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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Mortality of pathologists and medical laboratory technicians

SIR,—Dr J M Harrington and Mr H S Shannon (8 November, p 329) report an increased mortality from suicide among pathologists and medical laboratory technicians compared with all medical practitioners and all laboratory technicians respectively, as well as with the general population.

Although it will not have escaped the attention of those engaged in clinical medicine, it should perhaps be put on record that while there has been in recent years a large increase among the general population in suicide attempts by the use of drugs, fatalities are exceptional among those who reach hospital alive. It seems likely, therefore, that the excess mortality noted among laboratory workers is due to more efficient suicide attempts, based on greater knowledge of what is likely to be effective, as well as to the ready access to poisonous chemicals suggested by the authors. Implications that laboratory workers are less likely to use other methods of self-destruction may not be untrue but are unnecessary, since in the general population failed suicide attempts with the use of drugs must far outweigh successful suicide from all causes.

Other unexplained excess mortality figures reaching levels of significance in small subgroups, such as lymphatic and haemopoietic neoplasms in English male pathologists and aortic aneurysm in male pathologists, probably need no other explanation than the normal range of variation in the ratios of observed to expected deaths among subgroups, which is predictable in a survey wherein large numbers of valid comparisons are possible. It must be remembered that $P=0.01$ represents the chances that a parti-

cular event will happen as well as those that it will not.

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Ocular reactions to beta-blocking drugs

SIR,—I read with dismay the short report by Mr R B Cubey and Dr S H Taylor (8 November, p 327) suggesting a link between a beta-adrenoreceptor antagonist and transient ocular symptoms and signs. Since the initial publication (15 March, p 595) which described an oculomucocutaneous syndrome as an adverse reaction occurring in a very small percentage of people treated with practolol there have been scattered reports of non-specific ocular symptoms and signs without any real evidence to suggest that they might be considered as an adverse reaction to any drug. This most recent report deprecates the circumstantial nature of the evidence of earlier authors but offers yet more tenuous evidence rounded off by inaccurate references.

The only abnormal findings appear to have been reduced tear flow and some vessel changes in the conjunctiva. In the age group 50-70 years about 5% of patients will have evidence of reduced tear flow without any specific cause,¹ while very variable hyperaemia and vascular engorgement is the normal finding in any dry eye. Such non-specific changes without any scientific evidence to support the claim can in no sense be said to justify the title of an ocular reaction to a drug.

It is very desirable that doctors should report their suspicions concerning any adverse response to a drug, and this service is admirably provided by the Committee on Safety of Medicines. Meanwhile, many workers are endeavouring to discover the mechanism underlying the adverse reaction to practolol and will report their findings in due course. As part of this, my group has had the opportunity of examining most of the cases reported to the committee as having adverse ocular symptoms or signs to beta-blockers other than practolol. To date we have not seen a single case in which there was evidence to support the suggestion of an adverse response and all had other adequate ocular causes for their symptoms. Additional details will be published in due course, but so far there is no reason to believe that any beta-blocker other than practolol causes an adverse ocular reaction.

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¹ Whaley, K, *et al*, *Age and Ageing*, 1972 1, 197.

Treatment of meningitis and encephalitis

SIR,—The article by Dr C C Smith (8 November, p 335) raises some points worthy of discussion.

We would agree that meningococcal meningitis should be treated with penicillin but do not feel that there is any justification for intravenous therapy except on the grounds of causing less discomfort to the patient. Intravenous therapy in general is more hazardous than intramuscular injection; as stated in the article, it has special hazards such as the possible production of ventricular tachyarrhythmias and also, with the sodium salt, problems of fluid retention, and it is treatment which cannot be given other than

by a doctor. Intramuscular injection both in children and adults is perfectly adequate. We would not agree with the recommendation that cephaloridine should be used as an alternative to penicillin in the treatment of meningococcal infection as recovery is slow following cephaloridine therapy compared with other forms of treatment; chloramphenicol is the alternative drug of choice.

Dr Smith is not correct in stating that pneumococcal meningitis is the next most common form of meningitis in Britain. *Haemophilus influenzae* meningitis is the second commonest form of bacterial meningitis in Britain and has been for many years. We would agree that treatment with benzylpenicillin is effective in many cases of pneumococcal meningitis but there is good evidence¹ that cephaloridine is equal, or even superior, to benzylpenicillin in the treatment of this serious condition. Cephaloridine is the treatment of choice in the established case and avoids the possibility of penicillin hypersensitivity.

In meningitis due to aerobic Gram-negative rods there is much to be said for the use of gentamicin, perhaps combined with a penicillin or cephalosporin, because it is unusual to find aerobic Gram-negative rods resistant to gentamicin. It is surprising that this drug is not mentioned among the possible alternatives in the article. We would urge that these antibiotics be given initially while laboratory sensitivity tests are being carried out.

We were surprised to see the mention of *Mima polymorpha* in an article written in 1975 as this organism has clearly been defined as *Acinetobacter/Moraxella* and has been known as such in Britain for many years.

We are not aware that intrathecal isoniazid is regarded as standard treatment in tuberculous meningitis as this drug crosses the blood/brain barrier. When necessary we have found intrathecal streptomycin to be of benefit in the early days of treatment. It is, however, possible that intrathecal therapy with both drugs may be of help in cases which relapse.²

Although the article is concerned principally with clinical matters, it is unfortunate that the laboratory diagnosis of herpes simplex meningoencephalitis and toxoplasmosis was not outlined so that readers would know what specimens to take and how they would be dealt with by the laboratory. This is a vital step between suspecting the diagnosis from the clinical picture and deciding how to manage the case once the diagnosis has been established.

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¹ Love, W C, *et al*, *Postgraduate Medical Journal*, 1970, 46, suppl (October), p 155.
² *British Medical Journal*, 1971, 1, 1.

SIR,—We feel that the opinion expressed by Dr C C Smith (8 November, p 335) that "systemic corticosteroids, and in particular dexamethasone, should not be given" in the treatment of herpes simplex encephalitis (8 November, p 335) is open to question.

It is true that there are perfectly sound reasons, both virological and clinical, why

steroids should be withheld in certain infections caused by members of the herpesvirus group,^{1,2} but there are equally good reasons to suggest that dexamethasone may be of life-saving importance in the clinical situation resulting from *Herpesvirus simplex* invasion of the brain. The pathology of this form of viral brain affection is complex, but the clinical neurological and neuropathological evidence indicates that there is a significant degree of brain oedema. This oedema constitutes a serious threat to survival and must be controlled if recovery is to begin. The correct management of herpes encephalitis must surely aim at early reduction of this compressive brain oedema, and dexamethasone is one of the effective medical ways of achieving this.

Illis³ in his excellent contribution to the Southampton symposium on virus encephalitis, has set out other reasons why this steroid may actually be beneficial in the treatment of herpes encephalitis and not be as harmful as heretofore supposed.

The working party on herpes encephalitis has given careful thought to this problem and on the evidence available concluded that the practical advantages of dexamethasone far outweigh any theoretical arguments against its use. This steroid has therefore been included in the protocol of a clinical trial of cytosine arabinoside now in progress in 13 centres in the United Kingdom and Belgium.

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¹ Longson, M, and Beswick, J S L, *Lancet*, 1971, 1, 799.

² Juel-Jensen, B E, and MacCallum, F O, *Herpes Simplex, Varicella, and Zoster*, p 132. London, Heinemann, 1972.

³ Illis, L S, in *Viral Diseases of the Central Nervous System*, p 907. London, Baillière Tindall, 1975.

MRC mild hypertension treatment trial

SIR,—Many of your readers will know that the Medical Research Council is currently conducting a pilot trial to assess the feasibility of a large-scale national trial to determine the best management for mild hypertension. May we use your columns to solicit help in the expansion of this study?

The pilot phase has been in progress for 2½ years and has already shown the scientific and ethical feasibility of proceeding to the main trial. At present it includes 22 centres (general practices, industrial clinics, and screening organisations) which together have entered 1100 patients, all aged 35-64, with sustained diastolic (phase V) pressures within the 90-109-mm Hg range. These clinics have been selected in terms of known interest and enthusiasm. It is estimated that the full trial would need about 18 000 patients, each to be followed for five years. This would probably require the recruitment of about 200 collaborating clinics and the pilot trial should, we believe, include a demonstration that this is possible.

All area medical officers, secretaries of local medical committees, and family practitioner committees (and others) have recently been asked to recommend suitable centres. We hope that this may provide a list of over 200 clinics from which, at this stage, 10 or 15 would be selected by a random method. Recruitment of new centres by this means would show the feasibility of full expansion.

We are seeking practices of at least 7500 patients of whom about 2500 patients will be in the 35-64 age range; 3-5% of such patients are likely to be suitable for the trial. If any of your readers feel that their own practices—whether general or industrial—could contribute to this trial we would be glad to hear from them. In general practices it has been found⁴ that much of the additional work load imposed by the trial can be carried by a suitably trained part-time nurse provided she has ready access to medical advice. The MRC has usually provided funds for such an appointment during the first year, when the screening load is considerable. Once screening and the entry of eligible patients to the trial is completed the follow-up load for a large group practice can be covered by perhaps one doctor session and two nurse sessions a week.

Further details and a copy of the trial protocol can be obtained from: The Secretary, MRC Treatment Trial for Mild Hypertension, MRC/DHSS Epidemiology and Medical Care Unit, Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.

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SI units

SIR,—The recent correspondence in your columns on SI units seems to have been rather one-sided. The prophets of doom have pronounced verbosely from a position of ignorance, for they all appear to condemn the change without having had the experience of using the new system. We hold no brief for promoting SI units; indeed we share your correspondents' doubts on the value or desirability of the change at this time. However, the decision to change was made years ago by committees of considerable eminence, and we as clinicians will have to get used to the system. May we, as general practitioners, record our experience of using SI units over one year since our group laboratory at Cheltenham changed in September 1974? Is it not a fair scientific maxim that knowledge speaks louder than ignorance?

Shortly before the new units were introduced each GP in the area received a four-page document from the consultant pathologist outlining the history of the Système International and the reasons for the change. He also gave a short address on the subject at a lunchtime clinical meeting. There was a full explanation of the new units of measurement and a comprehensive list of biochemical values in general use expressed