

the risks they face and to be compensated if they lose their job or fall ill or die as a result of that occupational risk. For doctors this is not, it seems, considered necessary. The politicians agree, it seems, or do not feel disposed to help. What will happen if this attitude persists? We all know that some parts of the United States now have no obstetricians because lawsuits have made practice impossible, the rewards being insufficient to justify the risk. The doctor exposed occupationally to HIV is not just financially at risk but may also contract a fatal illness and then be penalised for doing so. Half our doctors now are women. Can we expect them to risk not just their own lives but also those of their husbands, and children—or expect male practitioners to put at risk their lives and those of their wives? If patients have a right not to be at risk of HIV infection acquired from doctors (or dentists) so have clinicians.

We have been hypocritical about AIDS and allowed what was at first often a self-inflicted disease to become a plague that hazards everyone. Dangerous or incurable diseases such as smallpox used to be subject to strict quarantine and even mumps and measles fell under rules of isolation. I believe that only in Cuba is such a law enforced for AIDS. Will those who think that doctors need no protection accept such quarantine? I think not. It is the youngest doctors who are most exposed—not their elders and the medical statesmen who speak for the profession.

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## CAGE

SIR,—Dr Murray-Lyon and Dr Waterson (Oct 26, p 1089) reiterate their concern, previously expressed in 1988,<sup>1</sup> that the CAGE questions are not a valid screening method to identify covert alcohol abuse. However, their comments fail to take into account the large hospital-based studies that have been published since that time which show, among general hospital inpatients in the USA, that (a) alcohol abuse is frequently underdiagnosed and (b) CAGE questions are a sensitive and specific aid in screening to identify covert alcohol abuse in these patients.<sup>2,3</sup> It is important to emphasise that CAGE questions should not be administered as a replacement for an alcohol history. Rather, they are a useful and simple way for house officers to identify those patients from whom a detailed alcohol history should be sought.

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1. Waterson EJ, Murray-Lyon IM. Are the CAGE questions outdated? *Br J Addiction* 1988; **83**: 1113-18
2. Moore RD, Bone LR, Geller G, Marion JA, Stokes EJ, Levine DM. Prevalence, detection and treatment of alcoholism in hospitalized patients. *JAMA* 1989; **261**: 403-07.
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## Down with double projection

SIR,—Could conference organisers not add to the boxes people are asked to tick when submitting abstracts a question about whether double projection is planned or not, and then give permission rarely? Our hearts sink when a speaker straightaway asks for the first slide, with no introductory chat. When this is followed by "Keep the slide on the left until I tell you and change the one on the right", the scene is set for one of those Laurel and Hardy type presentations. "No, change the one on the right . . . Can you move the left slide over a little . . . Can we go back on the right . . . sorry, no the left". If one projector can break down or refuse unusually thick or thin transparencies, having two seems to increase the risk tenfold.

There is a place for double projection. When simple slides with no more than seven or eight lines each and a simple diagram are paired intelligently they can complement each other. Many speakers, however, use it to try to bombard the audience with twice the information. At a recent conference there was a very effective presentation with all the text and graphs printed on a dot matrix printer and the colour provided by coloured acetate sheets behind white-on-black negatives. It was unsophisticated but informative

and entertaining. At the same conference another speaker discovered he had only half the time promised. Did he cull his slides, selecting only the most important? Of course not. His presentation was for dual projection and so he just went twice as fast. He also had unreadable tables with 20 or 30 lines of text: "I know you probably can't read this slide . . . This slide is a bit difficult but bear with me . . . There are a lot of data on this slide but I only want you to look at the top two (out of 20) lines". He said the lot.

Some speakers seem not to have heard of preparing tables specially for meetings, not just photocopying published ones, or of rehearsing their presentations. The most famous speakers are often the worst. And before you say "What about pathologists and two cassettes of slides for even 15 minute presentations?", we know—we too think that is awful. For many scientists our beautiful immunocytochemistry slides illustrating the finer points of the state of the art all look the same ("Seen one, seen them all", a colleague said) and the same is true of conventionally stained material. The masters of the art of presenting scientific data use simple slides—just a few spotlessly clean bright blue diazos not faded from frequent use or bearing out-of-date text—and they are asked all over the world to speak. Few of these masters use double projection.

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## Fish-hook removal

SIR,—Angling is very popular in Australia, and with respect to participants it is the most popular sport in Britain.<sup>1</sup> The commonest hazard of fishing is the hook becoming embedded in the angler's skin, usually in the finger. The barb on the hook prevents easy removal, and the distraught fisherman often presents at the casualty department.

Traditionally, removal of fish-hooks is done with local anaesthetic infiltration (forcing the point of the hook through the skin) cutting the barb, and withdrawal of the shaft. The fishermen of South Australia are accredited with a different method—they flick out the hook within a minute, dip the injured finger in the sea, and carry on fishing.<sup>2</sup> This technique (string method) is described here.

A piece of string is looped, the free ends are wrapped around the doctor's right index finger, the loop is placed around the hook, and the injured part is positioned such that the loop extends away from the physician. The hook is stabilised between the operator's left thumb and index finger. Slight depression of the hook disengages the barb. The string is slowly straightened horizontally in the plane of the long axis of the hook (figure). A sharp sudden jerk in the same direction spins the hook out of the finger, usually without enlarging either the track or the route of entry. The operator should wear protective goggles and keep out of the way of the released hook.

In this department, 32 patients were treated for fish-hook injuries during 12 months, and embedded fish-hooks were successfully removed by the string method in 26. In the remaining 6 patients, this method was unsuccessful, probably because of half-heartedness by the operator—one needs to be bold, quick, and confident, the loop of string should be correctly positioned, and the barb should be effectively disengaged before removal is attempted.

The string method is especially useful when anaesthesia is unavailable or when the barb of the hook lies too deep to be forced

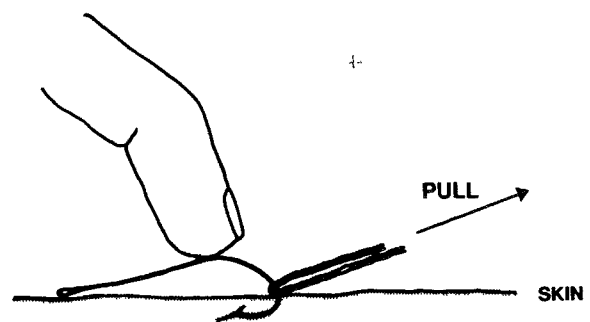


Diagram of fish-hook removal.