unnecessarily given to the over-65 age group, one-third hypnotics and tranquillisers, and one-third antidepressants (imipramine, amitriptyline, and protriptyline) and the so-called cerebrovascular dilators (cyclandelate, isoxsuprine, naftidrofuryl, pentifylline, and thymoxamine). In the hypnotic and tranquilliser group the following drugs were considered to be responsible, listed in descending order of frequency of occurrence: prochlorperazine, chlordiazepoxide, diazepam, dimenhydrinate, chlorpromazine, chlormethiazole, promazine, thioridazine, trifluoperazine, and meprobamate. No cases were found among patients taking chloral hydrate and analogues, glutethimide, or nitrazepam. Prescription of barbiturates and methaqualone hypnotics are infrequent in this area but again postural hypotension was not recorded with either.

Until such time as a simple and reliable test of autonomic nerve function comes into use, we should do well to ignore much of the advice of our enterprising pharmaceutical industry and select and administer vasodilators and antidepressant and sedative drugs to the elderly with extreme caution.

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Raynaud's phenomenon as side effect of beta-blockers

SIR,—We note the comments made by Drs C W Marsden and P F C Bayliss (17 July, p 176) concerning our study of Raynaud's phenomenon in patients taking beta-blockers (19 June, p 1498). We accept that the incidence of side effects obtained with specific questionnaires may be an overestimate. Equally, side effects may be missed when spontaneous reporting by patients is awaited.¹ We reported the results of observations made in clinical practice. The study was retrospective and consequently it would have been impracticable to have had a placebo-treated group and a double-blind design.

The mean doses of the three beta-blockers and the effect of dose on development of Raynaud's phenomenon are shown in table I. The relationship between the presence of cold extremities and blood pressure control for patients on beta-blockers is shown in table II. While there are clear differences in the doses used in the three groups, there is no relation-

ship between dose and development of Raynaud's phenomenon. Similarly, degree of blood pressure control was not associated with cold extremities. These facts, therefore, do not detract from the possibility that there are true inter-drug differences in causing this side effect. Such differences can be verified only by prospective studies.

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¹ Alexander, W D, and Evans, J I, *British Medical Journal*, 1975, 2, 501.

Alternatives to barbiturate hypnotics

SIR,—There is an obvious advantage in prescribing nitrazepam as a hypnotic because with this drug overdose is less likely to be fatal. It is certainly less dangerous than barbiturates and indeed other non-barbiturate compounds mentioned in your leading article (12 June, p 1424). However, another aspect of nitrazepam deserves a mention. It has been shown¹ in a double-blind placebo controlled design to be more persistent than amylorbarbitone. In this study single doses of 5 and 10 mg of nitrazepam and 100 and 200 mg of amylorbarbitone were given at bedtime to normal subjects. They were tested the following afternoon with psychomotor tasks and an electroencephalogram (EEG) was recorded some 18 hours after the test substances had been given. The recording was assessed "blind" in terms of drowsiness and sleep. Both the psychomotor tasks and the EEG showed significant changes after nitrazepam in terms of slowing of performance and increased amounts of drowsiness and light sleep on the EEG. Even more important was the fact that the subjects were unaware of any persistent drug effects. Anxious patients in a similar study² showed the same trends but the effects were less marked.

Of course these findings do not entirely negate the current trend away from prescribing barbiturates but emphasise the fact that no drug is ideal.

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¹ Malpas A, et al, *British Medical Journal*, 1970, 2, 762.
² Malpas A, Legg, M J, and Scott, D F, *British Journal of Psychiatry*, 1974, 124, 482.

Child-resistant containers and child poisoning

SIR,—Accidental poisoning in childhood results in some 30 000 admissions to hospital in England and Wales each year and salicylates are a major contributor to this total. The most effective measure in controlling this problem

in the USA has been found to be the use of child-resistant containers, and since 1 January 1976 all aspirin and paracetamol manufactured for children in the United Kingdom has had to be packaged in child-resistant containers.

We report the preliminary findings of an ongoing survey of accidental poisoning in children and compare the total numbers of children under the age of 6 years who were admitted to hospital either in Newcastle upon Tyne or in South Glamorgan with accidental salicylate poisoning during the first six months of 1975 and 1976.

	Newcastle	S Glamorgan	Total
Jan-March 1975	10	21	31
April-June 1975	9	25	34
Jan-March 1976	5	10	15
April-June 1976	4	13	17

Thus a total of 65 children were admitted between January and June 1975 compared with 32 during the same period of 1976; the difference between these is statistically significant ($P < 0.002$).

Many children are still being poisoned with aspirin which has not been dispensed in child-resistant containers, the manufacturers and retailers still working through old stocks, but the significant downward trend in poisonings should continue when these are exhausted. We report our early findings to give encouragement to those campaigning for better safety for children in the form of more widespread use of child-resistant containers.

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Priorities in the NHS

SIR,—In your leading article on this subject (12 June, p 1425) you made the interesting, indeed provocative, comment that "If a diagnostic aid or a new drug or procedure has been proved to make a substantial difference to mortality or morbidity then the doctors working in the specialty will not be content until they use the new treatment on their patients." This assertion was subsequently challenged by Professor A L Cochrane (3 July, p 41) who pointed out your failure to supply evidence to support the statement. In reply you listed six specific procedures, etc, in which financial constraints have caused doctors to operate a rationing system. One of these examples was the use of fibre endoscopes in the management of upper intestinal haemorrhage.

While I agree that a large number of articles have shown the diagnostic superiority of endoscopy compared at least with the conventional barium meal (rather than the double-contrast technique), I would suggest that there are few data to prove that it has made a "substantial difference to mortality or morbidity." Indeed, the authors of some well-controlled prospective studies²⁻³ have actually shown that it apparently makes no such difference at all. Even the much quoted retrospective study by Hoare⁴ found that the difference in mortality rates between the group of patients having routine endoscopy and the group of patients having selective endoscopy was not statistically significant at the 5%.

TABLE I—Mean dose $\pm$ standard deviation (mg/day)

Drug	Whole group	Raynaud's phenomenon	
		Present	Absent
Oxprenolol	536 $\pm$ 303*	453 $\pm$ 120	560 $\pm$ 336†
Atenolol	180 $\pm$ 120*	157 $\pm$ 113	192 $\pm$ 125†
Propranolol	280 $\pm$ 200*	242 $\pm$ 163	334 $\pm$ 240†

*Significantly different from other treatments ($P < 0.025$)
†No significant difference between presence and absence of Raynaud's phenomenon ($P > 0.05$)

TABLE II—Results (mm Hg) for whole group on beta-blockers. Mean $\pm$ standard deviation

	Raynaud's phenomenon		Student's <i>t</i> test
	Present	Absent	
Treated diastolic BP	92 $\pm$ 17	95 $\pm$ 13	NS
Treated systolic BP	157 $\pm$ 34	163 $\pm$ 23	NS
Change in diastolic BP	28 $\pm$ 17	28 $\pm$ 20	NS
Change in systolic BP	41 $\pm$ 27	39 $\pm$ 31	NS

NS = not significant