I realize that measles immunization will usually be given to those from 1 to 5, but nevertheless strong pressure is being applied to recommend that children who are entering school at age 14 should be immunized.—I am, etc.,

R. E. SMITH.

Board of Graduate Studies,
Faculty of Medicine,
University of Birmingham.

Medindex

SIR,—I hasten to support Dr. J. B. Metcalfe's plea to the publishers of *Medindex* (24 February, p. 515) and join him in requesting them to resort to the old format. I would also like them to include a list of drugs, arranged alphabetically, giving the scientific names first and the trade equivalents (if any) alongside. Many readers of publications such as the *B.M.J.* must spend a considerable time trying to find out what "drug" the authors of an article are writing about. The inclusion of a short list of equivalent names at the end of each article would make life easier for the not so scientifically minded.—I am, etc.,

Skipton, Yorks. C. H. ROBINSON.

SIR,—We have answered already through the post Dr. J. B. Metcalfe's criticisms (24 February, p. 515), but for the benefit of your other readers will you permit me to summarize briefly the position of *MIMS vis-à-vis Medindex*?

Until early in 1967, when this company took it over, *Medindex* was published quarterly. It was providing very similar information to that given in *MIMS*, which was, and still is, published monthly. We have evidence to show that *MIMS* was greatly preferred to *Medindex*. *MIMS* is intended as an *aide-mémoire* to proprietary drugs. It is not a textbook of pharmacology or therapeutics. In the autumn we are to publish the first edition of the *Medindex Compendium*, which will be issued annually. This will include monographs on proprietary drugs, lists of approved names, a colour identification chart for tablets and capsules, and additional information which cannot be included in *MIMS* if it is to preserve its unique character.

We are grateful for the numerous letters of appreciation of *MIMS* and for the helpful comments that we receive every day from doctors and pharmacists in general practice and in the hospital service. The *Compendium* has been planned with the support of the pharmaceutical industry and is expected to be the most comprehensive and detailed publication of its kind.—I am, etc.,

E. N. PULLOM,
London W.1. Editor, *MIMS*.

Selection of Medical Students

SIR,—My point (20 January, p. 176) is that some able students who would make good doctors are bad at physics and chemistry. Dr. I. M. Richardson (17 February, p. 445) would exclude them because they could not master first M.B. science, whereas I would replace first M.B. science by a general science course. Doctors need a scientific attitude, but this, far from being a pure scientist's prerogative, can be acquired by any able student.—I am, etc.,

Whickham, Newcastle upon Tyne. ANDREW SMITH.

Clinicopathological Conferences

SIR,—Doctors all over the world who are regular readers of the *B.M.J.* look forward to your instructive Clinicopathological Conferences. Apart from their intrinsic merits, they give us the feeling of personally sitting in on a very high-level discussion by experts who have developed special interests in certain subjects in their subspecialties.

However, the level of their discussion and knowledge is such that it is not always clear what specialties those taking part normally work in. For the benefit of those who are not familiar with the positions held by the staff at Hammersmith Hospital, I believe it would help in following the material presented even better if such indications as "Professor X—professor of pathology" or "Dr. Y—M.R.C. research fellow in clinical medicine" were added at least at one point.—I am, etc.,

Paediatric Department, Ashkelon General Hospital, Israel. AARON BLOCH.

Deaths from Asthma

SIR,—The investigations of Dr. F. E. Speizer and colleagues (10 February, p. 335) have confirmed the increased death rate from asthma in recent years, and they have made a valuable assessment of treatment (10 February, p. 339) in fatal cases. Although the cause of this increase remains quite uncertain, I agree that the fact that death was so often unexpected can be explained in some cases by previous misassessment of the severity of the illness. A contributory factor to this may sometimes have been the still widely held belief, especially in children, that asthma is largely a psychologically determined condition. In this way the main effort of assessment and treatment may have been directed to vague and quite unhelpful psychological factors and away from the critical physical state of the patient. Reluctance to use steroids is a likely consequence of this attitude.

Bronchial lavage, as you suggest, certainly has some place in the treatment of severe asthma unresponsive to routine measures. In acute status asthmaticus it is an entirely rational preliminary to the institution of assisted respiration, and if undertaken before the situation has become too desperate may even eliminate the necessity for this procedure. In the subacute and severe chronic asthmas the results of bronchial lavage are often extremely difficult to assess. In the York–Harrogate areas, in the last two years, 45 bronchial lavages have been carried out in 40 patients by the method described by H. T. Thompson *et al.*[1] The results have not yet been fully analysed, but in a few patients there could be no doubt that the results have been remarkably beneficial. In the majority there has been some improvement, but other factors may have been involved and the improvement has sometimes been brief. In others little or no improvement has been obtained. There have been no serious complications.—I am, etc.,

Scotton Banks Hospital, Knaresborough, Yorks. W. H. HELM.

REFERENCE

[1] Thompson, H. T., Pryor, W. J., and Hill, Jacqueline, *Thorax*, 1966, **21**, 557.

SIR,—Your leading article (10 February, p. 329) very rightly stresses the necessity of treating severe asthma with corticosteroids. It continues giving general advice how to treat routinely emergency cases, but this advice is in contrast to the opinion of most practitioners experienced in this field. You recommend "100 mg. of hydrocortisone should be given intravenously or intramuscularly every quarter of an hour until relief is obtained"—a tall order—to be followed by 40–80 mg. oral prednisolone "rapidly tailed off over one or two weeks." Many would feel that in such general advice intravenous aminophylline ought to have been included as preceding hydrocortisone; they would also object to the rapidly tailing off within one to two weeks, which could be easily understood as taking it off completely. This would be a rather dangerous procedure causing withdrawal symptoms and a possibly fatal outcome which I am sure you would want to avoid.

Less disquieting are some minor faults in your leader—for instance, the recommendation of a recent but not yet fully evaluated drug and the reference to irrelevant animal experiments about possible dangers of isoprenaline. I realize that leaders cannot always be faultless, but the major errors in this leader are potentially harmful and should have been avoided.—I am, etc.,

London N.3. H. HERXHEIMER.

SIR,—Thank you for publishing the papers on the increase in deaths from asthma by Dr. F. E. Speizer and others (10 February, p. 335). It is a pleasure to read such careful reasoning applied to such well-collected information. We all make mistakes and can therefore only welcome such a clear guide about how to avoid some of them.

I was disappointed therefore to read "your" suggestions (10 February, p. 329) on "What is to be done?" because so many of them are only practical if the patient has a physician in constant attendance. The papers show that any action must be taken quickly, because a third of those who are going to die in an attack of asthma are dead within two hours of the start of it. You comment that "steroids are urgently needed in all severe exacerbations of asthma." Are we then to teach every asthmatic to call us at the start of every attack so that we can start the suggested scheme of injected steroids if we find that the attack is severe? Surely guidance about what constitutes a severe attack would be more useful, so that the patient could take oral steroids and thereby