used the discovery of staphylococcus-killing products of a fungus to make penicillin which saved millions of lives. Other scientists used the principle of atomic fission to make weapons and bombs. Two of these bombs were dropped in Japan, and killed over 2 million people, and horribly crippled many more, in seconds. Some of the machines invented or made by scientists now spew out pollutants into the air and waters."

This, I believe, is the greatest contribution leading scientists can make to the welfare of mankind—to admit failures as readily as they admit apparent successes.—I am, etc.,

C. DE F. W. GOONARATNA

Dundee

Anorexia Nervosa

SIR,—In the leading article on anorexia nervosa (23 October, p. 183) you state "Though doubts have been expressed about its status as a distinct entity, it is generally regarded as a consistent syndrome." I have been trying without success to fathom what this means. I think I know what a consistent syndrome is; but I have no idea what is meant by "distinct entity," nor how one would decide whether or no "a consistent syndrome" is "a distinct entity." Could you enlighten me?—I am, etc.,

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Ampicillin and Mononucleosis

SIR,—Dr. I. J. Nazareth (3 July, p. 48) suggested that the hypersensitivity to ampicillin shown by the patients suffering from infectious mononucleosis is transient. I would like to report the following case.

A child of six developed a generalized maculopapular rash after having received three doses of ampicillin 125 mg each orally for pyrexial illness. This illness later turned out to be infectious mononucleosis. Ampicillin was discontinued and this rash cleared completely within 36 hours. Sixteen weeks later he developed an upper respiratory tract infection, which was presumably viral as suggested by W.B.C. count and negative throat swab for bacteria.

He was given ampicillin for five days orally and he did not show any hypersensitivity.—I am, etc.,

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Confidential Information and Cervical Cytology

SIR,—I have recently seen a copy of "Routine Cervical Cytology—Arrangements for Recall for Re-examination" (H.M.(71)79) and also the "Request/Report/Recall" form (H.M.(71)80) which, it would appear, is to come into general use (see *Supplement*, p. 28). While I do not wish to dispute the value of routine cervical cytology, these two pieces of paper raise a number of questions, and some of the implications I find disturbing.

First, what is the N.H.S. Central Registrar at Stockport, and who controls it? If it is just a centralized record of patients' names and addresses and their executive councils, how does it have the necessary data to know which women have had cervical smears and when? If it is not simply such a register, perhaps we could be told what other information about our patients is received and stored there, and how it is obtained? Perhaps you, Sir, or some of your readers, could enlighten me.

Secondly, with regard to the "Request/Report/Recall" form, I must protest at the amount of unnecessary information requested. The pathologist interpreting the smears does not need to know, for instance, the patient's maiden name nor her husband's occupation, nor indeed is her marital status relevant; so who wants all this information? I think we should be told this, as a fully and accurately completed form might show that an unmarried woman had had one of two pregnancies.

It seems that there is a grave risk that confidential information about our patients is being—or may be—spread too widely, and that without either our or our patients' knowledge and consent. I hope my fears can be allayed.—I am, etc.,

MARY PACK

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Trimethoprim and Sulphamethoxazole

SIR,—The advice given by Drs. J. N. Scragg and C. J. Rubidge (25 September, p. 738) to monitor the blood picture of patients on this drug combination prompts us to report the toxic effects in another patient.

A female aged 27 years complained of headache, fever, back pains, and dysuria. She had been treated for one week with ampicillin and then for eight days with trimethoprim 160 mg and sulphamethoxazole 800 mg daily. A blood count six days later showed neutropenia (650/mm^3), thrombocytopenia (60,000/mm^3), and a haemoglobin of 11·4 g/100 ml. A marrow aspirate yielded megaloblastic erythropoiesis and numerous giant metamyelocytes. The serum folate was 1·0 ng/ml and erythrocyte folate 16 ng/ml.

After admission to hospital her pyrexia and symptoms subsided without specific therapy. Anaemia developed and the haemoglobin fell to 8·5 g/100 ml. The platelet and neutrophil counts had risen considerably before admission and were normal 12 and 16 days respectively after the end of the drug therapy, while the marrow was still megaloblastic. Erythropoiesis became normoblastic after three weeks and the haemoglobin then rose to normal. The serum and erythrocyte folates slowly reached low normal levels. Before admission she had been anorexic for two months and had lost 10 kg in weight. She had suffered from recurrent cystitis for many years and there was a history of recent domestic troubles. Tests for malabsorption and a jejunal biopsy were normal. A course of sulphamethoxazole 1,000 mg daily for seven days, given when the blood count was normal, produced no change.

Neutropenia and thrombocytopenia are well recognized complications of trimethoprim-sulphamethoxazole therapy but megaloblastic change is very rare, though it has been recorded with long-term treatment[1] and when treble the conventional dosage has been given.[2] The erythrocyte folate level indicated that our patient had tissue folate deficiency before exhibition of the drugs which may have precipitated the anaemia. We do not know if the drugs caused the megaloblastic change because the marrow picture before their use was unknown. However, the presence of folate deficiency may be expected to increase a patient's sensitivity to this drug, particularly if human folate reductase is an inducible enzyme.

Unfortunately we were unable to estimate the enzyme level in our patient. We suggest that the drug combination be used with caution in patients known, or suspected, to have marked folate deficiency.—We are, etc.,

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R. C. ROUTLEDGE

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1 Jewkes, R. F., Edwards, M. S., and Grant, B. J. B., *Postgraduate Medical Journal*, 1970, **46**, 723.
2 Kahn, S. B., Fein, S. A., and Brodsky, I., *Clinical Pharmacology and Therapeutics*, 1968, **9**, 550.

SIR,—Clearly Drs. J. N. Scragg and C. J. Rubidge (25 September, p. 738) had not read our letter to this journal (23 January, p. 230) on dosage schedules of trimethoprim-sulphamethoxazole in the treatment of typhoid fever before publishing their results. We definitely suggested a dose of at least 10 mg trimethoprim, 50 mg sulphamethoxazole per kg body weight per day. This high dose is most important particularly in underweight and malnourished children, when the standard dose originally advised by the manufacturer is inadequate. They should try the correct dose.—I am, etc.,

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Transporting Patients with Chest Injuries

SIR,—Many patients with chest injuries who are transferred to regional thoracic units such as ours must travel considerable distances by ambulance. It is hardly surprising, therefore, that their condition is often worsened by the journey.

Personal observation has shown that in patients who are breathing spontaneously respiration is particularly embarrassed during and after deceleration of the ambulance. This is presumably owing to the abdominal viscera being thrown up against the diaphragm in a patient whose respiratory effort is predominantly diaphragmatic. Patients are customarily transported flat, with the head towards the driver, yet perhaps they would suffer less if carried with the head to the rear, for ambulances tend to be underpowered, and acceleration and their stresses, therefore, much less than those of deceleration. The ambulance attendants' normal reluctance to sit a patient up might also be modified with profit.—I am, etc.,

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Anticoagulant Interactions

SIR,—You rightly draw attention to the interactions between anticoagulants and certain other drugs (16 October, p. 128). However,