about 1 cm without discoloration or tenderness. The remainder of the physical examination, including visual field and ophthalmoscopic examination, was normal.

Laboratory investigations, including complete blood count, differential white cell count, serum electrolytes, chest x-ray, urine analysis, blood urea nitrogen, creatinine, and glucose, examination for antinuclear antibody and rheumatoid factor, and serum protein electrophoresis, were normal and serological test for syphilis was negative. The erythrocyte sedimentation rate (Westergren) was 4 mm in 1 h on three determinations.

After the third day in hospital the swelling decreased by about half and, since the patient remained free from other symptoms, she was discharged home. Diagnoses entertained included cranial arteritis, trauma, autoerythrocyte sensitivity, and allergic reaction, but none was established.

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International units and standards for proteins

SIR,—Those working in clinical immunology and protein immunochemistry will welcome the letter from Drs J H Humphrey and I Batty (10 April, p 898), of the International Union of Immunological Societies, listing some of the existing standards in this field and indicating others to be developed.

While agreeing with the need for sound, common standard preparations, we feel that the assigning of international units to such preparations is another matter. Total proteins and a number of individual serum proteins have been measured in weight per volume units for decades, and we would urge that for such measurements international units have little place in routine clinical practice, where clinicians have come to learn and accept results expressed in more conventional terms. Also, the International Federation of Clinical Chemistry Standards Committee has an expert panel on proteins which is aiming to have standards calibrated where possible in g/l by the best criteria currently available. The profession has already experienced an upheaval with the introduction of SI units, and there seems little practical advantage in causing another tremor by changing the mode of reporting of many human serum proteins.

We agree that when a pure preparation of a substance is not available and it is not possible to assign a weight value to a standard, there is obviously a good case for reporting in international units. We hope, however, that editors of journals will not adopt the suggestion in the last sentence of the letter from Drs Humphrey and Batty; in our opinion that would be a retrograde step and would discourage the search for a more rational mode of reporting based on weight or (when appropriate) molar equivalents.

The practical value of assigning immunoglobulin weight equivalents to international units has already been recognised, as indicated by Drs Humphrey and Batty, and we hope that their committee is gathering the necessary information from reputable international centres to enable it to issue weight equivalents for other serum proteins in its standard preparations. In the meantime the supra-

regional protein centres will continue to express results in terms of weight per unit volume for the convenience of their users.

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Flupenthixol for depression

SIR,—Dr J P R Young and his colleagues (8 May, p 1116) are to be congratulated on their study showing the equivalence of flupenthixol and amitriptyline in the treatment of depressed outpatients. As they admit, however, "the improvement . . . may have been due partly to anxiolytic drug effects," and here lies the crunch. The scales used are designed to measure the severity of dissatisfaction with life rather than to separate those with specifically biological symptoms of depressive illness. Furthermore, the marked response of their patients within the first week, before the antidepressive effects of amitriptylene take effect, also supports the conclusion that their sample contained many patients with mixed neurotic illness, who are not only prone to respond to placebo but also to any drug with sedative properties.

To help the practising doctor choose the most effective drug for the individual patient could the authors tell us the degree to which their patients had biological symptoms (such as loss of appetite and libido, retardation, etc) and the relationship of these to drug response?

It would indeed be convenient if we could find a drug that worked in all psychiatric conditions, the only decision being that of choosing the dose, a development that would quickly lead to unemployment among psychiatrists. Unfortunately for the public, I doubt whether the evidence supports this conclusion.

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** We sent a copy of this letter to Dr Young, whose reply is printed below—ED, *BMJ*

SIR,—In reply to Dr Kellett's letter on the recent trial of flupenthixol and amitriptyline, all the subjects included in the trial were referred to hospital with predominant symptoms of depression; all were felt to be clinically depressed on initial psychiatric assessment. For each patient four standardised questionnaires¹⁻⁴ were completed serially to quantify the severity of depressive symptoms. Each questionnaire was designed to measure depression. In addition, with each patient a formal assessment of the common biological accompaniments of depression was made at each visit using a standardised inventory.⁵ Each patient included in the trial was rated for alteration in sleep pattern, appetite and

weight change, libido, and diurnal variation in mood and energy. Every patient in the series was recorded as showing some "biological symptoms" of depression. Variation in these several functions was found, as expected, to follow closely changes in rating scale scores for depression during the course of treatment. Raw data for all the above "biological symptoms" are available on request. The alteration in sleep pattern for the series as a whole was represented in the paper in graph form. Changes in appetite and weight recorded in the trial are to be published later with other data relating to carbohydrate craving previously reported with amitriptyline.

It is to misread the paper, therefore, to suggest that the trial subjects were simply "dissatisfied with life" or that the sample contained "many patients with mixed neurotic illness." How many depressed patients are not dissatisfied with life, anxious, or otherwise neurotic? As stated in the paper, "though not severely depressed, the patients studied seemed typical of those referred to hospital for antidepressant outpatient treatment, their mean Hamilton depression score being 24."

The apparent antidepressant properties of flupenthixol, of course, require further confirmation. A longer follow-up assessment is required and, as suggested in the paper, it would probably be worth while to evaluate the drug against more severe forms of depression. It would also be interesting to attempt to differentiate more clearly between the anxiolytic and antidepressant effects of the drug.

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¹ Beck, A T, *et al*, *Archives of General Psychiatry*, 1961, **4**, 561.

² Medical Research Council, Clinical Psychiatry Committee, *British Medical Journal*, 1965, **1**, 881.

³ Crown, S, and Crisp, A H, *British Journal of Psychiatry*, 1966, **112**, 917.

⁴ Hamilton, M, *British Journal of Social and Clinical Psychology*, 1967, **6**, 278.

⁵ Pollitt, J, *Proceedings of the Royal Society of Medicine*, 1971, **64**, 1174.

Danger of instant adhesives

SIR,—Instant adhesives containing alpha-cyanocrylate and similar substances are both extremely rapid and efficient in action. Efficiency and rapidity combine to present dangers to patients and never more so than now and in the future owing to widespread television presentation and national sales.

The public should be warned of the dangers and the medical profession should learn of the difficulties ahead. The adhesives are quite capable of bonding surfaces, and these include human body surfaces, together in a matter of seconds, and once the surfaces are bonded the inanimate can be separated only by considerable force and the human by surgical intervention.

The containers of such adhesives that I have purchased have had explanatory leaflets enclosed with them in their cartons, but unfortunately sometimes the printing on these leaflets is so small that I am quite sure the public would not read it. On one leaflet there were five lines of print to the centimetre. I felt that the warnings were not written in strong enough terms, and, though the danger to eyes was mentioned, the fact that eyelids could be bonded together in seconds was missing. Furthermore, it was stated that immediate bathing of human surfaces with warm water or acetone would remove the

bonding, but I wonder how many of us could get to the cure in time.

These adhesives should be handled with a non-touch technique, but as the general public know little about this perhaps it would be safer were these modern adhesives restricted to use by technical staff until a general awareness evolves.

W G STRAWBRIDGE

Pontypridd,
Glamorgan

Alternatives to levodopa

SIR,—I am surprised that in your leading article (15 May, p 1169) you are luke-warm about combined therapy for Parkinsonism. You refer to a relatively enthusiastic article by Professor Marsden,¹ but conclude that "nausea and slow initial response can be overcome by combining levodopa with a peripheral decarboxylase inhibitor, but this has few other real advantages." In the elderly patients that I have studied (50 patients of average age 76 years) combined therapy has several advantages over levodopa. The speed with which dosage can be increased means that patients spend less time in hospital or can be treated as day patients. The relative lack of nausea means that more patients can achieve a therapeutic dosage (about 500 mg a day of levodopa with 50 mg of carbidopa in my group). In addition, the success rate measured by improvement in functional ability is higher. The relative lack of cardiac side effects is valuable in an age group in which multiple pathology is common. The limiting factors in the elderly appear to be the mental side effects of confusion, hallucinations, and sleep disturbance. Involuntary movements are not a problem on the low dosage recommended.

I agree with Professor Marsden's conclusion in a later article² that combined therapy is the present treatment of choice in Parkinsonism.

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¹ Marsden, C D, *et al*, *Journal of Neurology, Neurosurgery and Psychiatry*, 1973, **36**, 10.

² Marsden, C D, *et al*, *Lancet*, 1973, **2**, 1459.

Future of community medicine

SIR,—National Health Service Reorganisation was viewed with considerable trepidation by many of the older medical officers of health and with qualified optimism by some of the younger members of the specialty of preventive medicine. It is now clear that the older members of the specialty were right. Preventive medicine, as practised by doctors, no longer exists in Britain because it cannot compete successfully with the curative services for a share of the single purse from which the hospital and community health services are now provided. In the past, of course, preventive medicine was funded separately, mainly by the local authorities.

The new specialty of community medicine is merely medical statistics with some administration and is increasingly concerned with planning services for patients who are the victims of the lack of preventive medicine. At district level we are medical statisticians without the statistical staff or the time to

enable us to produce the detailed and accurate information required by the district management teams and without the power to put into effect the few ideas we may have time to produce.

The new circular HC(76)18 on joint care planning weakens the district management team further by making strategic and service planning a function of the new joint care planning team at area level and leaving the health care planning teams (now to be re-constituted as district planning teams) to carry out operational planning within the policy laid down by the joint care planning team, which incidentally has a large local authority input.

I will not take up your time with all the other problems of community medicine which make many community physicians feel that the specialty may not survive after the retirement of its present members. Perhaps this was one of the undeclared aims of reorganisation.

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Operation baby lift

SIR,—In a leading article (17 January, p 112) you suggested that the British Paediatric Association might take the lead in planning for the reception of large numbers of infants transported by air from a disaster area. The problem was therefore carefully considered by the Joint Accident Committee of the British Paediatric Association and British Association of Paediatric Surgeons at a recent meeting.

In the article it was suggested that there should be, among other things, a store of paediatric supplies and lists of accommodation and staff (both professional and volunteer) for the reception of up to 1000 babies, and that all large cities with a major airport should make plans along these lines. However, much time and money would be needed to establish the organisation necessary for this aid and the lists would quickly get out of date without continuous review. The chances of any one major city having to receive a consignment of babies without reasonable warning must be so remote that the committee felt that such a major exercise, with the inevitable expense, would be unjustified.

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Quality of life

SIR,—I read with interest your leading article concerning the quality of life for the elderly in long-stay wards and old people's homes (15 May, p 1168). Two points are raised—one is the quality of life that residents in these institutions may have and the second is the great need for appropriate allocation of scarce resources.

Many people concerned with the care of the elderly feel the need for urgent reappraisal of the type of accommodation we provide. While there may be differences in the amount of

nursing and other care that patients in different forms of institutions may require, fundamentally all such persons need a home-like environment and it is with this in mind that social services departments and hospital authorities should consider future joint planning. At the same time, of course, we must not revert to the deficiencies of the old "Poor Law" institutions.

At a time of extreme financial stringency appropriate use of scarce resources must be a firm aim. Early referral to a social worker and geriatrician is clearly an essential part of assessment of an elderly person for an old people's home, as it may be that alternative action is more appropriate. It will also avoid persons in need of hospital care being placed wrongly in welfare homes with the consequences that your article describes. However, on the other side of the fence one of the greatest problems at present is to utilise sheltered housing for the needs for which it was originally intended. There is certainly one London borough where it is difficult to house people in sheltered housing who require walking aids, as the housing department finds it impossible to recruit wardens for these developments if the residents are disabled. It is urgently necessary to reconsider the qualifications that are needed to fill a warden's post, and it may be that a period of training, with experience of minor nursing procedures, may be valuable. At present many elderly people who could benefit from sheltered housing are being maintained in totally unsatisfactory housing conditions for this reason.

More geriatric beds are clearly needed in some areas, but, as the recent consultative document¹ shows, there will not be a dramatic increase. Geriatricians have to distribute their scarce resources to as many as possible. Inter-mittent and holiday admissions go a long way to solving this, allowing the person to feel wanted by the family while at the same time relieving them of some of the burden of caring for an elderly relative. Early referral is essential and is best undertaken at an outpatient clinic or at a clinic for the elderly in a general practitioner health centre.

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¹ Department of Health and Social Security, *Priorities for Health and Personal Social Services in England: A Consultative Document*. London, HMSO, 1976.

Neuropathy or myelopathy?

SIR,—In their interesting paper on "folate-responsive neuropathy" Drs M Manzoor and J Runcie (15 May, p 1176), by not using conventional nomenclature, may have added confusion to what they admit is a controversial subject.

Neuropathy is commonly taken to mean peripheral neuropathy, and bilateral extensor plantar responses would not be "characteristic." The authors appear to indicate that their patients had spinal cord disease, and "folate-responsive myelopathy" would have been more accurate and less misleading. If their patients also had a peripheral neuropathy (thus emphasising a similarity to vitamin B₁₂ deficiency) the use of well-established neurophysiological techniques might have given valuable information about peripheral nerve function in these patients before and after treatment. An opportunity has been missed to show that folic acid may have a role in