discontinuation of the therapy and the patient with intractable diarrhoea relapsed while on therapy and died. No response was observed in the patient with acute myeloblastic leukaemia after two months of continuous therapy. No adverse or side effects were noted.

On the basis of this limited experience we believe that loperamide is a valuable adjunct to the management of life-threatening diarrhoea of varying aetiology and that further studies are warranted in larger series of patients.—We are, etc.,

J. P. BUTS
B. F. PETIT
R. DE MEYER

Department of Paediatrics,
Université Catholique de Louvain,
Belgium

¹ Dubru J. M., and Lambrechts, A., *Revue Médicale de Liège*, 1974, 29, 579.

Screening of the Newborn for Duchenne Muscular Dystrophy

SIR,—Your leading article (24 May, p. 403) raises the following questions concerning the method proposed by Zellweger and Antonik.¹

(1) Is the test ethically justified? Yes—at least that is the opinion of most parents of children with Duchenne muscular dystrophy (D.M.D.). We asked D.M.D. parents the following question: Would you have liked to have been informed at the time of birth that your child would eventually develop D.M.D.? Seventy per cent. of the parents with one D.M.D. child and 80% of the parents with more than one D.M.D. child answered "yes." The following reasons for their affirmative answers were given: "We would have selected another house (one storey with ramps and no steps, with wider doors to circulate more easily with the wheelchair, etc.)." "We would have moved to a town with better educational facilities for the handicapped than we have in our town." "We would have guided the child's interest in different directions than sports and physical activities." "We would not have disciplined our child so frequently for stumbling and falling when he was a toddler." "We could have prevented the birth of our affected son(s)." "We would have begun earlier with physical therapy and contracture prevention."

(2) Is screening financially justified in a disease as rare as D.M.D.? Yes, since the cost of the proposed firefly test is less than one dollar per sample, which is well within the cost range of other screening procedures and since D.M.D. is not at all a rare disease. The incidence of D.M.D. has been estimated to be 1 in 3600 liveborn boys.² Thus D.M.D. is more frequent than phenylketonuria or galactosaemia, for which screening is widely accepted.

(3) Is D.M.D. a preventable disease? Yes, it is in some instances. We have presently in our files 175 D.M.D. patients who came from 144 sibships. Thus 31 of them (17.8%) were born after one D.M.D. child was already in the family. These second and later cases could have been prevented if the D.M.D. of the first affected child had been diagnosed at birth or soon thereafter since a reliable method for carrier detection (in vitro protein synthesis by muscle ribosomes) is now available.³ Thus the possible prevention of 17-18% of all cases of D.M.D. would certainly justify this D.M.D. screening pro-

cedure. Screening of the newborn for D.M.D. can no longer be considered "controversial," as suggested in your article, so far as the medical and genetic aspects are concerned.—We are, etc.,

H. ZELLWEGER
V. IONASESCU
J. SIMPSON
M. WAZIRI

Department of Pediatrics,
University of Iowa,
Iowa City, Iowa

Antonik Laboratories,
Elk Grove Village,
Illinois

¹ Zellweger, H., and Antonik, A., *Pediatrics*, 1975, 55, 30.

² Morton, N. E., and Chung, C. S., *American Journal of Human Genetics*, 1959, 11, 360.

³ Ionasescu, V., Zellweger, H., and Conway, T. W., *Neurology*, 1971, 21, 703.

Airlift from Darwin

SIR,—Professor Philip Rhodes (16 August, p. 419) gives an account of the problems, medical and other, which followed the destruction of the city of Darwin by cyclone Tracy early on Christmas morning 1974.

While I appreciate that it would be impossible for Professor Rhodes to mention in detail the excellent work contributed by many people under the most adverse conditions during the Darwin emergency, I think it might be appropriate to record the role played by Australian civil aviation. Professor Rhodes mentions that the R.A.A.F. uplifted 22 000 people from Darwin. This total could be accurate, but our information leads us to believe that about 25 000 people in total were airlifted out of Darwin from 26 to 30 December. Of this total, Qantas Airways carried 4925, T.A.A. 3893, Ansett Airlines 3608, MacRobertson Miller Airlines 1004, and Connair 818—a total of 14 248. This left the R.A.A.F., assisted by the United States Military Airlift Command and one aircraft from the Royal New Zealand Air Force, carrying 10 752 people.

There is no criticism of the R.A.A.F. implied in this, nor have I any wish to enter into a comparative discussion of the work done by different organizations. In the Darwin emergency many pitched in and did whatever they could. Among this group were many people within the Australian civil aviation industry. Two Qantas medical officers positioned to Darwin on the first flight early on the morning of 26 December remained there for the following five days and the airline's nursing sisters who were positioned to Darwin worked on board all Qantas flights from Darwin to Sydney.—I am, etc.,

D. J. HOWELL
Director of Medical Services,
Qantas Airways Ltd.

Sydney, N.S.W.,
Australia

Sick Sinus Syndrome

SIR,—Dr. R. Sutton and his colleagues (9 August, p. 367) are correct in stating that in the past the aetiology of the sick sinus syndrome (sinoatrial disease) has been attributed to coronary artery disease. However, post-mortem evidence for this is extremely sparse and the role of coronary artery disease in this condition has been inferred from the

absence of other obvious pathological conditions and the reported finding of "arteriosclerosis" of the sinoatrial node artery. On the other hand, we have found little evidence of disease of the sinoatrial node artery in eight patients dying with the sick sinus syndrome.¹ Furthermore, in our experience the incidence of a past history of cardiac infarction is no higher in patients with sinoatrial disease than in those with complete heart block. In the Devon heart block and bradycardia survey, up to 1972 11 (10%) out of 106 cases of chronic sinoatrial disease had a past history of myocardial infarction and 29 (13%) out of 222 patients with chronic complete heart block had suffered from a previous infarction. In the survey sinoatrial disease was defined as chronic sinus bradycardia (atrial rate below 50 min) associated with one or more of the following rhythm disturbances: tachyarrhythmias (atrial fibrillation, atrial flutter, paroxysmal atrial tachycardia, paroxysmal ventricular tachycardia), periods of sinus arrest or sinoatrial block in which cessation of atrial activity persists for two seconds or longer, or profound atrial slowing (below 40/min) with junctional rhythm.

Of the 43 patients fitted with pacemakers in Exeter for sinoatrial disease there have only been two instances of failure of inhibition and both turned out to be due to a faulty system. It is possible that the characteristics of the pacemakers in use are responsible for the difference between our findings and those of Radford and Julian² and of Dr. Sutton and his colleagues. The majority of our patients (37 out of 43) were fitted with Vitatron on-demand units, which specify inhibition to an R wave of approximately 1.5 mV at 70 Hz and 1 V at 30 Hz, whereas 15 of the 21 pacemakers used by Radford and Julian were Devices units, which, we understand, require a higher voltage for inhibition, particularly at the 70-Hz frequency. Dr. Sutton and his colleagues do not give information concerning their pacemakers.—We are, etc.,

DAVID B. SHAW
C. A. KERWICK
W. C. BROWNLESS

Royal Devon and Exeter Hospital (Wonford),
Exeter

¹ Evans, R. C., Brownlee, W. C., and Shaw, D. B., *British Heart Journal*, 1975, 37, 779.

² Radford, D. J., and Julian, D. J., *British Medical Journal*, 1974, 3, 504.

Treatment of Clonorchiasis

SIR,—On the question of treatment of clonorchiasis Drs. J. P. R. Hartley and A. P. Douglas (6 September, p. 575) state that "treatment remains unsatisfactory" but make no mention of hexachloroparaxylol (HPX; chloxyle), a drug which has been used with success in China for over a decade.^{1,2} A few years ago, having been unable to obtain HPX from British or Continental sources, I was able to obtain a supply from Dr. Hatem in China, together with advice on dosage. Dr. Hatem recommended 30 mg/kg daily by mouth for 10 days or 30 mg/kg every alternate day for 10 doses and advised that the original dosage which I had quoted³ had since been shown to be unnecessarily high. Using this reduced dosage my colleagues at