many patients are being discharged to the community to lead a healthier and happier life. Geriatrics has already been established as a separate specialty. The skills accumulated by doctors, nurses, and remedial staff over the past 25 years are extremely valuable not only to provide a high standard of care to the patients in the geriatric wards but also to enable many people to remain in their own homes.

On many occasions elderly patients have told me that if admission to hospital is required for treatment they would prefer a geriatric ward as they find the staff in the general wards are too busy with the younger patients, the pace being faster, and they have little time and skill to deal with the special problems of the elderly. Recently I was asked by a doctor to see his father at home (the patient is in his eighties and the doctor is also his general practitioner) to advise him regarding management. The patient had multiple pathology including Parkinsonism and had difficulty in walking, incontinence, etc. After a short period of rehabilitation in the geriatric ward the patient made very good progress and at present he is enjoying an independent and active life in the community. If Dr Hurly would make an effort to visit an active geriatric unit anywhere in the country and would observe what is being done there for these patients, I am sure her impression would change, which is bound to benefit her elderly patients.

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SIR,—As a general practitioner in Hull for many years my experience is quite different from that of Dr Kathleen Hurly (7 August, p 371). A number of my patients who have dreaded admission to hospital have returned from one of our local geriatric units full of praise for the care and treatment given and the happy atmosphere of the ward. My own father was a patient in such a unit for 10 weeks and I cannot speak too highly of the teamwork of the consultant and all the staff. He was treated the same as the other patients, all of whom in my opinion greatly benefited by being looked after by medical and nursing staff used to the care of elderly patients, which cannot be the case on a general ward.

Perhaps we are unusually fortunate here on Humberside, but I personally feel that excellent geriatric units such as we have here are the only satisfactory answer to the increasing problem of the elderly sick.

GERALD P OXBORROW

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New look at malaria

SIR,—I wish to refer to Dr S L Henderson Smith's letter (5 June, p 1402), in which he questions the humanity of WHO in campaigning to eradicate malaria in African countries instead of concentrating on family planning.

In support of Dr Helen Kingston's statement (26 June, p 1593) that family planning work is being undertaken in African countries by several organisations and individuals I would direct attention to the pamphlet *Family Planning in Five Continents* issued by the

International Planned Parenthood Federation in November 1975, in which it is shown that increasing numbers of governments of countries in Africa are making contributions to unilateral programmes of the United Nations funds for population activities and are members of the IPPF.

With reference to the population increase a recent article in the *WHO Chronicle*¹ entitled "The epidemiology of infertility," based on the report of a WHO scientific group, states that "so much public attention has been directed in recent years to the problem of rapidly increasing populations in many of the developing countries (the so-called population explosion) that few people are aware of the existence of the opposite problem in others: a relatively static or actually declining population. . . . In parts of Gabon, Cameroon, the Central African Republic, and Zaïre the proportion of women 50 years of age and older who have never borne children ranges from 20% to 40%. Among younger women even higher percentages have been noted. A similar situation has been reported from East Africa, the Sudan, and elsewhere in the continent."

As the IPPF report shows, Africa has the lowest life expectancy of all continents (47.3 years compared with an overall figure of 55.2 years), while the birth rate is 2.6% compared with the overall rate of 1.9%.

Another article in the *WHO Chronicle*² on the impact of malaria on economic development gives some of the findings of a 22-month study in Paraguay sponsored by the Pan American Health Organisation. I wish to mention two salient ones—namely: (1) that health factors can diminish or negate the good effect of measures taken to improve economic opportunity; and (2) that diseases such as malaria may affect the labour force by incapacitating the individual worker or by reducing his efficiency when he is able to work. In addition to the foregoing I would reiterate the statement in your leading article (1 May, p 1050) that the disappearance of malaria "will not only help endemic areas but will solve the malaria export-import problem, which at the moment menaces the rest of the world." Dr Henderson Smith's new look is myopic.

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¹ *WHO Chronicle*, 1976, 30, 229.
² *WHO Chronicle*, 1976, 30, 223.

Alcoholism: wet hostels

SIR,—At a recent meeting of many disciplines dealing with alcoholism the notion of wet hostels for alcoholics was considered. These hostels, in some countries, provide shelter, food, and alcohol until the person dies, which one could construe as encouraging the alcoholic to die as quickly as possible.

As a result of this I devised a questionnaire which was circulated to 80 doctors in the north-east of England. Thirty-one replied to the questionnaire. It was interesting to note that 11 out of the 31 doctors who replied thought that to provide alcoholics with easily available alcohol and shelter was an appropriate solution, while the remainder rejected this. It is also interesting to note that 10 doctors wished that, in the event of themselves becoming alcoholic, they themselves would be provided with alcohol and shelter.

I personally am alarmed that so many doctors seemed to have such a hopeless view of alcoholism and, furthermore, fear that it reflects a change in the caring, benevolent attitude that is meant to accompany medical endeavour. I feel this result is not only a harbinger of uncaring solutions to social problems but also reflects demoralisation in the medical profession.

Those who wish for a more detailed copy of the results are welcome to contact me.

A FREED

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Sedatives for alcoholics

SIR,—I am becoming increasingly concerned about the way that the sedative drug chlor-methiazole edisylate (Heminevrin) is being used by general practitioners in the management of alcoholism. I fairly frequently come across patients who are being prescribed Heminevrin three times a day as "medical treatment" for alcohol problems. My own personal view is that it is undesirable for people with alcoholism to substitute the use of another central nervous system sedative for alcohol, and my experience has been that this really does nothing to advance solution of the many problems which arise in connection with alcoholism.

My experience with inpatients in the setting of a small special unit for alcoholics is that Heminevrin can be extremely useful during the period when a withdrawal syndrome is likely to occur, but that it can be reduced and stopped within about 10 days normally. It is also my experience in this setting that sedative drugs such as hypnotics are quite unnecessary and tend to perpetuate the alcoholic's continued demand for substitute drug therapy. To me a demand of this nature indicates that the treatment programme is being unsuccessful and that the patient is failing to accept the situation which he has to deal with.

I would like to draw attention to the problems likely to be produced by the prescription of drugs other than alcohol to alcoholics, which in effect sets the seal of medical approval on a drug-taking behaviour. The main effect of this in my view is to allow the alcoholic to escape the realities of his situation for a time, but it does nothing to provide a stable recovery.

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Seizures and metolazone

SIR,—In the short report of muscle cramps, collapse, and seizures in two patients taking metolazone by Dr M X Fitzgerald and Dr N J Brennan (5 June, p 1381), the symptoms are attributed to a serious adverse reaction to metolazone. In particular, the symptoms in the second case were tentatively ascribed to hypomagnesaemia.

A review of the standard texts on the subject of hypomagnesaemia inclines to the opinion that this condition occurs after prolonged parenteral feeding, malabsorption, alcoholism,

diabetic acidosis, primary aldosteronism, and sometimes after the removal of a parathyroid adenoma. Hypomagnesaemia is often associated with postdiuretic electrolyte imbalance; furthermore, hypomagnesaemia of more than a slight degree is usually due to diuretic therapy in general, and thus is not specific to metolazone.

In the first case reported the female patient had received 2.5 mg daily for three days before the onset of symptoms. An EEG was reported as being possibly indicative of epilepsy. There was no laboratory report of serum magnesium. The information on this case does not support an adverse reaction to metolazone, especially with such a small dosage over a short period of time.

In the second case a 70-year-old male was receiving diuretic therapy consisting of daily theophylline, salbutamol, frusemide 160 mg, and spironolactone 150 mg; later frusemide was increased to 200 mg. This treatment was continued for 14 days. Five days later one dose of 5 mg metolazone was given, following which the described epileptiform seizures occurred. The EEG, blood urea, serum sodium, potassium, and calcium were described as normal. Serum magnesium was given as 0.32 mmol/l. All drugs with the exception of metolazone were continued with no recurrence of symptoms. A past history recalls an episode of syncope two years previously, when the patient was not receiving any medication; this episode was preceded by a leg cramp.

In the second case, it would seem more reasonable to assume the low serum magnesium was due to the previous 14 days' diuretic therapy rather than a single 5 mg dose of metolazone.

A leading article in the *British Medical Journal* (25 January 1975, p 170) draws attention to the fact that most established diuretics such as thiazides and frusemide will increase magnesium clearance in the long term. The article also mentions that certain patients with heart failure are already magnesium-depleted before the beginning of drug therapy.

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Abortion and maternal deaths

SIR,—It is surprising that Dr Ann Cartwright (24 July, p 232) should now describe as a "random sample of women having an abortion" the 272 patients used for the study by her "Institute for Social Studies in Medical Care," commissioned by the Lane Committee and published as vol III of their report. Actually there is no reason at all to suppose that the sample will have been a random one, being seriously biased by the fact that 7 of the 30 NHS hospitals approached and over half (6 out of 11) of the private abortion clinics (only 25 of the private patients were from clinics not associated with the Pregnancy Advisory Service) refused requests to participate in the inquiry. This was correctly pointed out on p 3 of the introduction to the report as follows: "Our sample has an unduly high proportion of women having abortions in NHS hospitals, an appropriate proportion having them in clinics associated with the PAS, but women having them in other private clinics are greatly under-represented."

Extrapolating conclusions from a small sample can be justified only if the original sample really was a random one and representative of the whole population. This par-

ticular study seems to have been done under great pressure, and its results may well have been the best that could have been achieved in the time available. But it certainly was not (and wasn't even claimed to have been) truly representative. It should surely therefore not be used as an argument against your proposal (10 July, p 70) for "well-planned prospective studies in large, representative communities" as a basis for future policy decisions.

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Febrile fits

SIR,—Recent correspondence (19 June, p 1530 and 10 July, p 112) on this subject may have led people to ignore the potential seriousness of this condition. To divide the fits into "simple febrile convulsions" and "epileptic seizures precipitated by fever" certainly separates the mild from the severe, and obviously the former are not likely to result in brain damage. However, this reasoning seems to exclude the facts that all these seizures are epileptic and that epilepsy in any form is a symptom. All of us are liable to certain symptoms under particular conditions, and this seems to be especially so in the case of epilepsy.

It is not known why fever is a precipitating factor for epileptic seizures any more than why certain people are photosensitive. It is no doubt a complex matter, and in the case of febrile convulsions pyrexia is unlikely to be the only cause. Therefore if any child appears to be liable to the onset of fits when the temperature rises, he is at considerable risk of a complication which may lead to death or lifelong handicap, and the matter must be considered as an emergency. Any argument over terminology in the absence of knowledge about causation is likely to distract from the most important issue. If such seizures are not prevented or treated urgently, a number of children will suffer.

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BCG in cancer

SIR,—The writer of your leading article under this title (19 June, p 1487) recommends that more clinical trials are needed "if the potential benefits of BCG used in malignant disease are to be fully realised." Leaving aside this optimistic anticipation of the results of trials not yet done, we should point out that over 150 registered clinical trials of BCG in the treatment of cancer are currently in progress or projected.¹ It can be surmised that many unregistered trials also are in progress.

The question arises whether any limit is envisaged for the number of trials required to determine whether BCG does or does not make a realistic contribution to therapy. Many examples could be given from other branches of medicine in which a single fair clinical trial of a mooted form of therapy has been found sufficient to decide the issue. Immunotherapy of cancer is peculiar in that various techniques have been subject to clinical trial for over 80 years.

Your leader writer refers to preferential

modification of cancer cells by BCG-induced macrophages independently of the exertion of any tumour-specific antigenicity. However, the reference² is exclusively to studies in vitro. The fact is that the principal instigation of clinical immunotherapy has been the favourable results of in-vivo studies using rodent tumours induced by powerful chemical carcinogens or oncogenic viruses. A recent communication³ seriously questions the validity of these experimental systems as models of clinical cancer and reports a total failure to demonstrate immunogenicity in a wide variety of rodent tumours of spontaneous origin.

Projection to clinical trial of the results of immunotherapy experiments using animal tumours requires fastidious attention to the validity of the animal systems employed as models of the human disease. We believe that, very largely, this requirement has not been met. Until it has, the recommendation of yet further clinical trials of BCG in cancer signifies more domination by an *idée fixe* than a logical progression from laboratory experiments to clinical measures.

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¹ *Compendium of Tumor Immunotherapy Protocols*, No 3, October, 1975, Bethesda, National Cancer Institute.
² Hibbs, J B, *Science*, 1973, **180**, 868.
³ Hewitt, H B, *et al*, *British Journal of Cancer*, 1976, **33**, 241.

Raynaud's disease and the oral contraceptive pill

SIR,—Your reply to this question (17 July, p 156) is an oversimplification, which though it may be true in primary Raynaud's disease takes no account of the problem that may be arising in patients who are developing the secondary condition. My own experience has shown that apparently typical primary cases in young women coincided in their onset with the taking of ovarian steroids. Two girls proved to be diabetic, and one has since shown unmistakable evidence of scleroderma. In all cases there was an improvement when the pill was stopped.

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Economy in prescribing

SIR,—I must take issue in part at least on this matter with Dr P M Morris (31 July, p 304), in particular with his implication that cheaper drugs are inferior. I would suggest that very often the converse is true and that well-established *National Formulary* preparations are equally effective with fewer side effects. Three examples which come readily to mind are phenoxymethyl penicillin instead of ampicillin and tetracyclines for upper respiratory infections, thiazide diuretics in place of combined or loop diuretics in maintenance treatment of congestive failure, and aspirin or paracetamol rather than expensive and often highly dangerous proprietary analgesic/steroid mixtures in chronic rheumatic conditions.