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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Haemophilia centres

SIR,—Haemophilia centres were first established in 1954. The emphasis was on diagnosis and the need to avoid dangerous operations. In 1976 a revised three-tier system was set up with reference centres, ordinary centres, and associate centres. There are now over 150 centres, and the emphasis is on treatment and prophylaxis. As there are about 3300 haemophiliacs in the United Kingdom it follows that the average number of patients attending each centre is 20. Furthermore, as expertise in haematology extends more haematologists feel able to offer diagnosis and treatment. Directors of haemophilia centres have recently been discussing the organisation of haemophilia care, particularly that of supraregional reference centres.

If we are to have haemophilia centres it is sensible to insist on a minimum number of patients to provide a proper service. Twenty seems to me an acceptable minimum. Furthermore, to qualify as a centre, the hospital should provide a comprehensive, 24-hour, clinical and laboratory service. Staff should include a doctor in overall clinical charge, a nurse, a physiotherapist, a social worker, and a secretary. They may not all work full time in the haemophilia centre, but it should be their major commitment.

But do we need this hierarchy of haemophilia centres? Small associate centres provide a service which is no different from that provided by many unrecognised district hospitals. Does recognition serve any useful purpose? Many ordinary haemophilia centres provide the same service as reference centres. Their directors may not wish to refer difficult cases to their local reference centre, but prefer to deal with whichever centre they think is best able to help the particular patient's problem. The present tendency in health service administration is towards devolution at district level, and although there are too few haemophiliacs to justify a centre in every district it is more logical to base haemophilia centres on a regional and not a supraregional basis. I am unaware of any shortcomings in the service for haemophiliacs in the regions which have no supraregional reference centre compared with those which do have one.

Rather than deliberating about reference centres we should be trying to improve the standard of care in ordinary haemophilia centres. Our aim should be to have a network of centres all adequately staffed and all providing a service capable of dealing with most problems. Their size will vary and their expertise will depend on the interests of the staff in each centre. Their relation with local district hospitals can be settled locally and will depend on the interests and abilities of the haematologists together with their colleagues in these hospitals and on the preferences of the patients themselves.

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Benoxaprofen: effect on cutaneous lesions in psoriasis

SIR,—We read with interest the suggestion by Dr B R Allen and Dr S M Littlewood (30 October, p 1241) that benoxaprofen may have an important place in the treatment of psoriasis. They do not mention, however, any change in psoriatic involvement of the nails during treatment. We have seen two patients in whom there has been a considerable improvement in their psoriatic onycholysis during treatment with benoxaprofen for psoriatic arthropathy. At the same time their scalp psoriasis disappeared and cutaneous plaques improved. In one patient the onycholysis returned within a month of discontinuing benoxaprofen. Topical or oral methoxsalen plus ultraviolet-A irradiation has been shown to benefit psoriatic nails.[1 2] The photosensitising property of