which could lead to controversy on irrelevant matters.—We are, etc.,

T. H. TAYLOR.
D. LEIVERS.

London Hospital,
London E.1.

A. M. C. JENNINGS.

Northampton General Hospital,
Northampton.

REFERENCE

1 Department of Health and Social Security, Department of Health for Scotland. *Responsibilities of the Consultant Grade*. London, H.M.S.O., 1969.

House-dust and Asthma

SIR,—We are grateful to Dr. B. J. Freedman (18 July, p. 166) for his abstract from a discussion by Ramazzini on the effect of dust raised by beating and shaking mattresses. Dr. Freedman says that we found the greatest number of the house-dust mite in dust from mattresses.[1] We should like to add that the samples were taken from the surface of mattresses, obtained by brushing it.[1,2] Recently we examined also dust samples taken from the stuffing of used mattresses, and in those detected only a small number of mites or none. This work is still in progress.—We are, etc.,

MARGARET HUGHES.

Biology Department,
Royal Free Hospital School of Medicine,
London W.C.1.

KATE MAUNSELL.

Department of Medical Microbiology,
King's College Hospital,
London S.E.5.

REFERENCES

1 Maunsell, K., Wraith, D. G., and Cunnington, A. M., *Lancet*, 1968, **1**, 1267.
2 Maunsell, K., Hughes, A. M., and Wraith, D. G., *Practitioner*, 1970, (in press).

Too Much Protection?

SIR,—The leading article (25 July, p. 180) suggests that possibly too much effort is being devoted to protection against small doses of ionizing radiation.

I cannot agree that the measuring and recording of such doses is unnecessary in the light of our present knowledge of the effects, but I would support the contention that there is a great deal of unnecessary medical supervision. In a paper given at the recent congress of the International Radiation Protection Association, I reviewed the experience of 20 years of such supervision at the Atomic Energy Research Establishment at Harwell. This paper attempted to show that medical supervision with routine blood counts, etc., had contributed little or nothing to the protection of our workers. The paper concluded: "There is a growing world wide scarcity of medical skill. It would be unfortunate if, because of outmoded beliefs, the similarly growing nuclear industry aggravated this scarcity by absorbing medical effort for unnecessary procedures."[1]—I am, etc.,

A. N. B. STOTT.

Chief of Medical Services, Atomic Energy Research Establishment, Harwell, Berks.

REFERENCE

1 Stott, A. N. B., in *Proceedings of the Second International Congress of the International Radiation Protection Association* 1970, Oxford, Pergamon.

Fibrinolytic Activity and Venous Stasis

SIR,—We were interested in the article "Coagulation and Fibrinolytic Mechanisms During and After Normal Childbirth" by Dr. J. Bonnar and others (25 April, p. 200).

During our own investigations we have observed an anomaly, thus far unreported, concerning the fibrinolytic activity in these same subjects. Using a technique very similar to that of Nilsson,[1] we have studied the increase in fibrinolytic activity induced by venous stasis in 20 women in their third trimester of pregnancy. In all but two of the women venous stasis did not cause a sharp increase in fibrinolytic activity. The same test when performed on 10 women within one week after they had given birth showed normal results.

Our work on this subject continues.—We are, etc.,

N. CIAVARELLA.
J. CONRAD.
M. SAMAMA.

Department of Haematology,
Hotel Dieu, Paris 4.

REFERENCE

1 Nilsson, I. M., and Robertson, B., *Thrombosis et Diathesis Haemorrhagica*, 1968, **20**, 397.

Folate and Vitamin B_{12} in Epilepsy

SIR,—In answer to some of the correspondence (18 July, p. 164, and 25 July, p. 226) arising out of my paper on folate and vitamin B_{12} in epilepsy (27 June, p. 759), I would point out that the improvement in number and severity of fits, in behaviour, and in mental state was assessed by weekly ratings performed by the physician in conjunction with the nursing staff. Since I am aware that such observations lack an objective measurement it was decided to find out whether the change in the symptoms was reflected in the E.E.G. This investigation was carried out by Dr. Ian Fraser and myself and the results will be published in due course.

As regards the administration of folic acid to epileptics causing increase in the number or severity of fits I would comment that if the serum folate level tends to stay below 40 ng./ml., which appears to be the threshold for the precipitation of fits in children, no increase in the number or severity of fits will be noticed.—I am, etc.,

C. NEUBAUER.

Prudhoe Hospital,
Prudhoe, Northumberland.

Tablet Colour in Anxiety States

SIR,—We read the article by Dr. K. Schapira and others on a study of the effects of tablet colour in the treatment of anxiety states (23 May, p. 446). Although the authors checked on the number of tablets consumed by the patients, they make no mention of the results in their article. Reynolds *et al.*[1] during the treatment of anxious outpatients found that daily tablet consumption throughout the trial was less than that prescribed and differed, although not significantly, between the different treatments. They, however, found significant difference in tablet consumption by the patients of two physicians. It will be interesting to know if Dr. Schapira and his colleagues' patients reacted in the same manner to any particular colour or therapist, and if so, whether the results from these instances of low consumption were excluded from the analysis or not. Within the limitations of their trial the effective colours for depression and anxiety were yellow and green respectively. Did any of these coloured remedies lead patients to request continuation of the same treatment?

We are investigating the possible role of shape or form of medication in pharmacotherapy of anxiety states. The drug used is chlordiazepoxide, which is a widely used anxiolytic agent. The dosage used is 10 mg. three times a day. Twenty-nine patients have completed this cross-over trial between capsules and tablets, each prescribed for a period of a fortnight and the order of prescription being randomized. The patients completed a self-rating anxiety scale and were assessed weekly on the Hamilton Anxiety Rating Scale (A.S.R.S.). The mean consumption rate for capsules was 2·97 ± 0·58 (S.D.) and for tablets was 2·49 ± 0·32 (S.D.). The Table shows the result of mean A.S.R.S. scores.

At the end of the month these patients remained significantly better than at the start ($P<0.01$), but it is evident that the overall response to capsules is better than to tablets, and when patients were changed to tablets they showed slight overall deterioration, whereas those who were changed to capsules continued to improve. On symptom analysis, capsules were significantly better for relieving tension anxiety ($P=0.04$), phobias ($P=0.03$), broken sleep ($P=0.05$). Difference for depression did not reach significant level. Eleven patients requested continuation of the same treatment while receiving treatment with capsules, and on withdrawal of treatment the capsule group voiced more complaints.

It is concluded from these results that capsule form of medication in anxiety states is preferred by the patients and so is taken more regularly than tablet form. It also reflected that psychological dependence is more on capsules as compared to tablets. The differences in beneficial effects could have been due to more regularity in consumption of capsules or because of psychological preference of capsule form of medication.—We are, etc.,

M. Z. HUSSAIN.
A. AHAD.

Psychiatric Department,
Department of Public Health,
Province of Saskatchewan,
Canada.

REFERENCE

1 Reynolds, E., Joyce, C. R. B., Swift, J. L., Tooley, P. H., and Weatherall, M., *British Journal of Psychiatry*, 1965, **111**, 84.

No. of Patients		Initial		Two weeks			Four weeks	
		Mean	S.D.	Mean	S.D.		Mean	S.D.
15	Capsule	14·1	3·9	9·4	3·6	Tablet	9·8	3·5
14	Tablet	13·8	3·6	9·6	3·4	Capsule	9·1	3·2