or, unless the doctor is a 'person about the deceased' (see iv), to the coroner." It is regrettable that there is no authoritative definition of the vague and archaic phrase "person about the deceased," but it seems likely that it must mean someone, such as next of kin, who is in close daily contact with the patient before death. The doctor may be the appropriate person, or the only such person in certain circumstances.

It would be unfortunate if Dr. Price's otherwise excellent letter were to be interpreted as stating present law to be that a doctor is under a common law duty to report deaths to coroners. That the law requires amendment is made clear elsewhere in the Brodrick Report. The fact that there is no legal duty on a doctor to notify a death to the coroner is not to imply that a doctor need not or should not do so when the circumstances require such action, for moral, ethical, and traditional considerations are as much relevant as legal duties.—I am, etc.,

R. N. PALMER

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Medical Protection Society Ltd.

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1 Home Office, *Report of the Committee on Death Certification and Coroners*, Cmnd. 4810. London, H.M.S.O., 1971.

Effect of Methohexitone on Infants Delivered by Caesarean Section

SIR,—Unfortunately, the interesting study reported by Dr. Anita Holdcroft and her colleagues (1 June, p. 472) was undertaken on supine subjects. In addition, fetal umbilical venous blood-gas/acid-base status was measured, whereas umbilical arterial measurements would have been more representative of the fetal metabolic condition at birth.

Clinically, the infants delivered after the high dose of methohexitone were more depressed than those delivered after the lower dose. Calculation of the fetal umbilical venous base excess values, corrected for haemoglobin desaturation,¹ is of interest. Assuming a fetal haemoglobin level of 15 g/100 ml the mean result for the high-dose group is -4.19 mEq/l. (S.E. 0.99) and for the low-dose group -1.43 mEq/l. (S.E. 0.93). The difference between the two groups just fails to reach statistical significance ($t=1.9401$, $n=23$, $0.1 > P > 0.05$).

Analysis of the umbilical arterial blood-gas status and calculation of the maternal to fetal acid-base gradients carried out in a larger series might have revealed a more significant difference in metabolic status between the high- and low-dosage groups. The base excess values shown above, however, do suggest the presence of a relatively greater degree of acidemia in the high-dose infants. Is it not possible that at least some degree of the clinical fetal depression measured might have been due to biochemical fetal asphyxia? Perhaps the larger dose of methohexitone, administered to mothers in the supine position, resulted in a greater lowering of cardiac output and hence a reduction in uterine perfusion and fetoplacental exchange.—I am, etc.,

J. W. DOWNING

Department of Anaesthetics,
University of Natal,
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1 Andersen, O. S., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1963, 15, 211.

N.H.S. Contraceptive Services

SIR,—The signatories of the letter from the Doctors and Overpopulation Group (3 August, p. 340), which I understand is yet another pressure group bearing down upon those of us at grass roots who have to run the Health Service, seem not to be acquainted with the economic facts of running such a service at the incomprehensibly low fee of £1.72 now offered by the Department of Health and Social Security.

To have to pay for female staff assistance, lighting, heating, and secretarial work before we draw any financial reward ourselves would place us in the red at the end of the year such a scheme was working. It is well to inform the group at this stage that the D.H.S.S. is paying £6.40 per annum per patient to the Family Planning Association for the service and I have seen how poorly equipped some of their clinics are. How does the D.H.S.S. expect us to do similar work at a high standard of skill for a mere £1.72?

The last paragraph of their letter, in which they state we should think seriously of the implications of any pressure by doctors to delay the scheme, is not being really honest as I am not aware that any pressure has been exercised by us. We have only used our fundamental democratic rights to state that we do not wish to be involved in an unseemly scramble which might bring public annoyance to our surgeries. Mrs. Castle chose herself to rush the scheme without much consultation with the General Medical Services Committee and seemed confident three months ago that she could manage without our help. Now it seems the pressure is on the F.P.A. and they are already beginning to throw bouquets in our direction. How strange it all is—only a short while ago we were told we were not competent as general practitioners to do family planning at all. At least we have stayed out of the arena, and no doubt wisely too. We shall wait until a proper fee is agreed to cover costs of staff, etc. Meanwhile my working class patients (many now earning over £2,000 a year) do not seem a bit worried at paying for their contraceptives. It seems only the politicians and some academics have got themselves steamed up about the matter.—I am, etc.,

T. D. RICHARDS

Member, National Association of
Family Planning Doctors

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SIR,—As a member of the General Medical Services Committee who has been closely concerned in the negotiations with the Department of Health and Social Security in relation to a possible contraceptive service, may I reply to the letter by Sir George Pickering and others (3 August, p. 340)? It should be made clear that the G.M.S. Committee took the formal decision to reject the offer made by the D.H.S.S., on the advice of Lord Halsbury, only after consulting local medical committees and finding that two-thirds of them insisted on rejecting the present offer.

This view was reinforced by the decision taken at the Annual Representative Meeting of the B.M.A. at Hull when a resolution was overwhelmingly supported that no branch of the profession should enter into contract to provide contraceptive services until a satis-

factory contract had been negotiated with all branches of the profession (*B.M.J.*, 6 July, p. 288). It is heartening to see that at long last a united profession has served notice on the Government that it is not prepared to provide further services which in effect would be subsidized by the doctors taking part. It is surely not unreasonable, in view of the economic benefits which your correspondents believe will accrue to the nation in the event of a further contraceptive service being introduced, to accept that the Government will pay a realistic fee to the doctors who have to undertake this work.

Your correspondents' anxieties about overpopulation can hardly apply to the United Kingdom, as the latest Registrar General's figures show that there is now a zero population growth in the U.K. with the present level of contraceptive services. If, however, their main concern is with a world population explosion in under-developed countries may I suggest that they offer their own professional skills to those governments who still have a rising population and accept fees of approximately 25% of the normal rate, for this is what is being offered to their colleagues in this country.—I am, etc.,

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Treatment of Giardiasis

SIR,—The correspondence in your columns on giardiasis in the U.K. from Dr. A. M. Geddes (27 October, p. 236), Dr. P. A. Shave and B. T. Thom (16 February, p. 288), and Dr. Linda Stanton (9 March, p. 453) prompts us to report on the use of a short intensive course of metronidazole for the treatment of giardiasis in the U.K.

The patients were from two hospitals for subnormality and the infestations were found during a survey of intestinal parasites. All were passing cysts as determined by stool examination by the formal ether concentration technique.¹ The doses used are expressed below as the adult dose. The dose for a child was calculated according to Catzel's formula based on surface area² and was proportionate to age. If, as sometimes happened, the weight of the child was grossly abnormal, weight alone was used for the calculations.

Three dosage schedules were used:

(1) 2 g as a single dose daily on two successive days; (2) 2 g as a single dose daily on three successive days; and (3) 2.4 g as a single dose daily on three successive days. In the first schedule nine children were treated, in the second schedule nine children and two adults were treated, and in the third schedule eight children and three adults were treated. The ages of the children ranged from 1 to 14 years. The stools of the patients were examined after treatment weekly for a total of four weeks. It was considered irrelevant to follow up beyond that time owing to the liability of re-infection in these wards.

The first schedule cured six out of nine of the children. The remaining three children showed no parasites one week after treatment (two stools examined) but parasites were present at 14 days. The other two schedules gave 11 out of 11 cures in both

instances. There was no evidence of side effects.—We are, etc.,

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- ¹ Allen, A. V. H., and Ridley, D. S., *Journal of Clinical Pathology*, 1970, 23, 545.
- ² Catzel, P., *Paediatric Prescriber*, 3rd edn. Oxford, Blackwell, 1966.

Malaria in the United Kingdom

SIR,—Professor B. G. Maegraith's (27 July, p. 252) merits in stressing the dangers of imported tropical disease are too well known to need emphasizing and all of us owe him a debt of gratitude for his pioneering work in this and many other fields. It is therefore all the more regrettable to find ourselves so misunderstood and taken to task for a non-existing misdeed (29 June, p. 707).

Professor Maegraith appears to disagree with one point of our paper—namely, that the protection of the health of each individual is, in the final account, his own responsibility and that the medical profession or any other bodies can only inform, advise, and guide. No one denies that the airlines or travel agents have shown little interest in the problem of imported malaria in spite of the fact that this has been frequently stressed by the daily press, many professional journals, and the B.B.C. It is also true that the excellent "Notice to Travellers" produced by the Department of Health and Social Security should be given to any traveller when he buys his ticket. Better distribution of this leaflet is now being arranged by the D.H.S.S. But the only way to improve the situation is to stress again and again the potential seriousness of the imported tropical disease and to obtain the willing co-operation of travel agents and airline managers. Sanctions or legalistic measures relevant to malaria are unlikely to be acceptable at a time when the general trend of the new international health regulations leans towards some relaxation of vexing sanity policy, even with regard to such diseases as cholera. The World Health Organization gave much thought to the problem of introduction of malaria and the relevant conclusions of a special meeting¹ were as follows:

"International travellers (tourists) should not be subjected to any compulsory antimalaria measures. Information on preventive measures should be given to them for their own protection when they enter or leave malarious areas together with warning cards instructing them how and where to report should they develop fever."

Such warning cards are used by the military² and have been adopted by the Council of Europe for civilian use, though the results of the latter method have not been spectacular. Obviously, more could be done by the medical profession, by the information media, and by the travel industry to make the public aware of the importance of diseases contracted abroad.

Neither the Liverpool nor the London School of Tropical Medicine has been idle in this respect. But once again, in the final account it is the informed individual who must assume the responsibility for his or her

own protection from malaria, either by reducing the degree of exposure, by taking prophylactic drugs, or by consulting his doctor in case of sickness after travelling overseas. No one could disagree with this and we are not aware of any serious difference of opinion between Professor Maegraith and ourselves.—We are, etc.,

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- ¹ World Health Organization, *Prevention of the Re-introduction of Malaria*, Technical Report Series No. 374, Geneva, W.H.O., 1967.
- ² McKelvey, T. P. H., et al., *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1971, 65, 286.

Aspirin and What Else?

SIR,—Your leading article (6 July, p. 5) draws attention to the widespread use of aspirin in Britain and discusses the possible haemostatic defects that may arise. Until recently in our transfusion centre little attention was paid to aspirin ingestion in blood donors, despite the fact that platelet-rich plasma or platelet concentrate would be prepared from some of the donations. A survey in the U.S.A. showed that 42 (36%) of 118 donors gave a history of having taken a drug known to affect platelet function and the most common of these was aspirin: 36 (88%) of the 42 showed abnormal platelet aggregation.¹ In addition to the abnormal platelet aggregation in vitro aspirin also inhibits platelet function in vivo, since the bleeding time of normal subjects is increased after aspirin ingestion.² In view of these observations and the increasing use of platelet preparations, we decided to ascertain the frequency at which local blood donors had taken aspirin-containing compounds during the seven days before blood donation and to investigate platelet aggregation using adrenaline and collagen.

Donors were asked whether they had ingested any aspirin-containing substances within the previous seven days (as an aide memoire they were shown a list containing the names of 102 such substances). At the end of the normal blood donation in these donors a small sample of blood was taken and platelet aggregation (in response to collagen and adrenaline) was measured by a turbidometric method.³ Platelet counts were performed and plasma salicylate levels also measured. The findings of the medical questionnaire were broken down into the following groups. Group I, donors who had taken no aspirin-containing compounds or any other drug for seven days before donation. Group II, donors who had taken aspirin-containing compounds during the period of seven days before donation. Group III, donors who had taken other drugs during the period of seven days before donation but excluding those in group II. The donors in group III had taken either paracetamol, sleeping tablets, anti-histamines, or antidepressants. Altogether 111 donors were studied in this survey.

Our survey showed that 33% of donors had taken aspirin during the seven days before donation and a further 14% had taken other medicines within this period. There was a predominance of females in the aspirin-ingestion group. Of the donors with a history of taking aspirin (group II) 24% did not respond to collagen-induced aggregation compared with 8% of donors who had not taken any medication (group I). With adrenaline 70% of group II donors showed abnormal platelet aggregation compared with 29% of donors in group I who could not recall taking drugs. In group III the response to collagen and adrenaline was similar to group I. Positive plasma salicylate levels (>5 mg/100 ml) in 13% of group I donors showed that some may have unknowingly ingested aspirin during the seven days before donation.

The question now posed is: "Does abnormal platelet aggregation in aspirin-ingesting donors mean that these platelets are haemostatically ineffective? As little as 150 mg of aspirin has been found to suppress the second wave of adrenaline-induced platelet aggregation for as long as seven days but the in-vitro addition of only 10% normal platelets corrected the abnormality.¹ Stuart *et al.*⁵ showed that if the donor had not taken aspirin within 36 hours the platelets should prove haemostatically effective, but if within this time the donation should be pooled with those of other donors who have not taken aspirin. In view of this,, for regular platelet concentrate production of small pools (that is, for paediatric transfusions) aspirin-ingesting donors should be avoided but for adults, when large amounts are required, aspirin ingestion should not pose an unduly difficult problem.—We are, etc.,

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- ¹ Schwartz, A. D., *Transfusion*, 1972, 12, 344.
- ² Quick, A. J., *American Journal of the Medical Sciences*, 1966, 252, 265.
- ³ O'Brien, J. R., et al., *Thrombosis et Diathesis Haemorrhagica*, 1966, 16, 752.
- ⁴ O'Brien, J. R., *Lancet*, 1968, 1, 894.
- ⁵ Stuart, M. J., et al., *New England Journal of Medicine*, 1972, 287, 1105.

SIR,—Aspirin in normal doses (650-1,300 mg) slightly prolongs the bleeding time in normal people. This is attributed to its effect in preventing the release of adenosine diphosphate (ADP) from platelets and thereby interfering with platelet stickiness. Your leading article (6 July, p. 5), suggested that profuse gastric haemorrhage after aspirin ingestion was due to an underlying abnormal haemostatic mechanism being potentiated by this effect.

Small doses of aspirin (10-100 mg) do not produce significant changes in bleeding times in normal individuals. However, in patients with the syndrome of nasal polyposis and asthma associated with aspirin idiosyncrasy Fisherman and Cohen¹ have shown greatly prolonged bleeding times after such minute doses. Using Macfarlane's method for measuring bleeding times I have been able to confirm that the bleeding times were prolonged to double or more in 12 patients with this syndrome, whereas in matched controls the bleeding times were unchanged or even shortened.

No patient in this series had a history of haematemesis, and only one patient of a larger series (45) with this syndrome had suffered a haematemesis. This would tend to support the hypothesis made in the leading article that an additional haemostatic defect needs to be present before aspirin will result in a profuse gastric haemorrhage.—I am, etc.,

J. C. DELANEY

Walton Hospital,
Liverpool

- ¹ Fisherman, E. W., and Cohen, G. N., *Annals of Allergy*, 1973, 31, 182.

Metaclopramide and Prolactin

SIR,—Dr. H. W. C. Ward (20 July, p. 169) draws attention to the possible dangers of administration of metaclopramide to breast