It cannot be too strongly emphasized that this study was not designed to discover variations in intake levels of low statistical significance. Not only is Professor Yudkin's questionnaire too blunt an instrument for this, but interpretation of such circumstances is difficult because of statistical variation and the intrusion of minor variables, known and unknown. The object, with no preconceived ideas to advance or defend, was to confirm or refute, with larger numbers and using a fairly "normal" population, Professor Yudkin's earlier finding of a very significant difference in sucrose intake between I.H.D. and control groups.

Mean Sugar Intake (g./week) in 1,158 Controls and 170 I.H.D. Patients by Age Grouping and Social Class

Social Class	Controls Age			I.H.D. Age		
	< 44	44-48	49 and Over	< 44	44-48	49 and Over
1	543	546	523	502	523	319
2	622	524	527	571	353	412
3	506	574	540	359	428	580
4 and 5	589	600	504	605	474	438

We would agree that measurement of sugar consumption over a lifetime cannot be precise, particularly if a questionnaire is the instrument. It appears to us, however, that the real significance of changing sugar habits with time (and hence with age) is that few people retain unchanged habits over a lifetime. Clearly there is a danger that those who remain consistent in their lifetime habits will be a minor, biased, sample from which it would be inappropriate to extrapolate results to cover the whole population. Yet Professor Yudkin and Dr. Watson would apparently restrict investigations to those with unchanged sugar habits.

Since neither our paper, nor any other recent article which has come to our notice has offered any convincing evidence that "high sugar intake is the chief dietary factor causing ischaemic heart disease," we thought it eminently reasonable to suggest that considerably more confirmation in man is required before the hypothesis is accepted. We did not "reject sucrose"—as they suggest—nor did we say the hypothesis is wrong. Since our study did not extend to include fats or other dietary factors we have no comment to make, though we did find that no correlation

existed between sugar consumption and serum cholesterol, β -lipoprotein, uric acid levels, or other biological tests. This important finding should not be overlooked.

If Professor Yudkin and Dr. Watson would have us speculate on dietary sugar and I.H.D. then we would suggest that rather than the critical individual level of intake apparently suggested by them there may be a population threshold of intake generally exceeded in the Western world. This may not be incompatible with some observations of Cleave and Campbell⁶ in their study of sugar, carbohydrates, and other dietary factors. Nor would it be inconsistent with recent papers¹⁻³ which failed to find individual susceptibility to I.H.D. by intake level.—We are, etc.,

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Management of Unconscious Poisoned Patients

SIR,—Drs. N. Wright and J. A. Raeburn (13 September, p. 656) compared the duration of unconsciousness after poisoning with different types of barbiturates in terms of equivalent severity of poisoning. My remarks (19 July, p. 177) referred to the effects of equal amounts of drug. My own data, accumulated several years ago, are admittedly very limited and no doubt importantly influenced by the fact that all patients were treated energetically with forced alkaline diuresis from the time of admission. However, four patients admitted comatose, having taken an average of approximately 3 g. of phenobarbitone as the sole drug (other than alcohol), were in coma for an average of 18 hours. Ten patients having taken an average of approximately the same amount of pentobarbitone, amylobarbitone, or Tuinal (quinalbarbitone sodium and amylobarbitone sodium) as sole drug were in coma for an average of 28 hours.

Setter *et al.*¹ in their large series in fact quote an equal duration of unconsciousness for phenobarbitone and the alkyl-substituted barbiturates, the average quantity ingested, where known, being the same in the two groups. However, the amount ingested was known in only about half the cases, and in a considerable number other drugs were involved as well. These authors particularly remark on the fact that intoxication with "short-acting" drugs caused deeper and more rapid onset of coma and more severe complications than phenobarbital poisoning (my italics). Maher and Schreiner² emphasized the slower removal of "short-acting" (alkyl-substituted) barbiturates by haemodialysis. Bloomer³ emphasized also the relatively lesser efficacy of alkaline diuresis and

peritoneal dialysis in the case of pentobarbital intoxication. Thus differences in duration of effect are enhanced by active eliminative treatment.

There would seem therefore to be grounds for at least dubiety as to the longer action of phenobarbitone in cases of poisoning, and my contention is that there is little point in retaining a classification so based when there is a more logical way of classifying barbiturates on speed of onset of effect. This is valid at any dosage level and holds irrespective of subsequent events.

However, I would not wish controversy over this rather academic point to obscure the much more important one on which we are in agreement—namely, the desirability of abandoning the use of barbiturates as hypnotics at least for outpatients.—I am, etc.,

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Treating Erythema Nodosum

SIR,—Erythema nodosum is often a very painful condition. The skin lesions themselves can be painful and tender, and there may be local muscle aching and tenderness associated with arteritis, panniculitis, or (especially in sarcoidosis) myositis. Skin lesions and muscle pains were rapidly relieved by oxyphenbutazone in the following case.

A 33-year-old woman was seen at home in May 1969 with erythema nodosum of the legs and pain sufficiently severe to prevent her standing for more than a few minutes. The skin lesions were preceded by arthralgia in the shoulders, ankles, and feet, but at the time of examination there was no joint swelling or tenderness. Neither aspirin, 40–50 mg., nor indomethacin, 75 mg., had been effective in relieving the leg pains. There was a history of pulmonary tuberculosis in childhood. She was admitted to the Princess Alexandra Hospital, Harlow, where the results of investigations were: Hb 92%, E.S.R. 21 mm./hr. (Westergren), W.B.C. 5,700/cu. mm. (differential W.B.C. normal), serum calcium and phosphate normal, protein electrophoresis: slight elevation of gamma globulin, S.G.O.T. 56 units, serum aldolase and creatinine phosphokinase normal, urine analysis normal, throat swab negative, A.S.O. titre=300 Todd units, Rose-Waaler negative, Mantoux 1:1,000 and 1:100 negative, Kveim test positive. A chest radiograph showed bilateral hilar adenopathy, consistent with sarcoidosis.

A diagnosis of erythema nodosum associated with sarcoidosis was made. She was initially treated with bed-rest and salicylates (soluble aspirin, 60 gr. daily), the skin lesions remained static, and she was given oxyphenbutazone, 400 mg., daily. Within four days the lesions had completely subsided and she was pain-free; stopping the oxyphenbutazone was followed by recurrence of the rash, so she continued the drug in a dosage of 300 mg. daily after discharge on 25 June. A chest

radiograph taken in September showed that the hilar glands were subsiding, and she has remained well clinically.

Oxyphenbutazone has been shown to favourably influence the pulmonary lesions of sarcoidosis,¹ but there is no report of subsidence of erythema nodosum in association with this condition, though three cases of erythema nodosum (one associated with pulmonary tuberculosis, two "idiopathic") have been treated successfully with the drug.² It would seem that oxyphenbutazone and phenylbutazone can be of considerable value in the control of pain in erythema nodosum.—I am, etc.,

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College of Radiology

SIR,—Now that the College of Pathologists has achieved "Royal" status it would seem opportune to consider the formation of a College of Radiology by the amalgamation of the Faculty of Radiologists and the British Institute of Radiology. The problem of non-medical personnel in the latter can easily be overcome, as the R.C. Path. includes non-medical pathologists among those eligible for membership.

Only by the creation of a college will radiologists achieve their proper status, thus attracting new recruits and helping to stem the flow of emigrants.—I am, etc.,

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MYER GOLDMAN.

Fascioliasis Yet Again

SIR,—I have only just seen the laboratory report and correspondence about another outbreak of fascioliasis with 37 people infected (5 July, pp. 52 and 63). Indeed, since our report of a small outbreak in Hampshire in 1960¹ you have seen fit to comment on this infection in a leading article under the title "Fascioliasis Again,"² there having been several cases reported in 1961.^{3,4}

Now we have this disturbing news in a year notable for a long dry summer which is said not to favour transmission. In fact 44 people were infected in the first six months of the year. Untreated these flukes live for decades in the biliary tree and treatment is far from satisfactory.

Surely there is a case in view of these events for making it illegal to sell watercress from beds exposed to contamination by cattle and sheep? The demand for watercress must be such that farming this delicious salad could be restricted to safe, inspected beds.—I am, etc.,

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Innervation of the Bowel in Hirschsprung's Disease

SIR,—In their communication on adrenergic innervation of bowel in Hirschsprung's disease (9 August, p. 338) Mr. B. J. Gannon and his colleagues refer to our work on adrenergic fibres in the human intestine.¹ They interpreted us as claiming that there were adrenergic nerve cells in Auerbach's plexus of man.

We should like to correct a false impression which has arisen through inexactness in our translation from the original Italian. When we stated that the cellular elements in the myenteric plexus are not uniquely cholinergic in man, it was our intention to claim that we had observed adrenergic fibres approaching closely the pericellular regions adjoining the perikarya of the cellular elements and that the plexus, in addition to containing cholinergic cells, was rich in adrenergic fibres. In this work we did not see any cells which we considered to be adrenergic.

We have also expressed this view elsewhere.²

We are indebted to Mr. Gannon for having drawn attention to this anomaly.—We are, etc.,

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Pregnancy Tests Over the Counter

SIR,—Your leading article (20 September, p. 667) on pregnancy tests over the counter, which I read with a great deal of interest, has a few points which require comment.

The article states "the latex agglutination test is about 98% accurate . . . and no great skill is required." This statement is quite incorrect; on the contrary, to accurately perform any agglutination test requires more than a little skill, and the interpretation of the result requires more. In my experience, approximately 5% of latex agglutination reactions are not easily read, and comparison with positive and negative control tests is necessary before finally reporting on them. In interpretation of results the operator must realize that latex agglutination reactions are in some cases subject to prozone, and that further testing is often indicated when a negative reaction is encountered.

It is doubtful if all pharmacists are qualified to report such tests accurately and safely. Are they, for instance, aware that in certain circumstances a "negative" result is reflecting the high concentration of H.C.G. normally encountered in the early weeks (6–10) of pregnancy, in hydatidiform mole (incidence in Europe (1:2,000–1:2,500)), and in choriocarcinoma, or that a positive result may be due solely to excessive intake of drugs such as aspirin or to pituitary gonadotrophin.

The article goes on to say ". . . many women who use a testing service intend to seek an abortion." It will be tragedy indeed should these women seek the services of an abortionist when in fact there is no preg-

nancy to terminate, or who have incomplete evacuation of a "molar" pregnancy or choriocarcinoma.

It is my firm conviction that neither the pharmacy nor the surgery of the general practitioner is a suitable place for pregnancy testing. This is a procedure which should be performed solely by experienced personnel, in the clinical laboratory, where it may be carried out under properly controlled conditions, and correctly interpreted in the light of the relevant clinical history.—I am, etc.,

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Selection of Medical Students

SIR,—Dr. Alan Porter (1 November, p. 296) calls for an increase of discussion in the correspondence columns of the journals. This alone prompts me to comment on his remarks concerning the selection of medical students and his belief that present methods assume that originality and excellence may be equated with academic distinction. I know of no evidence that admissions tutors (or indeed anyone else concerned with medical education) harbour such thoughts. They can only deal with the applications they receive and are glad to make offers to those who seem intelligent enough to cope with the course and stable enough to complete it. There is little discrimination against those of humble birth or of eccentric school performance; such people seldom apply for medicine, which continues to attract, in the main, those of the middle class.

As to men like Darwin, it is surely unfair to suppose that the attitudes of schools and universities have remained unchanged in the last 150 years. I attended the same school as Darwin, but was not, like him, expected to study nothing but the classics, and since my time there has been a much more rapid change in outlook at that institution. Speaking only for the medical school which I serve, I can assure Dr. Porter that anyone who can achieve the basic qualifications for university entrance is considered, and we regularly admit clerks in holy orders, musicians, biochemists, and State-registered nurses.—I am, etc.,

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Thanks?

SIR,—In the paper on Pathophysiology of Postgastrectomy Hypoglycaemia by Drs. C. D. Holdsworth, D. Turner, and N. McIntyre (1 November, p. 257) there is a note at the end thanking three colleagues "for kindly allowing their patients to co-operate in these studies." There is not a word of thanks to the patients and controls, who, although consenting, endured between them intravenous infusion, arterial puncture lasting for three hours, and jejunal intubation.—I am, etc.,

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