the convolution rate. No such evidence has been published, and indeed in Thorn’s paper the recurrence rate was 12-0± on those with mean serum phenobarbitone levels over 61 μmol (14 mg%) and 12-8%, in those with lesser concentrations. Further, we do not like the concept that some children may be protected by phenobarbitone and others not, without evidence that we were treating two types of patient apart.

Even if there is a reduction in febrile convolution recurrence rates on phenobarbitone the cost must be counted. There is no evidence that the risk of later recurrent febrile convulsions (‘epilepsy’) is reduced,1 while the incidence of adverse effects is unacceptable high, even at lower blood concentrations.2

Although a recent publication3 indicates that sodium valproate may reduce the recurrence rate of febrile convulsions without the side effects often associated with phenobarbitone, we must reiterate our point that the really serious complication, febrile status epilepticus, usually occurs with the first convolution. The resultant brain damage must be prevented by a research-based country-wide emergency treatment service. In this field there is much anecdotal but little scientific evidence.4 Recommendations include paraldehyde, parenteral phenobarbitone, fever reduction, and diazepam intravenously, rectally, or intramuscularly with hyalase, chloramthiazole, and lignocaine. If other authors do have clear evidence of the relative value of one or other therapy or management of febrile status, then we and many of your readers would like to know where this evidence is to be found.

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1 Farrow, O, et al, Epilepsia, 1972, 13, 279.
4 Kerrich, J E, An Experimental Introduction to the Theory of Probability, Copenhagen, Munksgaard, 1946.
7 Cavazzuti, G B, Epilepsia, 1975, 16, 467.

Disodium cromoglycate and DNA-ase in treatment of bronchial asthma

Sir,—In the modern inhalational therapy of bronchial asthma disodium cromoglycate (DSCG) has received a wide application as a preparation capable of blocking the release of AB antigens on the surface of mastocytes, preventing the production of the mediators of the bronchial reaction (slow-reacting substance A, histamine, bradikinin).3 However, the effect of its application in allergic-infectious bronchial asthma may be reduced in some cases because of bronchial obstruction by purulent secretions.

DNA-ase, possessing a purificatory effect, has been used in modern curative programmes for chronic diseases of the lungs.3 We have therefore studied the value of the combined use of DSCG and DNA-ase in patients with allergic-infectious bronchial asthma complicated by difficulty in the evacuation of secretion from the respiratory tract.

DSCG was used in the treatment of 35 patients (in 16 cases the duration of the disease ranged from one to 20 years. Corticosteroid treatment (4-16 mg triamcinolone daily) was already being given to 11 patients. The infectious process was characterised by fever, x-ray changes of the lungs, leucocytosis, and a positive nitro-blue tetrazolium test (>15%). For two weeks all the patients received DSCG (80 mg daily); in those cases in which this was ineffective we added DNA-ase by inhalation (25 mg daily).

As a result of DSCG treatment we observed improvement in 25 patients after two weeks, while the treatment was ineffective in 10 patients (these were patients with difficulty in the evacuation of the bronchial secretion). After addition of DNA-ase to the treatment seven of the 10 patients in this group showed improvement both in the drainage of bronchial secretion and in the antiasthmatic effect of DSCG. Thus by use of the combination the effect of DSCG therapy was effective in 32 of the 35 patients (cessation or reduction in frequency of asthmatic attacks; mean rise in vital capacity by 15-10±4-03%, in maximum pulmonary ventilation by 22-62±1-16%, and in residual expiratory volume by 5-44±0-96%, decreased requirement of corticosteroids and bronchodilators). This investigation showed that the potential value of DSCG is limited in allergic-infectious bronchial asthma because of insufficient penetration and absorption of the preparation and that the combined use of DSCG and mucolytic enzymes (DNA-ase) can increase the effect of treatment in such patients.

I thank Dr Elena Movchan, who submitted additional information on patients included in the study.

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Rabies and human diploid cell vaccine

Sir,—With the danger of a rabies invasion from across the Channel now fully real and the emergence of a powerful and less painful postexposure vaccination programme (Professor Usha Shah and others, 24 April, p 997) will make many of your readers in the UK sit up and take notice. One remark, however, made we wonder whether they are being strictly scientifically fair to our old friend the Sempel vaccine when in their discussion comparing the human diploid cell (HDC) and Sempel vaccines the authors observe “judged by the criterion of antibody development by the 10th day the Sempel vaccine performed poorly.”

The Sempel vaccine was inoculated in large volumes of 5 or 10 ml on each of 14 consecutive days. Is it not possible, I asked myself, that any nascent antibody being liberated in the plasma would be continuously mopped up by the repeated daily injection of a great mass of antigen and hence would not be detectable in in-vitro serum neutralising antibody tests?

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Early diagnosis of head and neck cancer

Sir,—I confess to no surprise that my colleagues from Cardiff (17 April, p 996) find themselves in agreement with the principle sentiments expressed by Mr H J Shaw (14 February, p 379) and in my own brief letter (13 March, p 946). The reputation they have already earned in the care of patients with neoplasms affecting the head and neck is well known and must surely attract patients from well outside their city boundaries.

Unfortunately, the recommendations of the Special Advisory Committee in Otolaryngology over the past few years has revealed that this happy situation does not exist throughout Great Britain. Indeed, the training of ENT registrars is seriously hampered in many areas because of a lack of experience in this field of our work. Even in the United States, where head and neck surgery is a specialty on its own, 42% of practitioners treat less than 50 patients each year.1 Consequently many patients quite obviously will not find expert attention close at hand. Surely thought, what we are all concerned about is that they should be diagnosed early, treated expertly with kindness and consideration, and given their chance of cure.

Personally, my prime concern is the patient’s welfare and not the counting of heads (or necks), and if others have more to offer in the unusual and difficult problem then we are still fortunate that travel—even to the Principality—poses no formidable barriers to the seeking of such advice. Of equal importance is the close harmony that exists between those working in this field, thus ensuring that fresh thoughts and experience are quickly available to all.

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Screening for Down’s syndrome

Sir,—Dr S Haged and Miss Felicity A Carter (27 March, p 753) have attempted to tackle a difficult problem, comparing the costs of screening for Down’s syndrome in pregnancy with the benefits of termination for those affected. Many components of cost were considered in much detail, but I wonder whether they have obscured from themselves as well as from the non-economist reader some important points.

They suggest that the cost of permanent care of a cohort of 100 affected births is as low as £3000 per annum (or £30 per birth per annum) and that this cost is dependent on whether or not the mothers of the affected children would have undergone further...