referring hospital. Paraquat was detected in the urine by the alkaline dithionite screening tests and confirmed by derivative ultraviolet spectrophotometry as paraquat ion. At this stage we tested the blue-green fluid by diluting it 1/1000, and obtained a positive reaction for paraquat.

If we had not been led astray and had used our usual drug screening procedures we would have detected the paraquat sooner. The local suppliers of Gramoxone confirmed the colouring had been changed from brownish-purple to blue-green to make it less attractive to children. When we compared some authentic Gramoxone with our sample of fluid they were found to be identical. The change in appearance was not known to us, nor to the poisons unit consulted, and nor to the patient, who subsequently died.

Cases of paraquat poisoning should be on the decrease since there are now herbicides of similar power with less toxicity to humans. Stores of both old and new Gramoxone will be around for some time, however, and we would ask casualty officers, renal units, and clinical toxicologists to bear in mind the fact that Gramoxone may appear in two different guises.

We would like to thank Dr J Oliver, Department of Forensic Medicine, University of Glasgow, for performing the GC/MS and *x*-ray fluorescence analyses.

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Non-ionic contrast media

SIR,—In these times of recession we are being strongly encouraged to reduce spending and cut back on our budgets.

All radiologists and many clinicians will be aware of the considerable advantages of the newer non-ionic contrast media. This is particularly the case in peripheral arteriography, where a much better patient tolerance has been clearly shown. This and other advantages have enabled many cases of peripheral vascular disease to be investigated on an outpatient basis using local anaesthesia and a small catheter technique. Of course, the disadvantage, as with many new drugs, is cost. At present the newer contrast media cost about five to eight times more than the more conventional contrast media.

Despite the potential savings in bed usage, in anaesthetic sessions, and above all in patient morbidity, however, we are being encouraged to think carefully and cut back on their use. The extra cost of the newer and safer non-ionic contrast media "shows", the savings it produces do not.

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Admission of children to GP hospitals

SIR,—Perspectives on childhood illness from primary and tertiary care centres are inevitably different, but none of us would disagree with the assertion that all really sick children require admission to a consultant paediatric unit. The essence of our statement is the claim that there should be no rigid policy. The views of the British Paediatric Association (16 October, p 1113) are, of course, respected, but we feel they should be tempered by local conditions. A total ban on the admission of any children to any local hospitals under any circumstances is not acceptable to the general practitioners who staff these units. They are entitled to use their discretion in this as in every other part of their clinical work.

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Points

Hazards of taking cannabis

Professor J R SMYTHIES (University of Alabama, Birmingham, Alabama 35924) writes: In a review of the recent report by a Home Office expert group on cannabis use (27 March, p 957) Dr T Bewley pointed out that the report claims that there is as yet no firm evidence that cannabis use has any "positive and important harmful effects." The expert group appears to have overlooked the definitive study by Mendhiratta *et al*,[1] which showed that long-term heavy cannabis use among a population of 50 Indian subjects, who were known not to be using any other drugs, produced severe disturbances—slower reaction times, poorer powers of concentration, distorted time estimation, more neuroticism, and greater perceptomotor disturbances—than carefully matched controls. A further study by Janowsky *et al*[2] showed decreased interpersonal skills and decreased affective resonance among marijuana users. . . .

[1] Mendhiratta SS, Wig NN, Verma SK. *Br J Psychiatry* 1978;**132**:482-6.
[2] Janowsky DS, Clopton PL, Leichner PP, Abrams AA, Judd LL, Pechnick R. *Arch Gen Psychiatry* 1979; **36**:781-5.

Nicotine chewing-gum

Dr W J TROWELL (Great Parndon, Harlow, Essex CM18 7LU) writes: Further to the report from Mr M J Jarvis and others, on the usefulness of nicotine chewing-gum as an aid to stopping smoking, a 41-year-old patient of mine with granular proctitis of three years' standing whose present attack had not settled with sulphasalazine (Salzopyrin) and prednisolone (Predsol) enemas had immediate symptomatic cure with Nicorette 2 mg three times daily. She does not smoke.

Shortlisting trainees

Dr F M R KERRY (St Albans, Herts AL3 6AX) writes: I was dismayed at the patronising tone of Dr K J Bolden's article on the selection of trainees for the Exeter scheme (11 September, p 699). As we all know, the number of trainees currently greatly exceeds the number of training posts. We should not gloat on this sad fact but rather we should seek to increase the number of opportunities for the large number of able doctors who are unable to enter general practice. To be sure, were the position reversed the trainees would be writing articles on how to shortlist training schemes.

Effect of hypnotic drugs on actual driving performance next morning

Dr A J MACDONALD (Barrow Hospital, Barrow Gurney, Bristol BS19 3SG) writes: I was impressed by the recent article by Dr T A Betts and Dr Janice Birtle (25 September, p 852). Studies of flurazepam metabolism have suggested that if anything the handicapping effect of this drug is greater 16 to 20 hours after ingestion. It would therefore be appropriate for future investigators to repeat their test battery in the latter part of the day.

Terminology and classification of acute mountain sickness

Mr P H M MCWHINNEY (Guy's Hospital, London SE1 9RT) writes: Dr J G Dickinson (11 September, p 720) suggests that acute mountain sickness should be classified as benign or malignant. This implies a sharp distinction between two conditions for which there is no justification: there have been no reliable studies on the clinical progression, and there is no certainty of the pathological processes behind the disease. The title benign belittles what may be a premalignant condition and may give sufferers a false sense of security, spurring them on to precipitate malignant mountain sickness. Thus I would suggest the use of mild and severe for the two major categories. Though benign and malignant are less open to colloquial use many of the sufferers will be far from medical aid and may be prompted into an inappropriate course of action.

Must ethical committees inhibit research?

Dr DAVID SHORT (Cardiac Department, Aberdeen Royal Infirmary, Aberdeen AB9 2ZB) writes: Dr D L J Freed (9 October, p 1042) implies that ethical committees must inevitably inhibit research. I do not agree. They need not do so, and it is essential that they should not do so. Every ethical committee should have a procedure by which an urgent submission received some weeks before the date of the next meeting of the committee can be dealt with speedily. Often the matter can be appropriately handled by the chairman and vice-chairman. Occasionally all the members of the committee may need to be informed of the submission by post. In either case the approval of at least one non-medical member is essential.

Correction

Pulmonary fibrosis and amiodarone

An error occurred in this letter by Morera *et al* (25 September, p 895). In the third paragraph the sentence starting "The cumulative doses . . ." should have read: "The cumulative doses of the drug taken by the reported cases of amiodarone pulmonary toxicity vary from one to more than 1000 g."