

Immunisation and brain damage

SIR,—“Brain damage” occurs in infants and may or may not be causally related to immunisation procedures. Fortunately the number of cases is small; figures of between 1 in 10 000 and 1 in 100 000 are quoted.

Assuming for the sake of the argument that immunisation is a cause—we know it is not the only cause—why do we blame the pertussis component of the vaccine? Practically all immunisations in the past 25 years have been triple immunisations; the diphtheria or the tetanus vaccine could be as guilty as the pertussis vaccine. We have no large-scale experience with either “pertussis only” or with “diphtheria-tetanus only” vaccinations and in view of the rarity of the alleged serious sequelae a prospective study of one or the other of these alternatives would have to be undertaken on truly enormous cohorts.

I repeat, are there any facts, as distinct from hearsay and the irresponsible gossip of politicians and the media, that lay the blame—if there is any blame—upon the pertussis vaccine?

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SIR,—I read with interest your leading article on this subject (26 March, p 789).

In the first paragraph, line 6, I read: “Most differences . . . may be attributed to nutrition. Consumption of saturated fat shows a striking positive correlation with mean cholesterol concentration.”

In the second paragraph, line 5, I read: “Morres *et al* . . . have shown that this variability . . . cannot be attributed to variations in the intake of fat or other nutrients. In only one study . . . has fat consumption been correlated with serum cholesterol.”

It seems to me that these two statements are contradictory.

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* * * Our intention was to point out the multifactorial nature of serum cholesterol regulation. Comparisons of populations and feeding experiments attest to the dietary fat effect, but within-population variations must largely be due to other factors, including genetic ones.—ED, *BMJ*.

Dextropropoxyphene overdosage and naloxone

SIR,—Following your leading article (12 March, p 668) and the recent increase in interest in the effects of overdosage of drugs containing the morphine analogue dextropropoxyphene we would like to report a case in which an overdose of dextropropoxyphene (taken in the form of Distalgesic) with alcohol caused unconsciousness associated with acute respiratory arrest, which was reversed by the specific morphine antagonist naloxone.

A youth aged 17 was admitted unconscious to the casualty department of this hospital having taken an overdose of an indeterminate amount of Distalgesic and oxytetracycline. He had also drunk about six pints (3.5 l) of beer. Two minutes after

admission he developed acute respiratory arrest; an endotracheal tube was inserted and artificial respiration was performed. Spontaneous respiration returned after two minutes with 100% oxygen, but he remained deeply unconscious and unresponsive to painful stimuli. After an intravenous injection of 0.4 mg of naloxone the patient's conscious level returned to normal within two minutes.

We feel that physicians should be aware that the morphine antagonist nalorphine has been used before¹⁻³ with varying effect as specifically antagonistic to dextropropoxyphene and that naloxone could also be used in the event of dangerous complications occurring in dextropropoxyphene overdosage.

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Bournemouth, Dorset¹ Cawood, R, and Thirkettle, J R, *British Medical Journal*, 1966, 2, 1324.² Karliner, J S, *Journal of the American Medical Association*, 1967, 199, 1006.³ Swatts, C, *American Journal of Diseases of Children*, 1964, 107, 177.**Monitoring adverse reactions to drugs**

SIR,—There have been various proposals for surveillance of adverse drug reactions to new drugs.¹⁻³ One considerable problem besetting any system is the great degree of under-reporting of adverse drug reactions for various reasons.

In order to ensure as high a reporting rate as possible it might be appropriate for the Committee on Safety of Medicines to involve those practitioners who have already demonstrated their willingness to report adverse drug reactions under the existing procedure. A panel of such doctors could be approached at the start of the anticipated surveillance of new drugs and enlarged as reports are received under the existing system.

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London N7¹ *Lancet*, 1976, 2, 1312.² Dollery, C T, and Rawlins, M D, *British Medical Journal*, 1977, 1, 96.³ Lawson, D H, and Henry, D A, *British Medical Journal*, 1977, 1, 691.**Can cockroaches cause asthma?**

SIR,—Your leading article on this subject (19 March, p 734) suggested that the level and distribution of cockroach infestation in buildings in Britain are unknown. The two volumes of *The Cockroach* in the Rentokil Library^{1 2} summarise reports on almost 20 000 infestations. Nine types of building account for 85% of all infestations: houses and flats (14%), restaurants and cafés (14%), shops (12%), hotels and boarding houses (11%), public houses, clubs, and public halls (8%), food factories (8%), hospitals (7%), non-food factories (6%), and schools and colleges (5%). Their presence is invariably associated with warmth, moisture, and proximity of food, the numbers of insects often reaching tens of thousands in long-established infestations.

Most of the American work quoted on the possible relationship between cockroaches, asthma, and other allergies has involved studies with the German cockroach, although there is evidence also of sensitivity to oriental and American cockroaches. The German

cockroach is the principal indoor pest in the USA, but this is not the predominant cockroach in the UK, where the oriental cockroach is, on average, four times as abundant. Both species are common in buildings here, but they are not uniformly spread. Infested buildings in London and the surrounding counties contain only 30-45% of the German cockroach and the same applies in buildings in and around Glasgow. Elsewhere, notably throughout the midland and northern counties of England, infestations by oriental cockroaches outnumber German by more than ten to one.

The activities and environment created within buildings influence which of the two cockroaches is likely to occur, as shown by the ratio of German to oriental infestations in, for example, restaurants and cafés (1:1.5), hospitals (1:3), shops (1:4), cinemas and theatres (1:6), and homes (1:12). The kitchen is the preferred location of *Blatta germanica*. The less humid basement, boiler rooms, and ducts favour *B orientalis*. German cockroaches tend to occur less often in pre-war properties, where the oriental cockroach is five times as common. The latter is found only twice as often in post-war buildings. In all buildings oriental cockroaches are more widespread.

Quite apart from a possible relationship between cockroaches and allergies, all the species which infest buildings have been incriminated as potential but fortuitous carriers of pathogenic bacteria. This derives from their association with drains, gullies, toilets, and human food.

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Sussex¹ Cornwell, P B, *The Cockroach*, vol 1. London, Hutchinson, 1968.² Cornwell, P B, *The Cockroach*, vol 2. London, Associated Business Programmes, 1976.**Differentiation of streptococci from diphtheroids**

SIR,—Drs A M Emmerson and Susannah J Eykyn (2 April, p 905) give an important reminder that streptococci in blood cultures sometimes look like diphtheroids. A blue slide catalase test,^{1 2} quickly performed on a coverslip impression of colonies, is helpful, for it discriminates immediately between catalase-negative organisms such as streptococci, lactobacilli, actinomycetes, and clostridia and the bubbling catalase-positive colonies of corynebacteria, listeriae, and *Bacillus* spp.

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Elizabeth Garrett Anderson
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London NW1¹ Thomas, M, *Public Health Laboratory Service Monograph No 5*, 1974.² Thomas, M, *Monthly Bulletin of the Ministry of Health and Public Health Laboratory Service*, 1963, 22, 124.**Use of ritodrine in pregnant diabetics**

SIR,—A recent experience confirmed the importance of the report of Dr Judith M Steel and Mr J Parboosingh (2 April, p 880) on the use of ritodrine to inhibit premature labour in diabetics. A 25-year-old pregnant diabetic patient controlled on 56 units of insulin daily repeatedly threatened to go into labour from 33 to 35 weeks. Intravenous ritodrine was used