primary journal publication. These delays are due to the very factors which so unfavourably influence the cost of these publications, to say nothing of the long period of time required by many authors in submitting their original manuscripts in the first place.

As editors and publishers it is our established editorial policy to discourage in conference proceedings the inclusion of all but

the invited papers and symposia programmes, and thus to avoid, if possible, the inclusion of a large number of free and sometimes unimportant communications, all of which add to the cost—and hence to the ultimate price.—I am, etc.,

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Lewisham Hostel

SIR,—The letter from Drs. L. W. Kay, R. Gardiner, and M. Baum (4 October, p. 47) regarding the Lewisham hostel for ex-drug addicts suggests to us that they have not understood the type of hostel which is being proposed—their concept of a hostel does not resemble that which guides the thinking of the trustees of the Community Drug Project. Logically a hostel of the sort intended at Lewisham should be situated in the community, and therefore “in the environs of Council estates and schools.” The type of hostel envisaged by Dr. Kay and his colleagues should, perhaps, not be situated anywhere. These doctors would appear to be as far off any true appreciation of the reality of a properly run ex-drug addict hostel as were those who, in Lewisham at one time, opposed a now successful and well-accepted mental aftercare hostel, on the basis of a fear that all such ex-patients would be dangerous maniacs.

The Lewisham hostel concept is based upon the American experience of Phoenix House (New York), Synanon (California), and Daytop (Staten Island). It is not clear whether Dr. Kay and his friends have any personal experience of these hostels. As your leading article stated (27 September, p. 731) the American experience is relevant, although we ourselves would wish to stress that it will be necessary closely to examine the manner in which the American model has to be modified in the English setting. We are particularly fortunate in securing as head of the hostel a psychiatric social worker who has the necessary and double qualifications, firstly, of having had many years' English social work experience, and, secondly, a year's tenure of a staff position in New York narcotic rehabilitation services.

The policy of the trustees is that the Lewisham hostel shall aim only to admit ex-addicts who have been carefully assessed, are strongly motivated, and are considered suitable for such a rehabilitation process. Such ex-addicts will only comprise a very small

proportion of those who are admitted to hospital units for treatment of addiction at the present time. The selected residents will then be engaging in the life of an intensive and demanding form of therapeutic community. What is so difficult to convey to the person who has not familiarized himself with the work of the American hostels is the reality, intensity, and therapeutic force of the group spirit which such a community can generate. The group spirit is undoubtedly the strongest factor militating against the hostel becoming a drug-using house, but the American experience also points to the need for certain very rigid external controls which support and protect the group, and which are perceived as rational. We will, for instance, in the Lewisham hostel have the rule that during an initial period of residence the residents will only work within the house, and in the intermediate stage they will only go out accompanied. Urine testing will supplement (but not substitute for) other methods of control.

It would seem that the best reassurance to Dr. Kay and others would be the presence of a safe and successful hostel in which they themselves could show interest and visit. The encouragement of many people of good will in the Lewisham area, including those in the immediate neighbourhood of the prospective hostel, has been immensely heartening. This morning's post, for instance, brings the news that the pupils of the fifth form of a local school have, on their own initiative, decided to give £30 as a donation to the hostel. It seems that those who have understood our purpose, far from being afraid or antagonistic, see the hostel as a welcome focus for constructive community concern and community participation.—We are, etc.,

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Disodium Cromoglycate in Exercise-Induced Asthma

SIR,—Exercise-induced asthma offers a means of objective studies on the effect exerted by disodium cromoglycate, provided that the exercise is properly standardized. The duration of exercise should be 5–8 minutes at least, because the duration of the exercise is of critical importance.* For this

reason we decided to carry out a trial using bicycle ergometry.

The subjects were eight women and three men, between 17 and 50 years of age. Intracutaneous skin tests and allergen inhalation tests revealed clinical allergy in eight of these patients. Bronchodilating drugs were with-

held for a minimum of five hours preceding exercise. P.E.F. was measured with Wright's peak flow meter before and immediately after the exercise and 5, 10, 15, 30, 45, and 60 minutes after exercise. The mean of the two best expirations of five was taken as the P.E.F. value. The first exercise level was 250 kpm./min. for six minutes, followed by increase of the work-load in steps of 250 kpm./min. every six minutes. The patients were allowed to discontinue the exercise when dyspnoea or fatigue became unbearable. The greatest decrease of P.E.F. after exercise was noted.

Two to three days after this first “basal” ergometry (“Basal I”), the same procedure was repeated one hour after disodium cromoglycate inhalation (“D.S.C.G. I”), and the test was discontinued at exactly the same total work load as in “Basal I.” In the second examination period, “Basal II” and “D.S.C.G. II” ergometries were performed. However, in order to elicit the augmentation of physical working capacity after disodium cromoglycate, if any, the patients were allowed to continue with the exercise in the “D.S.C.G. II” test past the previously established basal limits.

As shown in the Table, the mean decrease of P.E.F. was significantly greater after “Basal I” than “D.S.C.G. I” ergometry in the first period. In the second period this difference was only marginally significant, but it is to be noted that in seven “D.S.C.G. II” ergometries the work-load was higher by 14–47% (mean 26%) than in the basal as well as “D.S.C.G. I” ergometries of the same patients.

Although it is very difficult to compare the amounts of exercise employed in this work and in earlier studies, the results are similar. It seems evident that disodium cromoglycate gives significant protection against exercise-induced airway obstruction, as revealed by the maximal bicycle exercise test in standardized conditions. When the total work performed increases, the protective effect seems to be somewhat lessened. In the light of this study it must be stressed that the relations between the protective effect of disodium cromoglycate, duration of exercise, and total work-load still await final clarification.—We are, etc.,

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Cancer Research

SIR,—Dr. M. Macleod (23 August, p. 473) expresses his view that very little benefit has accrued to his cancer patients from the expenditure of millions of pounds on cancer research, and that present activities in this line of research require “agonizing reap-

Maximal Decrease of Peak Expiratory Flow After Exercise in Basal and Disodium Cromoglycate Ergometries

Period	No. of Patients	Mean Δ P.E.F. $\pm$ SD (%)		Probability (t-test)
		Basal	DSCG	
I	11	-52.3 $\pm$ 20.6	-23.0 $\pm$ 14.4	0.001 < P < 0.005
II	11	-49.8 $\pm$ 16.1	-30.6 $\pm$ 23.9	0.025 < P < 0.05