storage of chemical products and increased publicity of the potential dangers of chemical agents.[6] Legislation in Canada and the United States will shortly make safety containers mandatory for drugs and household products.[2 5]

In November 1969 the Liverpool Regional Hospital Board agreed that the Palm-N-Turn container should be introduced into the region and that this programme should start in Birkenhead. It is hoped that child-resistant containers will be adopted in other areas and that their use may be made compulsory throughout the country as soon as possible.—I am, etc.,

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War Surgery in Nigeria

SIR,—I was very interested in the article by Mr. G. W. Odling-Smee (6 June, p. 592), particularly noting his views on major limb wounds in which fractures are combined with soft tissue injuries. I hope his advocacy of the use of immediate internal fixation in compound fractures is not taken at its face value without full reference to the paper by Dudley *et al.*[1] which he quotes. Too often one sees these injuries closed under tension or by unsafe local flaps and encased in plaster for six weeks with disastrous results. If internal fixation is to be used particularly when there is a skin defect there must be available "a team seized with the urgency of skin cover."[1] Trueta's work[2] and that of his predecessors and followers has frequently been mis-read or only half read by those responsible for the care of compound injuries, and the application of the principle of delayed primary skin cover too often ignored in the past, in war and peace.—I am, etc.,

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Ergotamine Tartrate in Migraine

SIR,—I am surprised that Dr. D. S. Freestone (6 June, p. 599) should be puzzled by the ineffectiveness of ergotamine tartrate shown by Dr. W. E. Waters (9 May, p. 325). The wonder is that the investigation, using a homoeopathic dose instead of a therapeutic dose, was ever undertaken.

For many years I, like Dr. Waters, followed the usage of textbooks and gave a dose of 1 or 2 mg. followed by 1 mg. half hourly. I was quite convinced that ergotamine tartrate was a drug of little value, except in so far as there was no other more effective drug in tablet form unless one happened to have discovered that a particular patient responded to some less conventional treatment, such as 400 mg. of sodium amytal.

One day I chanced to pick up a manual[1] in which I read that the American usage is to give 5 mg. initially followed by 2 mg. half hourly, if necessary up to the usual maximum dose of 10 mg. in a day. I now find that a single dose of 5 mg. is all that is needed to abort an attack of migraine in almost any patient unless vomiting necessitates an injection.—I am, etc.,

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Nifuratel for Trichomonal Vaginitis

SIR,—Drs. B. A. Evans and R. D. Catterall (9 May, p. 335) quote an early study by Dr. J. Delnon and myself on nifuratel[1] at the obstetrics and gynaecology clinic of the University of Berne. In further trials on 485 patients[2] I was able to compare the trichomonacidal activity of nifuratel (Magmilor; in Switzerland Macmiror) with that of metronidazole (Flagyl), referring also to my previous experiments with the latter product.[3]

The conclusions I came to are quite different from those reached by Drs. Evans and Catterall. In fact, in 1965-6, I observed that the cure rate attained by metranidazole was about 68%, and that by nifuratel about 80%.

In my experience, the activity of nifuratel in bacterial and mycotic infections was satisfactory in cases of mixed aetiology and in preventing mycotic superinfections, which often occur after treatment with metranidazole.—I am, etc.,

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1 Arnold, M., and Delnon, J., *Therapeutische Umschau und medizinische Bibliographie*, 1965, **22**, 490.
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3 Arnold, M., and Berger, M., *Gynaecologia*, 1961, **152**, 238.

SIR,—Drs. B. A. Evans and R. D. Catterall draw some rather rash conclusions from their comparison of anti-trichomonal activity between nifuratel and metronidazole (9 May, p. 335). The authors do not appear to have considered what is known of the epidemiology of trichomoniasis. The most detailed and up-to-date statistical data indicates that the incidence of trichomonas is about 10-15% in women generally and 70-75% in prostitutes.

Drs. Evans and Catterall neither treated the male partners nor considered the possibility of re-infection in the 12-week period which elapsed between the end of treatment and their last control. The fact that four patients presented with a gonorrhoeal infection during treatment is in itself very significant in this connexion.

Another questionable point is that the side-effects ascribed to nifuratel were general allergic reactions which occurred without any local intolerance, despite repeated insertions of pessaries into the vagina. The side-effects mentioned by the authors are more likely to be attributable to other drugs administered concurrently (penicillin, etc.) or taken by the patients in question.

These observations of mine are based on six years' experience with nifuratel (Magmilor) in hundreds of cases,[1] where I observed quite different results with no local or systemic side-effects. Treating trichomoniasis with nifuratel I attained approximately 93% recovery, which is a rate in agreement with that achieved by many authors in other countries. I stopped using metronidazole as the success rate was less than 70%.—I am, etc.,

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Pre-ulcerative Buruli Lesions

SIR,—In our recent paper on "Clinical Features and Treatment of Pre-ulcerative Buruli Lesions" (16 May, p. 390) it was not made clear that the five cases described were investigated bacteriologically, and that *Mycobacterium ulcerans* was isolated from the excised lesions in each case. We have commented[1] previously on bacteriological findings in lesions of different histological types.—I am, etc.,

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Sleep and Drug Overdose

SIR,—For some years I have followed Dr. Ian Oswald's work on sleep and related problems with interest and admiration so it is with some dismay that I read the article on late brain recovery processes after drug overdose (9 May, p. 318).

It may be that raised paradoxical (R.E.M.) sleep rebound indicates prolonged turnover of proteins in the cerebrum,[1] but it occurs in a variety of conditions—amphetamine withdrawal, barbiturate withdrawal, overdosage with tricyclic drugs, and after "E.C.T. overdosage." Dr. I. Haider and Dr. Oswald show that in Case 1 after an overdose of Mandrax R.E.M. sleep returned to normal according to their chart in 31 days, but in Case 4 after two episodes of overdosage with nitrazepam the R.E.M. remained abnormal for 33 days and more than 42 days.

In their third last paragraph they say that "nitrazepam is to be preferred to its contemporary rivals" because of its safety, but then go on to make a statement that indicates that co-ordination, emotional stability, and good judgement need not be