investigated 30 fatal cases in which we are convinced that dextropropoxyphene played the major part in the death. All these patients had taken Distalgic tablets, some with suicidal intent and many in association with alcohol. The combined cerebral depressant effect of dextropropoxyphene and alcohol seems particularly hazardous, although all the victims had apparently ingested the analgesic in doses exceeding the therapeutic range.

It appears to us from the absence of published material in Britain that the problem has not yet been fully recognised, although recent information, not at variance with our own experience, is now reaching us from the USA.^{2,3} We are at present in the process of collating our detailed results for publication, but feel that the time is opportune to highlight what we feel is an increasingly serious problem.

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¹ Martindale: *Extra Pharmacopoeia*, 26th edn, ed N W Blacow. London, Pharmaceutical Press, 1972.

² McBay, A J, and Hudson, P, *Journal of the American Medical Association*, 1975, **233**, 1257.

³ Kopjak, L, and Binkle, B S, personal communication.

Snake bite in Britain

SIR,—It is perhaps not widely realised that snakes are quite common in many of the country areas and that the traditional means of identification are not always present.

The only poisonous snake in Britain is the viper or adder. It is found anywhere in the country, perhaps more commonly in the south, in Devon and Cornwall, and in south and west Wales. It can attack livestock as well as humans and it can be a considerable hazard in this respect to farmers. It may be confused with the grass snake, also called the "ring-collared" snake, or, less frequently, with the slow or blind worm. The appearance of the viper is subject to considerable variation. It may be coloured black, brown, dark green, grey, or almost white, with markings on its body varying from deep red to black. The under surface of the body may be black, brown, grey, or blue and the tip of the tail orange, red, or yellow. Its most constant characteristic is the zig-zag stripe running down the centre of the back, which is said to vary in only 2% of vipers. The inverted V-shaped mark on the head is less constant and may be X-shaped or indistinguishable, particularly in the black vipers. The male snakes grow to about 56 cm (22 in) and the females to about 76 cm (30 in).

The grass snake rarely occurs north of latitude 54°—that is, roughly along a line joining Lancaster and York. It is olive green or brown in colour, with transverse black bars on the back and vertical bars on the flanks. There is a yellow or orange collar around the neck, bordered behind with black. The under-surface of the body is black or white and black and it grows to 1.1–1.2 m (3–4 ft) in length. The grass snake does not bite. When alarmed it emits a foul-smelling liquid at the hind end of its body.

The slow worm or blind worm is not a true snake but a legless lizard. It is light or dark brown in colour and may have longitudinal stripes. It rarely exceeds 38 cm (15 in)

in length, does not bite, and differs from snakes in having eyelids and an external ear opening.

I would therefore like to reinforce the suggestion by Drs D J P Barker and K J Foster (26 June, p 1591) that any snake bite should be attributed to an adder. There are, of course, occasional exotic snakes imported into the country, but this is a different problem. I have seen four snake bites in the past four weeks, only one of which was envenomated, but in addition to local swelling of the whole of the leg in this particular case there was generalised allergic reaction, which must not be confused with the general effects of absorbed venom. This particular patient had an allergic diathesis.

With regard to treatment, we have issued advice to the public in this area to the effect that the victim of the bite should be kept at rest, the bitten area kept as cold as possible, and transport arranged to the nearest large hospital. The severity of general symptoms appears to depend on the rapidity of absorption of the venom and these measures are intended to reduce the rate of absorption. In hospital we give prophylactic antihistamines, hydrocortisone, and a supportive intravenous drip. In the past 20 years I have had to use antivenom serum on only two occasions and in both these cases the bite was over the saphenous vein and venom appeared to have been injected intravenously. Now that human antitetanus serum is easily available I have added this to the treatment regimen in patients who are not otherwise protected against tetanus.

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Amoxycillin, talampicillin, and ampicillin

SIR,—It is stated in the new (1976–78) edition of the *British National Formulary* (p 104) that amoxycillin should replace ampicillin because it is twice as well absorbed after oral administration. Amoxycillin possesses antibacterial activity differing little from that of ampicillin,¹ but has the theoretical advantage of producing higher serum levels. Nevertheless, it has not yet been shown that amoxycillin is superior to the same dose of ampicillin in the control of infective exacerbations of chronic bronchitis, which is probably the most frequent indication for the use of these two antibiotics. Amoxycillin is, moreover, very much more expensive. The basic cost of 100 250-mg amoxycillin (Amoxil) capsules is £8.91, while that of 100 250-mg ampicillin (Amfipen or Vidopen) capsules is only £3.11. I feel that the Editorial Committee of the *British National Formulary* should be asked to explain why they have categorically recommended an expensive new derivative of ampicillin when there is no evidence that ampicillin itself would not be equally effective.

Exactly the same argument applies to another derivative of ampicillin, talampicillin (Talpen), which is at present being vigorously promoted by another division of the same pharmaceutical company which markets Amoxil. It is claimed that talampicillin (which costs £6.50 for 100 250-mg capsules) is less liable to produce diarrhoea than ampicillin,² but the statistical evidence for this claim is unconvincing.

The patent rights on ampicillin have now expired and there has been a significant reduction in the price of this drug. Unless evidence can be produced to show that amoxycillin and talampicillin are clinically more effective than ampicillin itself, general practitioners and hospital doctors who prescribe the new preparations must be open to the charge of wasting public money.

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¹ Sutherland, R, Croydon, E A P, and Rolinson, G N, *British Medical Journal*, 1972, **3**, 13.

² Leigh, D A, et al, *British Medical Journal*, 1976, **1**, 1378.

Coeliac disease and diffuse pulmonary disease

SIR,—I was most interested to read of the case reported by Dr J Cummiskey and his colleagues (5 June, p 1401), in which coeliac disease, diffuse pulmonary shadowing, and avian precipitins occurred together in the absence of "exposure to known organic allergens" (presumably including birds). While the pleural thickening and airways obstruction have not, as far as I am aware, been previously described in this context, I know of three other observations that may be relevant to the suspicion that "the occurrence of coeliac disease, diffuse pulmonary disease, and positive avian antibodies may sometimes be a manifestation of disease separate from or additional to extrinsic allergic alveolitis."

Firstly, Lancaster-Smith *et al*¹ discovered three out of 24 patients with coeliac disease to have evidence of diffuse pulmonary disease (widespread radiographic shadowing and impairment of gas transfer) together with avian precipitins² but no known contact with birds.

Secondly, in two of the five patients we recently reported with bird-fancier's lung and jejunal villous atrophy³ the pulmonary disease relapsed severely approximately 10 years after the initial episode, in the presence of avian precipitins, despite no known exposure to birds (over and above the small amounts we may all be exposed to in the atmosphere).

Finally, a higher than expected incidence of avian precipitins (to whole bird serum) has been observed in the serum from patients with coeliac disease by us³ and others^{2,4} (irrespective of bird exposure), and in three such individuals whom we looked at closely the carbon monoxide gas transfer factor (single breath method) appeared lower than expected by comparison with our own controls.

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¹ Lancaster-Smith, M J, Benson, M K, and Strickland, I D, *Lancet*, 1971, **1**, 473.

² Lancaster-Smith, M J, 9th International Congress of Gastroenterology, Paris, 1972, Abstracts, p 398.

³ Berrill, W T, et al, *Lancet*, 1975, **2**, 1006.

⁴ Morris, J S, et al, *Lancet*, 1971, **1**, 754.

SIR,—It must not be forgotten that the coeliac syndrome and diffuse lung disease sometimes occur together in patients with sarcoidosis. At least three patients with sarcoidosis have been shown to have jejunal villous atrophy^{1–3} and Kveim tests were positive in five of 17 patients with coeliac disease.⁴ Moreover, a woman