injected intramuscularly, the recommended dose is 0·25 mg.

Classical or common attacks of migraine rarely occur more than two or three times a week, so that the weekly dose of ergotamine tartrate should not exceed 6 mg. Patients with cluster headache may, however, require higher doses, but only over a relatively short period. Ergotamine tartrate should not be used prophylactically.

Overdosage with ergotamine tartrate is common, and has been reported as affecting up to 10% of patients attending a migraine clinic. Mild toxic symptoms, including nausea, vomiting, headache, and a feeling of vague ill health may occur, symptoms which are similar to those of an attack of migraine. Many patients with these symptoms imagine that their migraine is not controlled, take more tablets, and thus establish a vicious circle. The more serious features of ergotism —for example, burning pain, venous thrombosis, and gangrene—are rare.

At a clinic supported by the Migraine Trust it has been found that patients recover more quickly if they can go to sleep, and a significant proportion of those coming to the clinic for treatment of an acute attack do this. In these circumstances only about one in ten of those attending for the relief of an acute attack of either classical or common migraine requires ergotamine tartrate. Most patients improve with an antiemetic, a simple analgesic, and a sedative.

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R W Gilliatt
Raymond Greene
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Tranexamic acid in chronic urticaria

Sir,—Following the short report (26 August, p 608) from Drs R A Thompson and D D Felix-Davies on the successful use of tranexamic acid in "idiopathic" recurrent angioneurotic oedema, I tried this drug on two patients with previously intractable chronic urticaria. One had been investigated at a leading skin hospital, no cause or effective treatment having been found. The other patient presented to me with recurrent urticaria following exertion and showed no response to antihistamines. Both were given tranexamic acid 1 g four times daily, and both reported an appreciable reduction in the frequency and the severity of their attacks, which was sustained when the dose was reduced to a maintenance level of 0·5 g twice daily. Perhaps a trial of this drug is merited in other patients with this troublesome condition.

Darryl Tant

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What is a cohort?

Sir,—Dr V H Springett has rightly pointed out the correct use of the term "cohort" (13 January, p 126). As he says, the term was introduced by Frost[1] and this valuable method of epidemiological analysis is usually referred to as "Frost's method." I think it ought to be recognised that the method was in fact devised some years earlier by Andvord,[2] who used the Norwegian word *kull* ("brood" or "litter") to designate all members of a population born within a particular time period (in Andvord's paper five years). Reference to his paper will show that he used the method exactly in the way subsequently adopted by Frost and that his curves showing tuberculosis mortality rates by age in consecutive *kull* groups are the prototype of those published in Frost's later paper.

In Frost's paper (posthumously published in 1939, probably written in 1938) he stated that the original idea was Andvord's and gave the relevant reference. If eponymous terms are to be used in medicine it is surely right that the names be those of the true originators.

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[1] Frost, W H, *American Journal of Hygiene*, 1939, **30**, 91.
[2] Andvord, K F, *Norsk Magazin for Laegevidenskabens*, 1930, **91**, 642.

Not the language of medicine

Sir,—In his reply (13 January, p 120) to your leading article "Not the language of medicine," Lord Smith of Marlow appears to be content that the executive director of the Royal Society of Medicine replied on his behalf and in his absence to the writer of a long critical letter to the president, but this was unlikely to have satisfied the writer. Those of us who enjoy the services of personal secretaries expect them to acknowledge our mail in our absence, deal with urgent inquiries, and tell our correspondents that we will answer other points on our return. Could not a similar arrangement be made at the RSM for a president who has said he wishes to be "accessible"? Important as the complaints are, they could surely wait for the president's return and his personal attention.

Incidentally, had Lord Smith wished to answer some of these doubts "in full and in public," as your leader urges, he might in his lengthy reply have devoted some of the space to them rather than to his personal philosophy concerning the "freedom to disagree."

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Cataracts

Sir,—Referring to Mr P A Gardiner's paper on cataracts (6 January, p 36), I should like to point out to doctors that they have a good opportunity to observe the development of their own cataracts if—as they should be—they are in possession of a microscope. No slide is required; plain daylight illumination of the visual field is sufficient. If the eye is removed about 1-2 cm from the ocular and the condenser diaphragm closed by about half the cataract obscures the visual field so clearly that it can easily be drawn. A comparison of such drawings made at intervals of about three weeks clearly shows the progress of the lenticular opacity.

E Elkan

Pinner, Middx

Sir,—Mr P A Gardiner (6 January, p 38) very rightly points out that surgery for cataract is useless if the retina is unhealthy. I can think of nothing more heart breaking for a patient than to wait a long time for cataract surgery in the confident expectation that sight would be restored, only to find that the removal of the lens is in vain.

During the years from 1966 during which I provided ultrasonic diagnostic services at Moorfields High Holborn, I was astonished how few such patients were sent for exclusion of retinal detachment. The ultrasonic diagnosis of eye tumours admittedly requires much experience and preferably modern equipment, but Mundt and Hughes[1] showed how easily a retinal detachment may be detected with the simplest portable unit. Now that ultrasonic apparatus is widely available a cheap ophthalmic transducer can be connected. When the device is applied to the closed lids with a little jelly the absence of a detachment can be shown in an examination lasting barely a minute with hardly any training.

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[1] Mundt, H, and Hughes, W F, *American Journal of Ophthalmology*, 1956, **41**, 488.

Kielland's forceps

Sir,—At a time when forceps delivery is being questioned in public, it is reassuring to read in the two papers by Drs Malcolm L Chiswick and David K James (6 January, pp 7 and 10) that in the absence of evidence of fetal distress on cardiotocography, the use of Kielland's forceps was not associated with any significantly increased mortality or significant morbidity. The only difference between the study group and the "control" group of spontaneous deliveries was that the former group showed an increase in neonatal "abnormal neurological behaviour." The validity of this observation is questionable in this retrospective study, neonates not having been checked routinely for abnormal neurological behaviour, which was brought to the attention of the paediatrician only if the mother or midwife was concerned. English mothers are more likely to be concerned about their babies if they have been delivered by forceps, as this mode of delivery is not yet regarded as normal in this country.

The increased mortality and morbidity in the whole study group compared with the control group cannot be attributed to the use of Kielland's forceps, since the control group did not have a malrotation necessitating some form of operative intervention. The only way of deciding whether the use of Kielland's forceps increases mortality and morbidity is to randomly allocate cases of malrotation with fetal asphyxia in which vaginal delivery could be considered to different methods such as Kielland's forceps, ventouse extraction, and caesarean section. Then by assessing fetal and maternal outcome one may be able to decide the best way to manage these cases.

M Maresh

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Sir,—In support of Drs D K James's and M L Chiswick's paper on Kielland's forceps (6 January, p 10), I would like to add the following. Without doubt the only way to avoid the tragedy of a tentorial tear, assuming good technical application of the forceps, is to not exceed a certain force. This emphasises the obvious, that all such rotational deliveries