monitor adequately the problems that occur in the field. It was also pointed out that the professional organizations most intimately concerned, the British Association of Social Workers and the Royal College of General Practitioners, were limited to dealing with their own members when they tried to promote co-operation.

The meeting therefore decided to constitute itself formally and the title chosen for the group was "General Practitioner and Social Worker Workshop." We have drawn up a constitution and have appointed officers for the forthcoming year. It is unfortunately necessary for us to charge a subscription to cover the costs of postage, stationery, etc., and some small-scale research projects that we envisage being undertaken. We would stress that we see ourselves not as a rival organization to other professional bodies but rather as a body which has constituted itself to perform a special task. Should we find that the need for our existence no longer exists we would dissolve ourselves. Our experience so far, however, during two and a half years of informal meeting, is that there is a need for a group which can act as a focal point for those interested in general practice/social work co-operation.

If anyone is interested in joining the group details of our constitution and aims can be obtained by sending a reply paid envelope to me.—I am, etc.,

G. KEELE
Hon. Secretary,
General Practitioner and Social Worker Workshop

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Prescribing Barbiturates

SIR,—Dr. J. G. R. Howie's contribution on the subject of psychotropic drugs in general practice (26 April, p. 177) is as informative as it is thought-provoking. No one would argue with his warning that extreme caution should be exercised when psychotropic drugs are used with other medication.

However, his statement on his personal prescribing policy that he tends to allow patients to go on taking barbiturate hypnotics should not go unchallenged. Most of our patients receiving preparations, whatever their nature, are satisfied with what they get, provided the drug produces the desired effect. But the case against barbiturates has been made and is now widely accepted and to go on prescribing them on their merit of continued acceptability in the light of present knowledge is to be condemned.

In our practice in a matter of a few months we were able to change completely from barbiturates to benzodiazepines without any great difficulty. In fact, save for anticonvulsant medication, barbiturates are proscribed.—I am, etc.,

P. S. BOFFA

Croydon

Long-acting Phenothiazines

SIR,—Dr. P. F. Kennedy gives an excellent summary of the present position of orthodox treatment for schizophrenia and related paranoid psychoses (3 May, p. 257). However, when he discusses the use of fluphenazine decanoate (Modecate) and flupenthixol decanoate (Depixol) in maintenance therapy he states: "In old age few but the very robust can tolerate long-acting depot preparations. . . ." Experience of treating elderly people with paranoid psychosis over a period of nine years does not substantiate this observation. Fluphenazine decanoate produced few adverse side effects in patients whose ages ranged from 60 to 92 but admirably controlled their psychoses. Evidence of moderate or severe dementia was looked upon as a contraindication, since in these cases there was a risk of fairly serious extrapyramidal reactions.

Latterly I have been using flupenthixol decanoate and to date have treated 29 patients whose ages have ranged from 65 to 97. Four in this series had moderate degrees of dementia but did not develop extrapyramidal symptoms. This preparation has been as effective as fluphenazine decanoate in controlling the psychosis, with the added advantage of activating instead of mildly sedating the patients. The dose has ranged from 20 mg every month to 90 mg every three weeks. The latter dose was given to an 84-year-old woman who weighed about five stone (32 kg). She was maintained on this dosage for four years till her death recently from a cerebral thrombosis.

I would strongly oppose the indiscriminate use of long-acting depot preparations in the elderly, but I do consider that they have a definite place in the treatment of paranoid psychosis in old people provided there is no evidence of a serious degree of dementia and there are adequate community facilities so that they can be supported and observed. The majority of the patients I have treated would have spent their last years in an institution if treatment with long-acting depot preparation had not been available.—I am, etc.,

TONY WHITEHEAD

Department of Geriatric Psychiatry,
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Brighton, Sussex

SI Units

SIR,—Mr. B. H. Hand and his colleagues (17 May, p. 389) can be assured that their protests, like mine (28 December 1974, p. 267) and those of many others, will be ignored. Consultation in this matter has consisted of informing clinicians that this change is to take place. Serious and cogent objections have been neglected. It is clear that the allegiance of many pathologists is now directed to "pure" science rather than to the needs of clinicians in managing their patients. Moreover, we shall be divorced by the "unit barrier" from easy comprehension of past data, both in our patients' records and in the medical literature, not to mention much of the current U.S. literature. I was glad to see that the American Medical Association has rejected application of SI units.[1]

One further point. Your editorial footnote states that representative bodies were consulted. With regard to one of those bodies—namely, the Royal College of Physicians—I can tell you what happened. No reference was made either to Comitia or to the Standing Committee of Members. Judging by the pained surprise of most clinicians I have met, very few attempts were made by other bodies to apprise their members of the SI bombshell. Considering the danger, expense, and inconvenience of the whole exercise, this can only redound to their discredit. Perhaps, however, we shall at least be able to save the millimetre of mercury as Dr. A. Hollman (3 May, p. 281) proposes. One sighs for the day of the 100% haemoglobin scale and longs for the day of the unit normal deviate. But now we have chaos.—I am, etc.,

G. H. HALL

Exeter

[1] *New England Journal of Medicine*, 1975, **292**, 805.

Drugs for Common Cancers

SIR,—We were very interested to read your leading article (3 May, p. 235) which pointed out clearly the potential importance of adjuvant chemotherapy at an early stage in the management of malignant disease, especially of the breast. Fisher and his colleagues[1] have produced short-term results that appear impressive, but though melphalan has major advantages in terms of convenience and toxicity, it would be premature to draw conclusions on such a small number of cases. It would, however, seem logical to assume that micrometastases would respond optimally to that variety of chemotherapy demonstrated most effective in advanced breast cancer. Melphalan, unfortunately, is relatively ineffective when used in advanced breast cancer, producing short-duration responses in only a minority of cases.

Recent work with combinations of cytotoxic drugs has shown much greater effectiveness in late breast cancer. This group, for example, has completed one study comparing two combination regimens using intravenous cyclophosphamide, vincristine, methotrexate, and 5-fluorouracil. One of the regimens necessitated five daily injections, while the other was carried out as an infusion on one day. The three-month remission rate for the five-day treatment was 59% and the six-month rate 54%. The one-day regimen gave three- and six-month remission rates of 49% and 27% respectively. (There were 39 five-day cases and 41 one-day cases.) In consequence the shorter regimen was discontinued and we are now in the later stages of a second study, using the previous five-day treatment, compared with a two-day treatment in which the two treatment days are separated by four to six rest days. This regimen is currently producing response rates at least as good as the five-day treatment. The three-month remission rate (46 cases) is running at over 60% and the six-month rate (35 cases) at over 50%, while the five-day regimen continues to confirm its effectiveness as shown in the first trial. The statistical significance of the treatment comparison in this study has yet to be determined, but the convenience and low toxicity of this two-day regimen, together with its undoubted effectiveness, make it a strong candidate for evaluation in early cases.

A collaborative multicentre trial for poor-risk early cases using the two-day treatment with a slight dose reduction to minimize any

residual toxicity is currently in an advanced state of planning.—We are, etc.,

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1 Fisher, B., *et al.*, *New England Journal of Medicine*, 1975, **292**, 117.

Fibre Content of Bread

SIR,—Many of your readers may have watched the recent B.B.C. T.V. Horizon programme "A Spoonful of Roughage" with considerable interest because of the possible implications for the nation's health of the high fibre hypothesis. Relatively few of them, however, may have been aware of two significant inaccuracies which occurred.

Firstly, the background narrative referred at least twice to the wholemeal bread of 100 years ago in relation to the incidence of certain diseases, implying that this was the bread in general consumption. This is completely contrary to fact. White bread was as common 100 years ago as it is today, and the change from stone grinding to roller mills made very slight difference to the amount of fibre in white flour. Bread flour was sifted to produce a finer (whiter) product long before roller milling was introduced, and white bread was eaten in very much greater quantity than today. Whatever the reasons for the lower incidence of gastrointestinal disorders 100 years ago general consumption of wholemeal bread was not one of them.

Secondly, reference was made in the background narrative to improved national health and to lower incidence of intestinal disorders during the war years due to the higher content of fibre in the war-time national loaf. Official records show that the higher fibre content of flour was not introduced until April 1942, the extraction rate of flour being increased to 85%—at which level, incidentally, the fibre content of the flour was much closer to that of white flour than of wholemeal flour. Whatever the reasons for the lower incidence of diseases from 1939 certainly to well into 1942 a difference in the fibre content of bread was not responsible. Other foods *were* subject to changed conditions. Less fat, less meat, and less sugar were consumed. Bread was deliberately left unrationed to permit optimum consumption.

These two facts are quite easy to validate.

We in the flour-milling and baking industries share in the desire of Mr. Denis Burkitt and his colleagues that the whole field be investigated thoroughly and that the true facts should emerge in due course, whatever they may be. It is important in the meantime that the background presented by the media should not become distorted, even inadvertently, through inaccuracy, since sound judgement may be impaired.—I am, etc.,

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Dangers of Humidification of Inspired Air

SIR,—It is necessary to write a word of warning about the use of commercial humidifiers, whether they be small and domestic or large and industrial. The water in the reservoir is apt to act as a culture medium for bacteria and algae which are then sprayed over the unsuspecting people beneath, causing an acute alveolitis. Understandably, this is often called "influenza."[1] This culture is more likely when the reservoir is inaccessible (such as when attached to the ceiling) and when the atmosphere is very warm. Hospitals or large crowded overheated offices form good culture conditions.[2]

This bacterial or algal dissemination can be avoided by designing humidifiers without reservoirs which use instead water straight from the main. Introducing an antiseptic into the reservoir water is not safe as it merely sprays people with a potentially dangerous chemical aerosol instead of with bacteria or algae.—I am, etc.,

R. C. BROWNE
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1 H.M. Chief Inspector of Factories, *Annual Report, 1969*, p. 72.
2 Browne, R. C., *Proceedings of the Royal Society of Medicine*, 1973, **66**, 1165.

Prevention of Overdoses

SIR,—In order to prevent overdoses why cannot the commonly used hypnotics have incorporated in them a very small dose of an emetic? This could be gauged so that in correct dosage the emetic had no effect but with overdoses it caused vomiting.—I am, etc.,

P. M. VICARY
Weybridge, Surrey

Basic Science and Specialist Registration

SIR,—Your leading article "Perinatal Research" (3 May, p. 236) raises the question just how much experience in "basic science" a clinician can obtain before the requirements for specialist registration are jeopardized. Specialist registers of the royal colleges are now in operation and require hospital doctors to have spent a specified period in each of the training grades in an approved post. As most basic science positions offered to interested clinicians are not approved posts those who wish to gain insight into scientific and clinical research may find themselves ineligible for specialist registration when they wish to return to their chosen field. The anomalous position may therefore arise that someone wishing to increase his knowledge and therefore provide a better service to his patients may find himself unable to re-enter his specialty.

Until recently this problem has not arisen as many of those availing themselves of opportunities for basic study returned to university clinical departments. Training in such departments was not formalized and could be tailored to the individual's needs while advantage could be taken of the special knowledge or skills of the individual and ongoing education continued. However, it now seems that academic positions are to be assessed for specialist registration by the royal colleges. If this is so then it would seem that all university clinical posts have to be equated with N.H.S. positions and occupied by those who have followed, to the letter, the experience laid down for specialist registration.

This policy would make it more difficult for those who had either qualified abroad, studied abroad, or spent time at establishments such as the Nuffield Institute to enter university medicine in this country. The result of such a process would be a loss of diversity in academic medicine and consequently a loss of assets.

If the present character of university departments is to be retained the system has to be flexible enough to allow movement from basic science to clinical medicine and vice versa. In my opinion flexibility is being lost and the present trend should be halted before rigidity sets in.

If these problems are not considered now, then a rigid, sterile, and therefore inefficient system may be grafted on to the body of academic medicine for little reason other than conformity to the Treaty of Rome.—I am, etc.,

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Women Doctors

SIR,—Clearly shortage of space precludes full reporting of parliamentary proceedings in the *B.M.J.*, even when these are of interest and relevant to the profession. However, it is nothing short of censorship when you choose to report the beginning and end of a question-time exchange between the Secretary of State for Social Services and Mr. Bruce Douglas-Mann but neatly leave out a derogatory reference to the B.M.A. which occurs in the middle.

In a Medical News paragraph entitled "Conference on Women Doctors" (10 May, p. 347) you quote almost verbatim the member's question about "the steps taken to recruit, encourage, and ensure the effective deployment of women doctors" and Mrs. Castle's answer "that at present she was not satisfied that enough was being done." Mr. Douglas-Mann went on to ask, "Is my right hon. Friend aware that her attitude is extremely encouraging? Is she satisfied that the British Medical Association is doing all it can in this matter? Does she agree that it has a vital role to play in the efficient operation of the National Health Service? Is she aware that many people feel it is getting a little out of touch? Does she realize that it has recently made redundant the only woman doctor it employed?" Mrs. Castle replied, "I am aware of that. Naturally, as co-chairman of the Women's National Campaign in International Women's Year, I deeply deplore the reduction in the employment of any women in posts of responsibility."[1]

These few lines did not appear in your pages, and I wonder if it is because the