

little effect, and our conclusion remains unaltered. Indeed, the attack rates, adjusted for town as well as age and social class, are identical to one decimal place with those quoted in table IV of our paper.

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### Drug abuse: a new problem

SIR,—In their paper on accidental needlestick injuries to children from discarded syringes (29 August, p 526) Dr S S Walsh and colleagues state that "most of these [incidents] occurred after January 1987." Are we to take it that they are presenting evidence of an increased rate of such accidental needlestick injuries among the general public? Is there any evidence from the recovered needles and syringes or from their location that this increased incidence is related to the new injecting equipment exchange scheme established in central Liverpool at the end of 1986, or has any increase in incidents been more gradual, indicating that it is related to a more general and gradual increase in intravenous drug abuse itself?

The answers to these questions are important to the present debate about such exchange schemes, and Dr Walsh and coworkers should be encouraged to provide any subsequent figures that may have become available.

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**AUTHORS' REPLY.**—Dr Strang raises an important question, which we have also considered. Though most cases of needlestick injury from June 1985 to the end of April 1987 occurred after 1 January 1987 (eight incidents out of 13), we noticed no clustering of cases in dates of presentation or location of discarded needles and syringes, either before or after the introduction of the injecting equipment exchange scheme in Liverpool on 24 October 1986. Exchange needles and syringes are available from some pharmacies in the city as well as from the centre, and they all issue various standard types. Therefore, it was not possible to trace our recovered needles and syringes to any particular source.

The Royal Liverpool Children's Hospital has two branches—an inner city based hospital (Myrtle Street) and a suburban based hospital (Adler Hey). Of the eight patients with needlestick injury, five presented to the former and three to the latter. The children came from widely differing areas of the city and presented at a steady rate of one to three a month from January to April. Interestingly, since writing our report at the end of May we have seen five more patients, who presented at the same rate, emphasising that the problem continues.

Our latest information from colleagues at the exchange centre in Liverpool is that they have a positive balance of the order of 1000-1500 needles and syringes.

From all this information we concluded that the exchange scheme did not play an important part in the increasing incidence of needlestick injuries seen at the hospital. Probably of greater importance was the increased public awareness of the acquired immune deficiency syndrome as a result of media coverage and the government's advertising campaign. In our experience this was the main factor

that had prompted parents to seek medical advice when confronted with the problem.

We, like Dr Strang, obviously support any moves that may help in eliminating this problem.

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### Controlled trial of $\gamma$ linolenic acid in Dukes's C colorectal cancer

SIR,—The controlled trial of  $\gamma$  linolenic acid in Dukes's C colorectal cancer by Drs M B McIllmurray and W Turkie (16 May, p 1260) failed to show any benefit.

Their patients received 270 mg  $\gamma$  linolenic acid daily, which is insufficient for any therapeutic effect of this fatty acid derivative, which has been proved to be cytostatic in vitro. In our study, the abstract of which was quoted by Drs McIllmurray and Turkie, we used up to 36 capsules daily, providing 1.62 g of  $\gamma$  linolenic acid. We have patients with untreatable brain tumours surviving for 39 months and others with various tumours surviving for periods of up to three years.

Because evening primrose oil contains only 9%  $\gamma$  linolenic acid the volume of oil needed to provide adequate daily amounts of the acid becomes prohibitive. Work is currently under way, however, to produce concentrates of  $\gamma$  linolenic acid to enable adequate doses of this metabolite to be given to patients with a high tumour load.

Interestingly, the survival curves in the paper by Drs McIllmurray and Turkie show that  $\gamma$  linolenic acid was ahead of placebo for most of the study. In any further study the use of at least 1.6 g of acid daily should be attempted.

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**AUTHOR'S REPLY.**—The dose of  $\gamma$  linolenic acid chosen in our study was empirical as it is difficult to translate in vitro data into clinical practice. We thought that it was unreasonable to ask patients to take more than six capsules daily over a period of years. Thus the dose was considerably less than that quoted by Dr Van der Merwe (in an abstract published after our study was started), but the clinical circumstances were entirely different. We were treating patients with no evidence of residual tumour, and the tumour load was small.

The evaluation of higher concentrations of  $\gamma$  linolenic acid in patients with cancer may well be worth while, but we would urge that this be done only in controlled clinical trials.

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### Hypothermia in the elderly: scope for prevention

SIR,—Drs Catherine J Otty and M O Roland (15 August, p 419) do well to highlight the complexities of preventing hypothermia. For practical purposes strategies need to be considered for three categories of patient.

Those presenting with hypothermia without underlying illness are fortunately rare, with few doctors working in the community reporting appreciable numbers of cases even in a severe winter.<sup>1</sup> Most of these cases occur after a fall. An

effective strategy here is the increased use of dispersed alarm systems in the community to reduce the time patients lie immobile and exposed.<sup>2</sup>

It is difficult to conceive of effective preventive strategies for the second and far more common group with hypothermia, those in whom the condition is secondary to underlying illness. A warm environment is no guarantee against this form of hypothermia. It is not uncommon to record low body temperatures in patients developing bronchopneumonia in overheated hospital wards.

Patients in the third category are those who first develop hypothermia, which in turn results in increased rates of stroke and myocardial infarction owing to transient increases in blood pressure and plasma viscosity.<sup>3</sup> Unless studied epidemiologically, hypothermia often goes unrecognised as the predisposing event because the patients may have recovered a normal body temperature by the time the vascular episode presents several days later.<sup>4</sup>

There is real potential for preventing this last sequence by ensuring that the elderly live in a warm environment. However, the provision of heating in homes is by itself not necessarily an effective strategy. The Anchor Housing Association found that the provision of unlimited free heating in sheltered housing failed to prevent the increased mortality in occupants over the cold winter months.<sup>5</sup> This failure was attributed to the elderly turning their heating off, opening windows at night, or going for walks in the cold outdoors.

An attitudinal and behavioural change is also required. At present the authors' findings, mirrored by similar studies in fall prevention by McCabe,<sup>6</sup> suggest that limitations may be imposed on health maintenance strategies by the refusal of the elderly to change lifelong habits and adopt a more healthy lifestyle.

The final irony in the complexities of preventing hypothermia lies with the theoretical possibility that the more we encourage the elderly to live in warm environments, the less able they may become to acclimatise to cold conditions when encountered. Although mild cold exposure has not so far been shown to bring about an adaptive response in elderly humans, German, studying aged mice, found that intermittent cold exposure did effectively reduce the incidence of hypothermia during cold challenge.<sup>7</sup>

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### Pneumothorax in the supine patient

SIR,—We thank Drs Andrew R C Cummin, Michael J Smith, and Alan G Wilson (5 September, p 591) for their guidelines to help clinicians to recognise a pneumothorax in a supine chest radiograph. We believe, however, that there is a second lesson to be learnt from case 1.