They may like to try packing one-sixth of a 25 mg. tablet of promethazine (Avomine) into the cavity with the head of a bent pin. This, like local aspirin, will relieve the pain for four to six hours, but unlike aspirin it does not appear to aggravate the condition and cause severe after-pain.—I am, etc.,

Rugby, Warwicks. S. C. ROGERS.

Multiple Therapy

SIR,—The purpose of my previous letter (16 July, p. 171) was to draw attention to the difficulties in multiple therapy of apportioning the blame for any observed toxic side-effects, and not to present a punctilious biochemical explanation for the clinical findings of Dr. S. D. Mahomed *et al.* (25 June, p. 1581). Despite the "critical examination" by these authors (10 September, p. 644) of my suggestion that the mineralocorticoid effects of carbenoxolone might be stimulated by barbiturates, the fact remains that to attribute toxic effects to a single drug when several are being administered is both unjust and unscientific. Any side-effects of new drugs must, of course, be promptly reported and publicized whenever they occur, but to make a new drug the scapegoat for toxic phenomena which could result from more complex causes, such as interaction with other drugs, is merely negating progress.

It is propitious to see that others in your columns (Dr. R. Lancaster, 6 August, p. 362) have also drawn attention to this problem in multiple therapy.—I am, etc.,

St. Mary's Hospital Medical School, London W.2. DENNIS V. PARKE.

Buccal Oxytocin

SIR,—Mr. G. W. Theobald (10 September, p. 645) acknowledges the dangers of the "pharmacological oxytocin drip"—O'Driscoll's figures[1] amply confirm this, since his 13 cases of uterine rupture occurred in the obstetric practice of a single not very large city even if the period involved amounted to 14 (? 15) years. In several years' experience of the "physiological drip," however, in the use of which we attempted to follow the excellent principles laid down by Mr. Theobald,[2] although no case of uterine rupture occurred, we found much individual variation, ranging from a complete lack of response to hypertonicity associated with slowing of the foetal heart and other evidence of foetal distress which led us to discontinue the drip in these cases; and in one or two cases to have recourse to caesarean section. In some of these, of course, the primary indication for induction of labour was such that placental inadequacy was to be expected, and the foetal distress may be attributable to this rather than to the oxytocin, but there were many cases of foetal distress in this group where no placental abnormality was detected and where there seemed to be little doubt that the changes were due to induced hyperactivity of the uterus.

Mr. Theobald's hypothesis of altering sensitivity of the myometrium to oxytocin may well be true, and there seems to be little doubt that the response elicited will vary according to the state of integrity of the membranes, and to the level of oxytocinase present in the body as well as to other even less clearly understood factors. It seems to me, therefore, that even if a known amount of oxytocin is placed in the blood stream, so many factors may modify the response of the target organ that careful monitoring is inescapable, and I believe this to be as true of intravenous as of buccal administration. I would agree with Mr. Theobald in deploring "the use of stupendous amounts of oxytocin," and at Worcester it has been our object for the past three years to find the lowest dosage of oxytocin which, when administered by the buccal route, will give us results as good in terms both of successful induction and in safety for mother and foetus as those we formerly obtained with the intravenous drip. We are in fact currently using a dosage scheme one-twentieth of that we originally employed, and which I agree was far too large, but even with this I regard it as vitally important that the most careful observations of the response be maintained, just as with the intravenous drip. Finally, I would join Mr. Theobald in hoping that it may not be long before a new and perfectly safe method of inducing labour, such as is not available to us today, will be found.—I am, etc.,

Ronkswood Hospital, Worcester. J. A. CHALMERS.

REFERENCES

1 O'Driscoll, K., *Proc. roy. Soc. Med.*, 1966, **59**, 65.
2 Theobald, G. W., in *British Obstetric and Gynaecological Practice*, 3rd ed., ed. A. Claye and A. Bourne, 1963. Heinemann.

Visiting in Maternity Hospitals

SIR,—I had expected a spate of answers to Mr. B. Eton's letter (30 July, p. 304), but since none appeared I asked my assistant matron if it is uncommon for children to visit their mothers and the new baby in hospital. She informed me that it is not common. The idea is catching on slowly, enthusiastically supported by those with experience and being rejected out of hand by those without.

At the British Hospital for Mothers and Babies visiting by children has been practised since 1961. The children must be the parents' own—in the early days one proud father brought all the neighbours' children to see his baby. There is no limit to the number of their children who may visit, neither is there an age limit. They must be accompanied by their father, or if this is impossible by an acceptable substitute. The time is Saturday afternoon from 2.45 to 3.15. The mothers are always asked if they want their children, and a few, fearing emotional upsets, prefer not to have them. The mother sits in a chair by the bed so that she may take a small child on to her lap (no boots on the bedclothes). The sad thing is that the little ones are only interested in the baby, which is there in its cot but which may not be handled, and not at all in mother. This must be explained in advance. The older child is more interested in mother and not so much in the new rival.

We presume that parents know when their children are ill and keep them away. They don't come up with colds and spots. In five years none of the dreaded bacteriological complications has occurred and Saturday afternoons are the happiest days in the hospital. As John Hunter would have said, "Try it out."—I am, etc.,

London W.1. KEITH VARTAN.

Ointments and Babies

SIR,—In reply to the letter of Dr. Gordon Scott (18 June, p. 1541), which I have recently read, I would like to comment about the use of zinc and castor oil cream.

He suggests that zinc and cod-liver-oil cream would be better on a very reddened area, to prevent absorption of castor oil, and aggravation of diarrhoea. As a doctor and a mother, I would dislike the smell that this would leave on everything. Surely in such circumstances a silicone-containing barrier cream gives more protection for the excoriated buttocks, and promotes more rapid healing. This will not aggravate the diarrhoea, and zinc and castor oil cream can be used again for general protection when the soreness is healed.—I am, etc.,

Dodoma, Tanzania. GLENNYS S. KERR.

Metric System

SIR,—Dr. J. D. Wigdahl's letter (17 September, p. 702) on the subject of metric containers fails to mention the even more confused state of metric liquid dosage.

Most proprietary liquid preparations are based on a 5 ml. formulation which necessitates a large teaspoon, as distinct from a 3.5–4.0 ml. formulation (equivalent to 1 fluid drachm) which requires a small teaspoon. The standardization to a 5 ml./10 ml. volume dose and the distribution of spoons measuring this quantity are long overdue. To mention but a few proprietary preparations not formulated to a 5 ml. dosage would include: primidone suspension 3.5 ml., phenytoin suspension 4 ml., chloramphenicol paediatric 4 ml., Englate syrup (theophylline sodium glycinate) 4 ml.

The first two examples, which are sometimes prescribed concurrently, illustrate an error of 12% in dosage of active ingredient even when using the same small domestic teaspoon.

The *B.N.F.* permits the dilution with, for example, syrup of paediatric preparations in order to obtain a whole spoonful dose rather than a fractional part of one. It does not, however, add that chloramphenicol and fusidic acid suspension should not be diluted with water.—I am, etc.,

Scunthorpe and District War Memorial Hospital, Scunthorpe. G. HUGHES, Group Pharmacist.

Labelling of Drugs

SIR,—Dr. B. Taylor (24 September, p. 768) complains that hospital outpatients are given the form E.C.10(H.P.) with which drugs are obtained from a local chemist, and that these are commonly unlabelled and unidentifiable. While this must cause confusion and annoyance it also raises the question as to the proper use of the form. I have always understood that it was intended for use only in an emergency such as the necessity to ensure continuity of treatment for an inpatient being discharged from hospital. For example, a diabetic newly stabilized may obtain insulin in this way, although in practice it may be more satisfactory to give the