

Since May 1st four cases have been brought to my notice where medical practitioners have refused to write fresh prescriptions for the barbiturates and have required the patient to receive his supplies from them. Whether or not the practitioners have kept any record of these supplies it is impossible to say, since the Rules contain no provisions for the inspection of records of medical practitioners. It was contemplated that under the new legislation the physician who had not hitherto supplied drugs to his patients would write a prescription which should be dispensed by the pharmacist subject to the statutory safeguards. He need only mark the prescription "To be repeated" to secure a regular supply to patients who are compelled to take the barbiturates (for example) over a long period.

Without wishing to raise the old and difficult question of the respective functions of the pharmacist and of the physician, may I make an appeal to those practitioners who have had it in mind since May 1st to commence the supply of these substances direct to their patients to give further thought to the difficulties they are creating by so doing? In the event of their present freedom to supply these drugs being abused, they run the risk of the concessions which their representatives have gained for them being withdrawn; they lay themselves open to unjustified but easily made charges that they are seeking the fee payable by the patient on each occasion that he receives a fresh supply of drugs, and that they are using an exemption designed to facilitate the carrying on of their legitimate professional activities as a means of turning themselves into sellers of drugs; while in particular they are causing unnecessary irritation to pharmacists and retarding the progress of the friendly relationship between the two callings which can do much to facilitate the work of both.—I am, etc.,

HUGH N. LINSTEAD,
Secretary, Pharmaceutical Society
of Great Britain.
17, Bloomsbury Square, W.C.1,
May 27th.

Histidine Treatment of Peptic Ulcer

SIR,—When the histidine treatment of peptic ulcer was first introduced I made, with the help of Dr. A. M. Nussbrecher, a careful clinical trial of it. At the end of several months we were entirely unconvinced that this treatment had any value, but we were certain that it was of great potential danger in that it provided temptation to patients and practitioners to neglect essential dietetic treatment in favour of something which was rather simple and somewhat dramatic. Since that time I have seen so many cases which have failed to improve or got worse under this treatment that I am convinced that, so far from being an advance, it is a retrograde step in therapeutics. I have seen several patients to whom knowledge of its uselessness had come through the occurrence of a dangerous haemorrhage at the end of a course of histidine treatment. I have seen one who had perforated during treatment, and I have seen numbers in whom no improvement had occurred. In almost every case I have been satisfied that the bad result could have been avoided if the patient had been correctly treated with diet and alkali on orthodox lines.

In an article on "the treatment of peptic ulcer which I recently contributed to your columns I was at pains to confine reference to histidine to a few words, which I hoped would do nothing to check the speedy abandonment of this treatment by the profession. But since that time it has become so evident that wide clinical trial continues, to the disadvantage of sufferers from this disease, that I feel it imperative to add strong support to the letter which Dr. A. F. Hurst has now written to you.—I am, etc.,

London, W.1, May 27th. T. IZOD BENNETT.

SIR,—The letter of Dr. A. F. Hurst in your issue of May 23rd (p. 1077) quotes some American views on the histidine treatment of peptic ulcer, and among them mentions the results of Sandweiss's investigations, reported in the *Journal of the American Medical Association*, which state that of twenty-four patients treated by this method not one showed disappearance of the ulcer deformity as judged by radiological or operative observation. As to the ultimate value of this treatment one must reserve judgement, but the above figures give an unfair picture if they are contrasted with reports in this country (Bulmer, *Lancet*, December 8th, 1934, p. 1276; and Smith, *British Medical Journal*, July 27th, 1935, ii, 154).

Of four cases of gastric ulcer treated by myself during the last six months, and chosen because they showed a visible, unmistakable niche in the radiograph, all showed a normal stomach contour within periods varying from four to six weeks after commencing treatment. One has since returned with symptomatic and radiological recurrence. A small series, but, taken in conjunction with the other results reported in this country, it does not seem that the value of the treatment can, as yet, be so easily dismissed.—I am, etc.,

London, W.8, May 26th. W. M. PRIEST.

A Crusade Against Acute Rheumatism

SIR,—During 1932-5, while in general practice in a distressed area, sixty-three "rheumatic" cases came under my care. Sixteen were cases of acute rheumatism and forty-seven of established heart disease, of which thirty-seven had had acute rheumatism and ten had not. An analysis of their histories showed:

Acute Rheumatic Cases (16)			
	History	Cases	Percentage
Obvious sepsis	...	8	50
Chilling or wetting	...	7	43.75
Malnutrition	...	5	31.25
Rheumatic family history	...	3	18.75

Established Heart Disease following Acute Rheumatism (37)			
	History	Cases	Percentage
Obvious sepsis	...	19	51.35
Chilling or wetting	...	8	21.62
Malnutrition	...	7	18.92
Rheumatic family history	...	15	40.54

Rheumatic Hearts of Insidious Origin (10)			
	History	Cases	Percentage
Obvious sepsis	...	7	70
Chilling or wetting	...	—	—
Malnutrition	...	—	—
Rheumatic family history	...	3	30

"Obvious sepsis" included quinsy, tonsillitis, appendicitis, cholecystitis, pyorrhoea, and general sepsis (boils, whitlow, and mild erysipelas). Relations were either father, mother, sister, or brother, and their rheumatic history included acute rheumatic fever, rheumatic hearts, erythema nodosum, rheumatoid arthritis, and acute sciatica. It seems, therefore, that some or all of the following factors are necessary to develop a rheumatic condition:

- (1) An infective focus, absorption from which produces supersensitiveness to that allergen.
- (2) Malnutrition decreasing resistance to (1).
- (3) A rheumatic family history suggesting inherited idiosyncrasy to the allergen or simply general low resistance.
- (4) An exciting factor, such as chills or wetting, occurring after (1) and allowing a fresh flood of allergen to invade the body, producing acute rheumatism or an exacerbation.

Twenty-five of the series had a mild febrile illness preceding the acute attack by a few weeks or months. Eight others had chorea as the initial illness. These attacks probably coincided with the sensitizing period.

In any crusade against rheumatism, primarily, an attempt must be made to treat all likely sufferers, to

remove infective foci, to build up nutrition and resistance, and to recognize the preliminary sensitizing illness. All children up to 16 with a family history of rheumatism and all those who have had a febrile—possibly rheumatic—illness should be examined every six months and all others every twelve. All examinations to be performed by the family doctor, and payment to be on a capitation basis, as in the national health insurance. In this way the person who treats the child in sickness watches over it in health, and the slightest departure from normal should be quickly recognized.

Dr. R. P. Garrow's suggestions are excellent (*Journal*, April 25th, p. 859), as is also Dr. Ritchie's scheme for clinics for the established rheumatic case. But the most essential scheme is that which finds the earliest cases of rheumatism, the potentially rheumatic child, the patient with the so-called "influenza"—slight temperature, general malaise, and mild aching pains; the child brought up for a "tonic" because it is not eating, is pale, tired, or not gaining weight. Many of these, I think, are in the state of being sensitized, and with early recognition, adequate care, and close supervision acute rheumatic sequelae should be preventable.

The close observation of seemingly trivial cases is difficult to maintain in a private practice, but in a national-paid service children could be brought up instantly and often for those apparently slight ailments which may, however, be the first step in the production of a life-long invalidism. The routine examinations would discover those children in whom the slight preliminary illness had been unnoticed by the parents.

Hence any scheme to prevent acute rheumatism must have repeated examinations by the family practitioner as its basis, and to keep him on the alert a State-provided post-graduate course in child ailments every five years would be advisable.—I am, etc.,

ROBERTA IRENE HUTCHINSON, M.B., Ch.B.
Birmingham, May 25th.

Congenital Deformities of Mechanical Origin

SIR,—Your report (May 30th, p. 1123) of my address to the Royal Society of Medicine on this subject was an excellent summary of a complicated and compressed argument. But on two points I was misunderstood. First; the spina bifida associated with talipes occurs at the point of greatest bending, not greatest pressure. And secondly, in a very hurried conclusion, I said that I did *not* consider that congenital constrictions and amputations were caused mechanically.—I am, etc.,

London, W.1, May 29th. DENIS BROWNE.

Food, Health, and Income

SIR,—The report on a survey of the adequacy of diet in relation to income—*Food, Health, and Income*, by John Boyd Orr—has not alone in England but also in other countries raised a discussion of far-reaching importance. The survey considers optimum requirements, and a tentative conclusion is that a diet completely adequate for health according to modern standards is reached at an income level above that of 50 per cent. of the population.

Using the figures of the report, but considering the health of the population as depending on the part of the diet in which the foodstuff is present in its natural form—that is, where the balance between proteins, fats, carbohydrates, minerals, and vitamins is as found in nature—we arrive at the following distressing result with regard to the quantities of food consumed at different income levels in the United Kingdom:

Group	I	II	III	IV	V	VI
Average expenditure on food per week per head	4s.	6s.	8s.	10s.	12s.	14s.
Calories in natural balance	33%	40%	43%	47%	47%	53%
Total calories consumed						

By the estimate of the foodstuff in natural form—called "calories in natural balance"—it has not been allowed to cover a vitamin deficiency of margarine, for instance, by an apparent vitamin surplus of vegetables or fruit consumed. Of the total calories consumed 30, 28, 27, 23, 26, and 24 per cent. respectively have been treated industrially at high temperatures or chemically. This percentage of the foodstuff may thus contain traces of substances that are not found in the natural foodstuff. High temperatures will produce carcinogenic substances in organic matter, for instance. The traces of substances introduced by industrial treatment may hence be quite as detrimental to health as the vitamins are beneficial. Coffee, chocolate, and tobacco smoke not included in the estimate may further add to the amount of foreign products introduced.

The absence of traces of foreign substances—that is, substances not found in the natural foodstuff—and a more natural balance of the composition of each part of the food consumed may thus be the reason for the striking state of health at places like Tristan da Cunha. It is not enough that the balance of the entire foodstuff consumed is correct—a certain balance may be required in each part of the whole.—I am, etc.,

Copenhagen, May 23rd. JOHAN E. NYROP.

Percentage of Alcohol in the Blood

SIR,—In your issue of May 23rd Dr. H. Kenneth V. Soltau (p. 1048) gives some details of a method of estimating the alcoholic content of the blood of persons who have taken alcohol, and he states that if a police surgeon (or the first available doctor) were to take a drop of blood at the time of arrest "conclusive evidence" would be obtained. The reasons given for suggesting such a test for the alleged alcoholic motor driver are: "the difficulty of deciding whether or not a person is under the influence of alcohol" and "the number of occasions on which even medical opinion differs." To this condition, about which it is difficult to decide and in regard to which there is frequent disagreement, it is sought to apply estimations of minute percentages of alcohol in the blood and so give "conclusive evidence." In giving slightly varying percentages of alcohol in the blood as indicating different degrees of alcoholism in a way that will prove "conclusive," one wonders how the difficulty of decision and the differing medical opinions have been surmounted.

Mention is made of "the advantages of the test over other methods of determining whether a person is or is not under the influence of drink as required by the Road Traffic Act, 1930," but the Act should have been read more fully. It reads: "Any person who, when attempting to drive, or when in charge of a motor vehicle . . . is under the influence of drink . . . to such an extent as to be incapable of having proper control of the vehicle . . ." It is the incapacity from being under the influence of drink that determines the offence. Incapacity from alcoholism is most variable, and it is affected by many circumstances. It varies in different individuals, and, even in marked degrees of alcoholism, it will vary in the same individual within short spaces of time, during which the alcoholic content of the blood cannot have changed materially. It seems impossible to determine incapacity by the alcoholic content of the blood.

In actual practice, except in somewhat rare cases where