patients with glandular fever almost invariably develop a rash if given ampicillin,²⁻⁵ and the same is true to a lesser extent for some other antibiotics.

A survey of the literature shows that there has been a particularly high incidence of rashes in patients treated with ampicillin for *Salmonella* infections. It has been postulated that some of the rashes may be produced by endotoxin released by rapid lysis of bacteria, though there is little evidence to support this. Many of these patients received high dosage, but we have been unable to show a significant relationship between dosage and incidence.

An intensive investigation is being undertaken in an attempt to provide information on many of the unexplained features of the rash associated with ampicillin therapy.—I am, etc.,

E. T. KNUDSEN.

Medical Director,
Beecham Research Laboratories,
Brentford, Middx.

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Jakob-Creutzfeldt Disease

SIR,—The statement in your leading article (1 March, p. 528) that the term "Jakob-Creutzfeldt disease" has been erroneously used by British neurologists and physicians for many years is simply not true. There is no evidence whatsoever that the cases so recognized by neurologists in Britain at least up to 1954 were not in general similar clinically and pathologically to the five patients described by Jakob. The fact that Spielmeier, the renowned German neuropathologist, suggested the term "Jakob-Creutzfeldt disease" for what you wish to describe as "corticostriatonigral degeneration" you seem now to consider of no importance. It is surely folly to change without reason the name of a disease or syndrome, as it only confuses the student and hinders the advance of knowledge. The clinical condition which you label "Jakob-Creutzfeldt disease" and which has been transmitted to a chimpanzee was never described by either of these authors. It would be lamentable if our literature were allowed, in any degree, to become a mixture of unreality and make-believe, in the justification of which it becomes necessary to discredit our distinguished predecessors.—I am, etc.,

S. NEVIN.

Maida Vale Hospital,
London W.9.

** It is true that W. Spielmeier suggested that the term Jakob-Creutzfeldt disease should be applied to a neurological syndrome characterized by the slow development of a Parkinsonian-like picture, often associated with dementia, signs of corticospinal tract degeneration, and amyotrophy in the limbs. More recently, however, many neurologists have come to the conclusion that the cases which Jakob and Creutzfeldt originally described almost certainly represented a different diagnostic entity from that referred

to by Spielmeier. The general consensus of opinion among many neuropathologists in Britain and the majority in the U.S.A. is that the term Jakob-Creutzfeldt disease is more properly used to identify a syndrome characterized by rapidly progressive dementia developing in the presenium, often associated with myoclonus, and by a spongiform type of degeneration in the cerebral cortex seen at necropsy. The matter is still controversial, but majority opinion seems to be leaning towards the view expressed in our leading article rather than towards the more traditional British use of this diagnostic title as stressed by Dr. Nevin.—Ed., *B.M.J.*

Cerebral Malaria

SIR,—I agree with Dr. P. W. Hutton (1 March, p. 578). I see no major difference between quinine and the 4-amino-quinolines (in the absence of parasite resistance) in the treatment of cerebral complications of falciparum malaria, so long as reasonable care is taken during administration to avoid the precipitation of medical shock.

Recent discussions (25 January, p. 256) indicate some misunderstanding of the processes involved in the development of coma, which is primarily due to incompetence of the cerebral circulation following leakage of protein and water through the endothelial walls of the small brain vessels. Quinine and chloroquine (and the corticosteroids for that matter) reverse this process, acting as anti-inflammatory agents; the restoration of the circulation leads to return of consciousness, often in a few hours. The antiparasitic activity of the drugs at this stage is not a factor in the immediate clinical response. We are lucky to have two such powerful schizonticides which are equally active anti-inflammatory agents.

May I say how pleased I was to read Dr. Hutton's warning on falciparum malaria as it occurs in the United Kingdom. It is time the public and the profession appreciated the potential risks of overseas travel in this respect.—I am, etc.,

BRIAN MAEGRAITH.

School of Tropical Medicine,
Liverpool 3.

New B.N.F.

SIR,—I should like to draw attention to what, in my view, is a possibly lethal error in the "Classified Notes for Prescribers" in the new edition of the *British National Formulary*.¹ I refer to p. 76, where speaking about chlorpromazine it says, "It is, however, very effective in more severe agitated states, especially in the elderly in whom other drugs may cause confusion. Single injections (300 mg. or so) can be used to control acutely disturbed patients." It is not absolutely clear from the context whether this dosage is recommended only for the elderly, or for any acutely disturbed patients. However, none of my colleagues have ever used more than 150 mg. in a single injection, the usual maximum being 100 mg., while the manufacturers, who admittedly tend to err on the conservative side, recommend only "25-50 mg. in an injection."²

Dr. P. S. Nemetz (18 January, p. 186) has recently drawn attention to the danger of injecting even 100 mg. of chlorpromazine in the elderly: "There is great potential for postural hypotension with brain softening, myocardial infarction, syncope with trauma, and even irreversible shock and death." He stresses that intramuscular injections have four or five times the potential of an oral preparation, and in my own experience it is rarely necessary to exceed a total oral daily dosage of 150 mg. in elderly patients. Intramuscular doses of 300 mg. would clearly be dangerous.—I am, etc.,

T. D. E. RICHARDSON.

Department of Psychological Medicine,
Midland Nerve Hospital,
Birmingham 15.

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B.N.F. Recommendations

SIR,—The *British National Formulary* 1968 makes admirable recommendations about the abbreviations which should be used in prescribing. Perhaps a future addition would advise on the rationalization of the terms "b.d.," "t.d.s.," "t.i.d.," "q.d.s.," "q.i.d.," "nocte," and others which are commonly used on prescription sheets, especially in hospitals.

A complete standardization of terminology in prescriptions should be useful for pharmacists, doctors, and nurses. In the interests of accuracy, simplicity, and safety in prescribing today the writing of prescriptions is too important a matter to be left to the whims and fancy of individual doctors.—I am, etc.,

Westwood Hospital,
Bradford 6, Yorks.

D. A. SPENCER.

Transfusion and Perforation

SIR,—In reply to Dr. D. J. Formby (8 March, p. 643), who suggests a possible link between the use of citrated blood and perforation of the gut, we can confirm that our cases were transfused with citrated blood, as we believe is the practice in the majority of British centres. We accept that acidosis may occur in these infants. In our original article (9 November, p. 349) we postulated that hypoxia may play a part in the aetiology, and one knows that hypoxia is usually followed by a fall in pH. If acidosis is the chief factor, however, it is surprising that perforation is not seen more often in those conditions known to produce hypoxia and a fall in pH in the newborn, such as respiratory distress syndrome and cyanotic congenital heart disease. In our experience, however, the incidence of perforation of the bowel in these conditions seems to be low.

From the records of this hospital over a period of seven years we have found four more similar cases in addition to those already

published, but in patients who did not have an exchange transfusion. Of these, two had respiratory distress syndrome, one had suffered cyanotic heart disease, and one followed a precipitate unsupervised delivery. The total number of admissions to the special care baby unit here for the same period was 3,329, of whom 670 were diagnosed as having the respiratory distress syndrome. These figures are not directly comparable with those in our paper, as only two of the cases quoted there were born in this area, the remainder being drawn from a number of different parts of the country.

It would be interesting to know whether perforation of the gut following exchange transfusion has been noted in those centres where heparinized blood is used.—We are, etc.,

SHEILA M. EADES.
R. L'E. ORME.

City Hospital,
Exeter, Devon.

Immigrant Doctors

SIR,—Deficiencies in learning, intelligence, and adaptability doubtless occur in immigrant as well as indigenous doctors, but it would be less than fair not to recognize that some of the former also have qualities of heart and head that would grace any medical service throughout the world. I have been fortunate in having some of these as colleagues in the past few years; and I am grateful for their contribution to the welfare of our patients.

The heritage of medicine is a unity of purpose and ideals which has always been world wide. It is worth cherishing—especially now that the values and customs of yesterday's Western world no longer afford easy guides to conduct.—I am, etc.,

C. W. M. WHITTY.
Department of Neurology,
Radcliffe Infirmary,
Oxford.

Casualty Officers and Coroners

SIR,—Dr. V. Gopala's letter (15 March, p. 718) about the plight of Commonwealth casualty officers who are required to appear before coroners engenders sympathy. However, his suggestion is unnecessary that "every junior casualty officer, particularly if he is not a native Englishman, should ask his hospital to provide him with legal representation in the coroners' courts," for this is a responsibility that the medical protection organizations willingly undertake when they feel that legal representation would be in the doctor's best interests. Indeed, during the past weeks an increasing number of our members from overseas have been represented at inquests. Members of the Medical Protection Society should therefore have no

hesitation in contacting their society by letter or telephone if they are likely to be called to an inquest. The advisability of their representation by a lawyer can then be assessed by a member of the Society's secretariat and/or the Society's lawyers.

Finally, there are some cases where it is best for the doctor to be represented by a lawyer instructed by his hospital, and where there is no conflict of interest this is arranged in appropriate cases between the society's solicitors and the legal advisers of hospital authorities.—I am, etc.,

HERBERT CONSTABLE,
Secretary, Medical Protection Society Ltd.
London W.1.

Dissatisfactions of Regional Consultants

SIR,—Undue emphasis is being placed on the theoretical training and "siting" of trainee consultants. With each new regulation regarding training our increasingly scarce junior staff are being forced to spend their time in the over-full and over-specialized undergraduate hospitals.

Surely the place to train them is where the experience exists. Basic science primaries, fellowships, or memberships do not in any measure supersede practical training and experience. The busy regional hospitals perform the major part of the health service work; surely this is where our own graduates are needed and should be trained. While sympathy to the trainee regarding his studies is not out of place, consideration of the care of patients by our own graduates is also a major factor. Dilution of the regional consultants, removing their aspiring registrars,

and compelling them to do their junior staff work will simply destroy these consultant posts. Evidence of this is already known. The popularity of the regional consultant posts is markedly on the wane.

The regional consultants are restive and feel increasingly isolated. The practical and theoretical teaching of our junior staffs now and over the years is seemingly of minimal importance. If now we are to be almost completely excluded from the training programmes, if we are to lose the remaining keen registrars to the undergraduate hospitals, if we must go "cap in hand" to our practitioner friends to ask them to spare a half a day to help us with our work, it really makes the overworked poorly paid posts in the periphery distinctly unwholesome.—I am, etc.,

Hitchin, Herts.

JOHN SHIPMAN.

Precision in Death Certification

SIR,—I should like to draw the attention of doctors to the need for having certain details of diagnosis on death certificates. The International Statistical Classification of Diseases, Injuries and Causes of Death (I.C.D.) is used the world over to classify the causes of

death entered on death certificates, and it is of course from these certificates that mortality statistics are derived. The I.C.D. is revised every 10 years, and as medical progress leads to more precise diagnosis so the classification becomes more detailed.

The 8th Revision of the I.C.D. came into use in 1968. In response to requests from epidemiologists and other research workers category 151, malignant neoplasm of stomach, is now broken down into 151.0 cardia, 151.1 pylorus, 151.8 other specified parts, and 151.9 part unspecified. Where the certifying doctor writes only "cancer of the stomach," an inquiry form is sent from the General Register Office, since more precise information may be available, and the replies confirm that this is frequently the case. Such inquiries are a nuisance to the doctor especially if further information is not available. They could be avoided if doctors would specify the part of the stomach involved where this is known, or write "part of stomach unknown" otherwise.

In addition to this particular example there are other sections of the I.C.D. which have been improved by greater precision, and so it is important in general, when writing diagnoses for death certificates, to be as specific as the available information allows. The histological type of cancer should be given if known.

Doctors may be assured that their efforts in this field are greatly appreciated. The certificates are essential for the production of statistics and for many research projects.—I am, etc.,

A. M. ADELSTEIN,
Chief Medical Statistician,
General Register Office (England
and Wales).

London W.C.2.

Points from Letters

Implications of the Seeborn Report

Dr. U. P. SEIDEL (London N.3) writes: A psychiatrist should be the only one in charge of psychiatric and mental health social workers. Very few patients once returned to the community are cured of their mental disorder, and according to our modern and enlightened outlook these people are returned to their homes even earlier than was practiced hitherto. A successful transfer can be established only if an efficient community psychiatric service exists in the area, and by the very definition of the state of the patient such a service should be in the charge of a suitably qualified and experienced doctor. There is no getting away from this fundamental principle, and no social worker, or any other person for that matter, can be made responsible for the care of sick people.

If the links between psychiatrists and psychiatric social workers are loosened the supervision of the mentally disordered will deteriorate and may lead to the disintegration of the community psychiatric services.

"Immigrant" Doctors

Dr. A. S. M. M. HAQUE (Glasgow) writes: Much adverse publicity about foreign doctors is going on in the press and in medical journals, but it is a pity that these doctors have been called "immigrants." With a few exceptions, the doctors from Afro-Asian countries come to get postgraduate training and experience leading to diplomas like the F.R.C.S. or M.R.C.P. Most of the doctors from overseas usually go back to their own countries after being successful in the diploma examination.