered by a scab. Healing may leave depigmented or hyperpigmented remains. Secondary impetigo is so frequent as to be almost part of the standard picture. The number of lesions varies between a few and many hundreds and, although they tend to be most profuse on the trunk, no area is spared invariably. Itching is severe especially at night, the child is restless and, in a severe attack, genuinely ill, particularly when severe dietetic restrictions have been imposed. Patients are referred to dermatologists under a great variety of provisional diagnoses, of which chickenpox, chronic impetigo, food allergy, and scabies are the commonest.

In all but the most recent text-books papular urticaria is usually described as a disease entity and reputed to be caused by food allergy, infection, or nervous instability. Rare observers of the past, such as Sir Jonathan Hutchinson, considered that the lesions not only looked like fleabites but were fleabites; these observers were scorned by their contemporaries.

Recent observations have shown, however, that most cases of papular urticaria are due to acquired sensitivity to the bites, or rather to the salivary secretions of certain insects, notably fleas and bedbugs. Blank *et al.*[1] tested 30 sufferers from papular urticaria with antigens for fleas and bedbugs and found 77% sensitive to one or both; only 2 of 124 normal controls were sensitive. Bolam,[2,3] in England, investigated the homes and the pets of affected children and found fleas (cat-fleas predominantly) in 27 of 40 cases studied.

Sensitivity to insect bites is an accepted phenomenon. Another example is urticaria multiformis endemica caused by phlebotomus bites. In the Middle East, where this condition is popularly known as *harara*, infants, immigrants and other non-immune adults develop a bullous or papular rash on exposed skin, and old lesions flare up when the patient is bitten afresh. Immunity is soon established and recurrences in the second or subsequent years are rare.

Acquired sensitivity to bites of parasites explains these points long observed in the natural history of papular urticaria: the disease is commonest and most severe in summer; admission to hospital is curative, but attacks begin again when the child returns home; the onset of disease may coincide with removal to a new house or complete change of environment may be curative; the poor are attacked more often than the rich, except in the Cape Peninsula, where the fleas do not distinguish between U and non-U! Reactivation of subsiding lesions often accompanies the appearance of fresh bites.

Papular urticaria in South Africa is commonly caused by fleas. Cases caused by bedbugs are distinguishable by the fact that lesions are usually fewer and tend to be bullous and haemorrhagic. The systematic use of insecticides such as DDT or BHC in the house, and pyrethrum for pets, is almost invariably followed by great improvement or cure. Details of disinfestation are given in articles by Bolam[2,3] and Rook and Frain-Bell,[4] but we have found that a liberal dusting of insecticide powder on the sheet on which the child sleeps is an essential manœuvre. DDT and BHC powder do not irritate the skin. When parents take umbrage at the suggestion that their child is flea-ridden, good results can still be obtained by prescribing the insecticide suspended in calamine lotion for application at bedtime.

1. Blank, H., Schaffer, B., Spencer, M. C. and Marsh, W. C. (1950): Pediatrics, 5, 408.
2. Bolam, R. M. and Burtt, E. T. (1956): Brit. Med. J., 1, 1130.
3. Bolam, R. M. (1958): Bull. Soc. franç. Derm. Syph., 65, 388.
4. Rook, A. and Frain-Bell, W. (1953): Arch. Dis. Childh., 28, 304.

WISSELSKAAL VAN LEDEGELDE

By 'n vorige geleentheid het die Federale Raad van die Mediese Vereniging 'n spesiale komitee saamgestel met die opdrag om die wenslikheid en uitvoerbaarheid van 'n wisselskaal van ledegelde vir definitiewe groepe lede binne die Vereniging, te ondersoek. Die Federale Raad het hierdie stap gedoen omdat hy begaan daaroor is om aan alle groepe binne die Vereniging ten volle reg te laat geskied ten opsigte van hulle verpligtinge teenoor die Vereniging, veral met verwysing tot hul onderskeie finansiële verantwoordelikhede. Na deeglike studie en oorweging van al die feite tot hul beskikking, het hierdie komitee sy aanbevelings aan die Federale Raad voorgelê by geleentheid van sy onlangse sitting in Johannesburg van 8-10 April, en die Federale Raad het toe soos volg besluit:

1. Om dit goed te keur dat ledegelde vir huisdokters £2 2s. 0d. per jaar bedra.

2. Om dit goed te keur dat praktisyns gedurende die eerste twee jaar van hul praktyk na die huisdokterskap £2 2s. 0d. per jaar as ledegelde betaal. Dit geld vir geneeshere in die private praktyk sowel as in die hospitaalpraktyk.

3. Die ledegelde van afgetrede dokters wat nog lede van die Vereniging wil bly, sal £2 2s. 0d. per jaar beloop.

4. In gevalle waar die man sowel as die vrou lede van die Vereniging is, sal dit net van een lid van die paar verwag word om die volle bedrag van £4 4s. 0d. per jaar as ledegelde te betaal; die ander lid sal £2 2s. 0d. per jaar betaal.

5. Die ledegelde vir alle ander lede van die Mediese Vereniging sal £4 4s. 0d. per jaar bedra, afgesien daarvan of hulle in die algemene praktyk staan en of hulle in die een of ander voltydse hoedanigheid werksaam is.

Miskien sou dit goed wees om hierdie besluit van die Federale Raad van naderby te beskou. Daar was nog altyd die gebillikte beskouing dat voltydse personeel op die een of ander graad van voorkeurtariewe geregtig was by die vasstelling van ledegelde van die Vereniging—omdat dit in die verlede gevoel is dat die vergoeding van voltydse personeel oor die algemeen heelwat minder was as dié van algemene praktisyns. Met die onlangse algemene verhoging van salarisse het hierdie posisie nou egter verander. Die basis van besoldiging van voltydse mediese personeel in die verskillende munisipale en regeringsdienste, en op die universiteitspersonele, vergelyk oor die algemeen redelik goed met die netto inkomste van private praktisyns as 'n groep. Meer nog, die werk wat voltydse geneeshere in die verskillende voltydse diensafdelings doen, kan nie as aparte dienste beskou word nie. Die hele bolwerk van mediese dienste funksioneer as een onverdeelbare geheel. En die hospitaal- en ander gesondheidsdienste in ons land kan maar slegs voortgaan omdat hulle funksioneer teen die agtergrond van die buitepraktyk.

Ons wil hier 'n spesiale pleidooi lewer vir die nouer samesnoering van voltydse mediese werk en praktisynswerk binne die raamwerk van die Mediese Vereniging. Slegs deur gesamentlik ons verpligtinge na te kom as lede van 'n groot geheel, kan ons werklik 'n sterk en blywende organisasie opbou. Die hospitaalpraktisyn en die voltydse mediese beampte het die ondersteuning nodig van die algemene praktisyn en van die praktiserende spesialis. Aan die anderkant kan die praktisyn weer slegs op die volle hoogte van sake bly as hy gedurige kontak bewaar met sy kollega in die hospitaal. Dit sal baie goed wees as die verskillende Takke en Afdelings planne kan beraam om, meer as in die verlede, kollegas uit alle vertakkinge van voltydse werk, meer aktief in die werksaamhede van die Mediese Vereniging te betrek.