stabilized beforehand, because it seems to us to be more desirable clinically to establish the correct anticonvulsant treatment rather than add another therapeutic agent to an already complicated regime in order to achieve the same result. Though only one specimen of blood was taken for estimation of serum folic acid, the estimations were routinely carried out in pairs in order to eliminate experimental error. We do however agree with the increasing evidence that estimation of red cell folate is a more reliable test of folate deficiency; unfortunately, this test could not be carried out as a routine at the onset of the trial.

Finally, we certainly agree with Dr. Richens that case reports such as that of Chanarin *et al.*[2] cannot be dismissed and that further work is required. Our conclusions, we pointed out, are based on observations of people whose epilepsy and related problems are of such severity to require residential treatment for varying periods of time. It seems important to carry out a prospective trial in new cases of epilepsy to determine whether folic acid administration will prevent some of the mental deterioration due to anticonvulsants.—We are, etc.,

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1 Reynolds, E. H., *Lancet*, 1967, **1**, 1086.
2 Chanarin, I., Laidlaw, J., Loughbridge, L. W. and Mollin, D. L., *British Medical Journal*, 1960, **1**, 1099.

Safety of Hypnotics

SIR,—Recently there have been reminders in your correspondence columns of the advantages of nitrazepam (Mogadon) over barbiturates as a hypnotic by Dr. F. O. Wells (28 November, p. 552) and Dr. H. J. S. Matthew (26 December, p. 801). While nitrazepam is an effective hypnotic its abuse potential appears to be negligible as does the risk of dependence. No deaths have been reported due to overdose. Preliminary findings on drug metabolizing capacity in subjects exposed to this hypnotic indicate that it has a further important advantage over barbiturates.

Plasma antipyrine half-life and urinary 6β-hydroxycortisol: 17-hydroxycorticosteroids ratio were used as indices of drug metabolizing capacity in 10 subjects before and after a two-week course of 5 or 10 mg nitrazepam nightly. The drug did not significantly alter either index measured, suggesting that nitrazepam does not effect drug metabolizing capacity in man. This is in marked contrast with the barbiturates, which are potent liver enzyme inducers in man.[1] Induction leads to alteration in plasma drug levels and therefore to changes in the intensity and duration of effect of many of the drugs which are metabolized in the liver. The interaction of barbiturates and the oral anticoagulants is a good example. In view of the above findings it seems unlikely that such drug interactions occur with nitrazepam.—I am, etc.,

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1 Kuntzman, R., *Annual Review of Pharmacology*, 1969, **9**, 21.

Labelling Drugs for the Elderly

SIR,—For many years I have concentrated on the increasing geriatric side of my practice, mainly the result of originally being responsible for the medical care of those in financial distress prior to the inception of the Health Act. The improvements in the general treatment of chronic illness in the elderly is of course one of the medical wonders of the past 15 years, but has brought many problems in its wake which are not fully appreciated.

Many elderly patients with failing sight are maintained on multiple therapies, in many cases being on tablets which, unless close vision is good, can easily be confused. This refers particularly to digoxin, bendrofluazide, and some of the modern thyroid derivatives. It is not an infrequent practice also for elderly patients to mix tablets together, in some cases just a week's supply at a time, as an *aide memoire*, or in others as part of a confusional state which is often not appreciated at the time of prescribing. Many of these patients, when closely questioned with great tact, which is necessary here to avoid what may appear to the patient to be an unwelcome pedantic role, admit to being unable to read the directions on the label supplied by the chemist owing to the small size of the print or writing.

I would suggest, therefore, that this is an urgent problem. As libraries already cater for this deficiency in the elderly, by large-print books, so the pharmaceutical industry should be altered to prepare large-print labels and containers with easily removable tops and stability, to alleviate some of the iaotrogenic distress now being caused in the treatment of many geriatric cases.—I am, etc.,

J. A. FRAIS

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Specialist Registration and the Common Market

SIR,—I was disappointed to read in the *Middlesex Hospital Journal*[1] an interview with Dr. Derek Stevenson in which he states that he is opposed to postgraduate training for general practitioners on the lines envisaged by Todd[2] and also strongly opposed to registration of specialists, and even suggests it would be important to join the B.M.A. in order to lead a campaign against these recommedations.

That the average British doctor should ignore the reasons behind Todd's recommendations is not the least surprising, but that a leader of the profession who has been sitting as an observer on the Common Market permanent committee of doctors for nearly 10 years should show such apparent lack of interest of what is going on on the other side of the channel is quite astounding. In fact, the Todd recommendations were a courageous attempt to prepare the British medical profession for membership of the Common Market.

If some central body such as the G.M.C. does not control specialist registration as is the case in all the European countries then British specialist qualifications just will not be recognized in Europe. I proposed specialist registration by the G.M.C. in a long report to the B.M.A. Common Market Committee in 1962, and this report was circulated among all leading members of the profession, including the Ministry of Health, nine years ago. I fail to see why B.M.A. leaders are feigning surprise at so-called Government "precipitation".

I only hope that with spring ahead and the end of the postal strike, the heavy fog which still seems to exist in the English Channel will at last be lifted.—I am, etc.,

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1 *Middlesex Hospital Journal*, 1970, **70**, 145.
2 Royal Commission on Medical Education, 1965-68. *Report*, Cmnd. 3569. London, H.M.S.O., 1968.

Smoking in Hospital

SIR,—I am horrified to find that in spite of the recent royal college report on smoking,[1] hospitals, through their League of Friends and other media, still sell cigarettes on the trolleys going round the wards (including chest wards) and in the hospital shops.

Surely we, as doctors, cannot condone this type of situation when we claim that we are doing everything in our power to make our patients give up smoking because of the risk to their respiratory, cardiovascular, and gastro-intestinal systems, and yet on the other hand either as a result of sheer folly or else, even worse, of hypocrisy, we allow organizations which are meant to be working for the benefit of patients to cause their health to deteriorate even further.

One of my patients, who has recently returned home from a ward for acute chest cases, informed me that she had to ask some of the other patients to stop smoking because they were causing her fits of coughing, which she had previously not experienced at home.

I feel that all members of the medical profession and their colleagues working in every field of hospital administration must surely in all honesty come to the one conclusion—that the sale of cigarettes on hospital premises must be stopped forthwith.—I am, etc.,

L. T. NEWMAN

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1 Royal College of Physicians of London, *Smoking and Health Now*, London, Pitman, 1971.

Estimation of Hip Rotation

SIR,—Since my note on hip rotation tests (16 January, p. 178) I find that the prone method was described and illustrated as far back as 1947 by Dr. J. Cyriax in his *Textbook of Orthopaedic Medicine*. He fixes the pelvis by doing both hips together.—I am, etc.,

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Cullen's Sign in Perforated Duodenal Ulcer

SIR,—I read with interest the article by Mr. D. M. Evans (16 January, p. 154).

I saw an elderly man presenting with pallor, shock, abdominal guarding, possessing Grey Turner's and Cullen's signs. The man did not have acute pancreatitis. He had a ruptured aortic aneurysm.—I am, etc.,

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