Distribution of Oral Contraceptives

SIR,—Discussion is going on at present as to whether or not nurses are to be allowed to prescribe the oral contraceptive pill. But what is really at issue is whether or not it is acceptable that doctors should be expected to cover a relatively unqualified person, a nurse, in history-taking, in medical and gynaecological examinations, and in the issuing by her on her own initiative of prescriptions for a scheduled drug—an unheard-of precedent. There would be no question here of the nurse taking responsibility. This would rest, as always, on the covering doctor.

If this procedure is to be called "delegation" what has to be considered is whether or not the skills and experience of a doctor can be delegated at all in this way. If not, then such delegation would be deception, for it would give the appearance of doctor care when in fact this was being carried out by a nurse. In such circumstances the covering doctor might well be vulnerable to action against him for negligence. The silence of the defence societies, who must be concerned, and the B.M.A. is curious. It is an issue which should be debated by the whole profession.

It would be foolish for doctors to allow themselves to be robbed of their professional rights, and thus have their earning power eroded, by acceding to a situation in which they will be placed in a position of accepting still more responsibility without any real control over the actions of the medically unqualified persons they would have to cover. The profession would be wise to retain the control of all prescribing in its own responsible hands and refuse to accept a dangerous precedent with perhaps far-reaching consequences for all doctors.—I am, etc.,

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Prophylactic Fluoride Treatment and Aged Bones

SIR,—We are stimulated to respond to the article by Dr. J. Inkovaara and others (12 July, p. 73).

Many investigations have clearly shown the deleterious effect of fluoride alone on bone and on the skeletal status of individuals who already have severe bone loss and osteoporosis. The authors of this article suggest that 25 mg of fluoride ion per day is too high. In fact, examination of the literature shows very clearly that it is not this amount of fluoride but the lack of accompanying calcium in the present study that was the important factor.

Our data on long-term treatment of patients with osteoporosis with fluoride and calcium have continued to suggest that this is a successful form of treatment. One should not expect cessation of vertebral collapse or of other fractures until bone mass is significantly increased. And, in fact, three of eight patients sustained further fractures during the first 12 months of this combined treatment. In the subsequent six years vertebral collapse appears to be significantly decreased in a group of 30 patients who have been on treatment for a year or more.

Our investigation of the treatment of osteoporosis now includes 11 years of experience and 55 patients and we believe that

there are some important considerations in this type of study. One is the need for long-term investigation, meaning at least two years and preferably longer. We also believe that it is necessary to have some objective means of evaluating change in bone mass, such as quantitative radiology or bone biopsy. Incidence of fracture is clearly related to stress as well as to bone mass and can be an unreliable index in short-term studies.—We are, etc.,

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Antibiotic Policy

SIR,—Briefly, Mr. O. J. A. Gilmore and Dr. P. J. Sanderson (13 September, p. 653) have convinced us neither of the development of bacterial resistance after a single intracutaneous dose of cephaloridine nor of the wickedness of coin-tossing for randomization.

Professor P. Armitage¹ states that "the choice of treatment for each unit should be made by an independent act of randomization such as the toss of a coin or the use of random number tables." Coin-tossing is an excellent method, but can result in an untidy inequality of numbers.

The criticism that in our comparison of povidone-iodine with cephaloridine² we had no untreated controls hints at a fundamental disregard of the purpose of controlled clinical trials. After such a trial,³ which showed the superiority of single-dose intracutaneous cephaloridine over untreated controls, we obviously felt it was impossible for ethical reasons to leave the control group untreated in future.—We are, etc.,

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** This correspondence is now closed.—ED., B.M.J.

The Mite and Childhood Asthma

SIR,—In a leading article (2 August, p. 263) you discussed the importance of mite allergy as a cause of wheezing in childhood and described measures for reducing inhalation of mite dust. The rationale of these simple environmental control measures was based on original reports^{1,2} which showed higher numbers of mites in dust from the surface of mattresses than from other sites within the house. More recently high numbers have been found in blankets³ and inside the covers of an old quilt.⁴ These suggest that such coverings may also be important sources of mite allergen.

We would now like to report a few examples of very high levels of infestation inside bed covers and feather pillows. Samples from these were obtained by snipping off a small triangular corner section (10 × 10 cm) from each pillow or quilt, cutting open the stitching and seams, and carefully brushing out the contents, from which the mites were

extracted using a lactic acid flotation technique.⁵ In the quilts cotton padding and loose flock replaced feathers as the filling material.

Quilts. Samples from two old Indian quilts from the beds of a 7-year-old boy and a 43-year-old woman, both with mite-sensitive asthma, yielded 2000 and 6500 mites respectively.

Eiderdown. This sample, of feathers only (6.1 g), taken from inside the eiderdown of a 25-year-old man with severe mite asthma yielded 2061 mites.

Pillows. These samples, taken from the feather pillows (15-50 years old) of four mite-sensitive children aged 5-11 years yielded 1640, 240, 120, and 3415 mites respectively. All came from homes with high standards of domestic hygiene.

These articles formed extensive reservoirs of infestation largely unaffected by normal hygiene control measures, and until their removal from the patients' bedrooms they continued to act as major vectors of mite allergen. Further work is now needed to relate the age of such articles and the conditions under which they are kept to the levels of infestation and to discover whether bed covers and pillows filled with other materials are also susceptible to infestation.

It is therefore suggested that much greater emphasis be placed on the removal, as early as possible, of old articles of bedding such as these from the bedrooms of patients with mite allergy. They are so often overlooked that careful questioning of the parent or adult patient may be necessary to discover their existence.—We are, etc.,

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- 1 Cunnington, A. M., *Acta Allergologica*, 1969, **22**, 408.
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- 4 Pickering, C. A., and Gabriel, M., *Bulletin of the Hong Kong Medical Association*, 1973, **25**, 95.
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Loperamide in Treatment of Persistent Diarrhoea in Children

SIR,—The paper by Drs. G. N. Tijtgat and K. Huibregtse (21 June, p. 667) on the use of loperamide in ileostomy patients was of special interest to us. This drug has recently been reported to be effective also in the management of acute infectious gastroenteritis in children. Over a period of one year we have evaluated loperamide in 10 children presenting with various chronic disorders who were all affected by severe persistent diarrhoea.

The patients' ages ranged between 2½ and 52 months (mean 16½ months). The underlying disorders were cow's milk intolerance (3 cases), coeliac disease (1 case), intractable diarrhoea (1 case), bone marrow transplant in amegakaryocytic purpura (1 case), acute myeloblastic leukaemia (1 case), neuroblastoma (1 case), congenital uropathy (1 case), and irritable colon (1 case). The drug was given in a dosage of 0.08-0.24 mg/kg body weight daily in two or three doses. In eight patients a positive response was observed within a median time of 2½ days. The patient with cow's milk tolerance relapsed after