and would not wish to change the opinions expressed there.

In our study of fluphenazine decanoate (17 March, p. 633) 78 chronic schizophrenic patients aged under 65 attending St. Olave's Hospital constituted all those with the defined characteristics in the catchment area known to be on the drug. Eight of them could not, for various reasons, be adequately managed on fluphenazine decanoate alone and did not enter the trial. During a 15-month period six of the 34 patients receiving active fluphenazine relapsed (including one who dropped out and relapsed). Assuming that a similar number among the 36 on placebo would have relapsed had they been receiving active medication, it can be estimated that 20 patients out of 78 (26%) could not be managed adequately on fluphenazine decanoate alone. This estimate takes no account of the unknown number of patients who may have begun fluphenazine injections but for various reasons did not continue and were therefore not included in our original group of 78.

So far as Drs. Daniel and Schiff's remarks on the dose level are concerned, it should be pointed out that our patients received a minimum level of 25 mg monthly. The dose could have been adjusted at the monthly visits if the clinicians in charge of the patients had wished. In fact, most relapses were fairly sudden. There was no evidence in the case-note describing the previous routine visit of any prodromal deterioration which might have given a clue that an increase in dosage was necessary. Our results suggest that the drug is effective in low doses.

In view of the hazards of long-term phenothiazine treatment, which have not yet been fully explored so far as injected fluphenazine is concerned, we would suggest that these drugs must be used in a cautious and balanced way. Our papers indicate their value in preventing relapse in many patients, but they also indicate that not all patients are likely to benefit and that some patients may not need to take maintenance medication at all.—We are, etc.,

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J. P. LEFF
J. K. WING

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¹ Leff, J. P., and Wing, J. K., *British Medical Journal*, 1971, 3, 599.

Meningococcal Meningitis

SIR,—The article by Dr. J. Stevenson which dealt with bacterial meningitis (19 May, p. 411) was timely. Though Dr. Stevenson notes that meningococcal infection is still the main cause of pyogenic meningitis, he states that its position is now less dominant than it once was vis-à-vis the other two main causes—*Streptococcus pneumoniae* and *Haemophilus influenzae*. I have recently drawn attention¹ to a recrudescence of meningococcal meningitis since 1967 which is apparent in the statistics of mortality, notifications, and hospital discharges as well as in the number of isolations reported by the Public Health Laboratory Service which he quotes. The latest information indicates that this trend is continuing and may indeed be accelerating. The number of noti-

fications of acute meningitis specified as meningococcal in the December quarter of 1972² was 189 and the provisional figure for the March quarter of 1973 is 360. These compare with 115 and 185 notifications respectively in the corresponding quarters of the year before. In 1971 the estimated total number of hospital discharges³ ascribed to meningococcal infection passed the 1,000 mark for the first time since 1964. The number of isolations reported by the P.H.L.S. rose from 519 in 1971 to 601 in 1972, and the latest cumulative total for this year stood at 395 as compared with only 280 at the corresponding time last year.⁴

Dr. Stevenson refers to the hazard of delay in reaching the correct diagnosis in the home or in hospital. It may be that a greater awareness of the trend revealed by these statistics will help clinicians to be on their guard.—I am, etc.,

PETER M. LAMBERT

Office of Population Censuses and Surveys,
Medical Statistics Division,
London W.C.2

¹ Lambert, P. M., *Community Medicine*, 1973, 129, 279.

² Registrar General's Quarterly Return for England and Wales, Fourth Quarter, 1972. London, H.M.S.O., 1973.

³ Department of Health and Social Security and Office of Population Censuses and Surveys, *Report on Hospital In-patient Inquiry for the Year 1971*, Part I. London, H.M.S.O. In preparation.

⁴ Public Health Laboratory Service, 1973 (unpublished).

Treatment of Bacterial Meningitis

SIR,—Dr. J. Stevenson (19 May, p. 411) suggests cephaloridine as an alternative treatment in cloxacillin-resistant neonatal staphylococcal meningitis. This is an unexpected suggestion and I would be interested in the evidence on which it is based. According to Garrod and O'Grady¹ "there is always cross-resistance between methicillin, cloxacillin and cephaloridine and staphylococci proved to be resistant to either of these penicillins may be assumed to be resistant to cephaloridine."

Is there any evidence that the in vivo activity of cephaloridine against cloxacillin-resistant staphylococci is different from its activity in sensitivity tests in vitro?—I am, etc.,

J. S. CARGILL

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Royal Infirmary,
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¹ Garrod, L. P., and O'Grady, P., *Antibiotic and Chemotherapy*, 3rd edn., p. 461. Edinburgh and London, Livingstone, 1971.

Prescribing Mandrax

SIR,—As my main interest in the last 30 years has been continually learning and teaching the skilled selective use of physical treatments of psychiatric patients, I hope I may comment on the proper clinical use of Mandrax and methaqualone in view of some of the things said about them in your columns, such as Dr. P. R. Smith's letter (2 June, p. 552) reporting that his committee had been told, and seems to believe that "addiction could be rapid and that withdrawal symptoms are just as bad as heroin." He asks for a voluntary ban on its use in as many parts of the country as possible.

I have used various forms of continuous sleep treatment since 1940 on several thou-

sands of patients, and recently patients have been kept under narcosis for two or more months while intensive electric convulsion therapy can also be given; the longest course of narcosis has been over four months. Large amounts of phenothiazines have been used, but sedatives have to be given as well. We have finally fallen back in the last 500 or more patients on the use of Mandrax or methaqualone in preference to other sedatives such as barbiturates, chloral, Mogadon (nitrazepam) etc. as it seems to produce less withdrawal symptoms and tendency to addiction than the barbiturates and it works so well. At present I have 10 patients on this regimen at a nursing home, if any "committee" doctor would like to check up on clinical realities; and there are hundreds and hundreds of clinical records to consult at St. Thomas's and Belmont Hospitals.¹

I have also used Mandrax as a sedative for many years and find it often preferable to the barbiturates as regards addiction, and more effective as a sedative than Mogadon. No addiction (the taking of rapidly increasing doses and a severe withdrawal syndrome) has been seen except in the young, in psychopaths, or in very ill depressed people, who needed more antidepressants and not increasing sedation. If one uses Mandrax or Mogadon, one should give only one tablet if possible as a sedative at night, with additional antidepressants given at the same time (amitriptyline or trimipramine 50-150 mg) to stop early waking; one should not just increase sedatives. One can also start with Mogadon, and use Mandrax only if the former does not work, in preference often to the barbiturates.

And, please Sir, no more suggested drug bans. But more B.M.J. articles on the skilled selective clinical use of drugs, and fewer articles on non-clinically useful double-blind sample results.—I am, etc.,

WILLIAM SARGANT

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¹ Sargent, W., and Slater, E., *An Introduction to Physical Methods of Treatment in Psychiatry*, 5th edn. Edinburgh and London, Churchill Livingstone, 1972.

Eclampsia and Social Change in the Tropics

SIR,—I suggest that Dr. D. Jenkinson (26 May, p. 487) may be able to correlate the ability of Zambians to speak English with increased social status and prosperity on the one hand and a tendency to be older and heavier at the time of their first pregnancy and to gain more weight during pregnancy on the other.

In the U.K. the incidence and severity of pre-eclampsia in primigravidae increase with increasing age, weight, and weight gain during pregnancy. This is also the case in Yorubas in Western Nigeria,¹ but they are younger, lighter, and gain much less weight during pregnancy than in the U.K. and the incidence and severity of hypertension during pregnancy are correspondingly less. However, the blood pressure frequently rises for the first time during labour, so that the combined incidence of hypertension in pregnancy and labour is very similar. The incidence of eclampsia in Yorubas is probably greater than in the U.K. because of the rapidity in which the condition can develop during labour. On the other hand, the risk for the baby is greater in the U.K. because

severe pre-eclampsia may occur early enough to retard fetal growth. It is therefore important to distinguish between pre-eclampsia and eclampsia in such comparisons.

The relatively small percentage of Yoruba primigravidae who are over 25 years of age tend to be overweight and to show a higher than average incidence of pre-eclampsia during pregnancy of the type seen in Europe. These women are usually in non-manual occupations. There is good evidence that hypertension is common in Yoruba women in middle life.—I am, etc.,

DUGALD BAIRD

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Centre for Social Studies, Aberdeen

¹ Thompson, B., and Baird, D., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1967, 74, 499.

Subclinical Brucellosis

SIR,—To advise in a short article on brucellosis (31 March, p. 791) that the term "sub-clinical" should be used with care does not mean that it should be used rarely or even reluctantly—provided there is no doubt—but I apologize to Dr. R. J. Henderson (5 May, p. 306) if I failed to express myself clearly. I wonder, however, how many clinicians would agree that in practice subclinical brucellosis is always a perfectly obvious state. Continuing ill health in brucellosis is not always immediately apparent and thus a paragraph on chronic brucellosis later in the same article is partly an apology for some of my own imperfections.

The term "subclinical" should not be used merely because antibody tests remain positive after recovery, and neither does it seem fair if during an earlier acute illness, however mild, the diagnosis was not considered. During Dr. Henderson's 1966-7 inquiry¹ many persons, among them 50 veterinary surgeons, were visited and interviewed and their histories were recorded. If these subjects were not also examined, for a few the description "subclinical" may not have been appropriate. Seven of 70 veterinary surgeons in a comparable survey in south-west Wales had splenomegaly, an abnormal clinical sign², and in one who was symptom-free liver biopsy showed cirrhosis with heavy iron deposition, an indication for repeated venesection. Brucellosis was possibly a contributory factor, in which case the deceptive term "subclinical" would hardly apply. But for the great majority of veterinary surgeons who, despite the laboratory findings, are well, why another label?—I am, etc.,

EIRIAN WILLIAMS

Pembroke County War Memorial Hospital,
Haverfordwest, Pems

¹ Henderson, R. J., *Lancet*, 1967, 2, 353.

² Williams, E., *Veterinary Matters*, 1972, pt. 5, p. 2.

Use of Naloxone in Opiate Poisoning

SIR,—In their letter Drs. R. A. Tarala and J. A. H. Forrest (2 June, p. 550) describe the treatment of dextropropoxyphene poisoning with naloxone.

Other cases of poisoning with dextropropoxyphene have also been successfully treated with naloxone,¹ which has considerable advantages over the currently used opiate antagonists. It is a potent antagonist

which, unlike the other antagonists, has no respiratory or circulatory depressant action, even in patients deeply unconscious from non-opiate drug poisoning.² This allows naloxone to be given safely to unconscious patients where the diagnosis of opiate poisoning is suspected but not confirmed. In addition, naloxone has a high safety margin, having been given in large doses with no toxicity,³ it is effective in the treatment of pentazocine poisoning,² it has no addiction potential,⁴ and produces no psychotomimetic effects.⁵

Naloxone, when available, should be regarded as the treatment of choice in all opiate poisonings, and in view of its proved qualities I hope that it will soon be made available for general use in Britain.—I am, etc.,

L. E. J. EVANS

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Newcastle upon Tyne

¹ Kersh, E. S., *Chest*, 1973, 63, 112.

² Evans, L. E. J., Roscoe, P., Swainson, C. P., and Prescott, L. F., *Lancet*, 1973, 1, 452.

³ Zaks, A., Fink, M., and Freedman, A. M., in *Committee on Problems of Drug Dependence 31st Meeting*, Palo Alto, 1969.

⁴ Jasinski, D. R., Martin, W. R., and Haertzen, C. A., *Journal of Pharmacology and Experimental Therapeutics*, 1967, 157, 420.

⁵ Hasbrouck, J. D., *Anesthesia and Analgesia Current Researches*, 1971, 50, 954.

Poisoning by Dry-cleaning Fluid

SIR,—We recently treated a small child who had drunk dry-cleaning fluid in a launderette. Apparently this liquid was left in a beaker on a low table so that customers could remove spots before general cleaning. The main supply was kept nearby in a lemonade bottle.

I do not know how widespread this practice is, but it is manifestly an extremely dangerous one in areas where there are liable to be many people with young children.—I am, etc.

CYNTHIA M. ILLINGWORTH

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Doctors and Overpopulation

SIR,—I would like to make a personal comment on the thoughtful letter from Dr. F. Difford (12 May, p. 369). Perhaps for the benefit of readers who are not familiar with the Doctors and Overpopulation Group I can include a summary of our aims?

These are: (1)—To exhort the Government to admit that a population problem exists in this country. (2)—To press for a large extension of family planning services, emphasizing that such facilities must be provided free of charge within the framework of the N.H.S. (3)—To endeavour to ensure that the abortion law remains liberal and that more facilities be available under the N.H.S. (4)—To see that the facilities for male and female sterilization be massively increased and made available under the N.H.S. (5)—To urge a reappraisal of the laws and policies that govern the employment of women in society with a view to bringing about a significant improvement in their career prospects. (6)—To be in the vanguard of a nation-wide campaign of population education.

Dr. Difford objects to the third of these and particularly in the context of population control. Everybody I am sure agrees that prevention is infinitely preferable to the

termination of an unwanted pregnancy. It is for this reason that we regard an efficient contraceptive service backed up by education as of the greatest importance. However, even the best contraceptives when used efficiently do have a failure rate. Given this and human fallibility, it would seem that in the foreseeable future there is likely to be a need for termination of pregnancy.—I am, etc.,

GEORGE MORRIS

Secretary,

Doctors and Overpopulation Group

London N.10

Clinical Work in Public Health

SIR,—The Public Health Committee would wish it to be generally known that in April of this year they established a working party "to review as a matter of urgency, and in depth, the role, organization, training, grading structure, and future functions of those doctors currently undertaking clinical work in the public health field who will all be transferred to the reorganized health services." The members of the working party, in addition to myself, are: Dr. Catherine Atkins (a principal medical officer), Dr. Athene Baldwin (a clinical medical officer on the upper salary range), Dr. Rosemary Graham (a principal medical officer), Dr. Mary Patricia Jenkins (a clinical medical officer on the upper salary range), Dr. R. Mayon-White (a consultant paediatrician), Dr. Maud Menzies (a principal medical officer), Dr. A. Reeves (a general practitioner) and Dr. H. G. Robinson (a deputy medical officer of health).

The working party concluded that it should first identify the range of work carried out by clinical public health doctors at the present time and move from there to a consideration of the future. The major part of this operation will be to produce a concept or concepts of the longer-term future of this group of doctors. In the light of the collective experience of the members it has already made considerable headway with these tasks, but it recognizes that there may be other individuals with special experience who may wish to draw attention to facets of the matter which they believe might not otherwise occur to members of the working party. If this is so, then my colleagues and I would be delighted to receive such observations, which should be sent to B.M.A. House, Tavistock Square, London, WC1H 9JP.—I am, etc.,

C. D. L. Lycett

Chairman, Public Health Committee

B.M.A. House,
London W.C.1

Distinction Awards

SIR,—The decision of the Annual Representative Meeting calling for renegotiation of the distinction award scheme (*Supplement*, 16 June, p. 117) gives the profession an opportunity to take a fresh look at methods of remunerating consultants in the light of the attack on private practice. The growth of private practice is an indicator of unmet needs in the National Health Service and we would do well to consider how the privileges sought by private patients can be offered to all. Patients seek private attention to obtain more time, privacy, and consideration than a consultant can offer in a busy outpatient