hepatitis was 30,000 cases with nearly 3,600 deaths. No account was taken of the incidence of anicteric hepatitis, and, in general, the accepted ratio is 1 overt case for at least 10 actual infections, although in 1965 it was estimated that the ratio of anicteric to icteric hepatitis after blood transfusion could be greater than 100:1 (based on a small number of patients).⁵ Casting aside for the moment the economics in terms of mortality and morbidity, it would have been quite a useful exercise in economics to calculate the cost of treatment of patients with hepatitis. This indeed has been done in one reported series from the United States.⁶ The "average" patient suffering from post-transfusion hepatitis required hospital treatment for 35 days, incurring hospital costs of £300 to £670.

There are no completely reliable tests available at present for the detection of carriers of the virus of hepatitis, but no matter what method of case finding was used the lowest incidence of post-transfusion hepatitis was seen when commercially supplied blood was avoided.⁷ Mosley⁸ recently wrote that virus hepatitis is now the most important complication of the transfusion of blood and blood products, and it is as well to remember this.

Hepatitis is not generally notifiable in this country, but there is no reason to suppose that we are in any way unique as far as the incidence of hepatitis is concerned, and it would be unwise to ignore the facts collected in other countries. The case for the notification of hepatitis in the United Kingdom and the organization of the follow-up of all patients who receive blood transfusion⁹ can only be made stronger in the light of our ignorance as to the real incidence of the disease. This information should be available well before the economists guide us into the purchase of blood.—I am, etc.,

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Railwaymen and Drug Side-effects

SIR,—The number and variety of therapeutic agents prescribed for the general population continue to increase. Railwaymen, like everyone else in the community, may at times be treated with these preparations, and my railway colleagues and I are concerned at the unwanted effects resulting from the use of some of them. In addition people can and do buy proprietary preparations for various minor ailments which may have similar undesirable side-effects.

Locomotive drivers and other railwaymen have always been aware of their responsibility

for public safety. It is clearly most important, both in the interests of public and personal safety, that they should be made aware of any side-effects likely to arise from preparations prescribed for them and particularly of the danger which could arise if these are taken in combination with even moderate amounts of alcohol. I would therefore be grateful to my colleagues in general practice and in hospitals if they would warn such patients of possible side-effects. I may say that discussions have taken place with the Railway trade unions and they are equally anxious that every step be taken to keep railwaymen informed on this subject.—I am, etc.,

J. SHARP GRANT,
Chief Medical Officer,
British Railways Board.

London N.W.1.

Factor IX Levels and Oestrogens

SIR,—When reading the disturbing paper by Dr. D. G. Daniel and others (30 March, p. 801) I wondered why they used such large doses of stilboestrol to suppress lactation. I re-read their previous paper¹ and found that even larger doses were used then. In the recent paper a total dose of 180 mg. is given in nine days. The order of dosage discussed by Barnes² has always seemed to me satisfactory. We have used a total dose of 54 mg. over six days (that is, 5 mg. t.i.d. for two days, 3 mg. t.i.d. for two days, and 1 mg. t.i.d. for two days).

Before considering whether we should abandon the use of oestrogens altogether in the inhibition of lactation can the authors tell us whether the same effect on factor IX is found with smaller doses?—I am, etc.,

A. M. DICKINS.

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Slimming and Sleep

SIR,—I read with interest the report of Dr. Ian Oswald and others (30 March, p. 796) on the effects of diethylpropion and fenfluramine on sleep. While in no way attempting to minimize the theoretical value of these observations, I would question their clinical applicability. We have recently studied in a more clinical setting the effect of an evening dose of diethylpropion (Tenuate) on sleep.¹

I consider that our findings are of greater relevance to the clinical situation than those of Dr. Oswald and colleagues for the following reasons.

We administered 25 mg. diethylpropion, which is the recommended and usual dose, rather than the 50 mg. given by Dr. Oswald and colleagues.

In our trial the tablets were taken at 6 p.m., a time chosen to produce the maximum anorectic effect during the evening when it was most needed, whereas they gave their subjects medication "one to one and a half hours before lights-out."

We examined the effects of diethylpropion on sleep in a group of overweight patients of the type for whom the drug is generally prescribed in practice, not "paid healthy young adult volunteers" as used by Oswald *et al.* In such a clinical setting, under strict, double-blind, controlled conditions, we found that diethylpropion

did not significantly or materially affect the quality of sleep reported by the patients. Whatever the E.E.G. effects might have been, there was no clinical evidence to indicate that our patients' sleep was in any way disturbed by diethylpropion taken at 6 p.m.

I would like to discuss a further point raised by Dr. Oswald and his colleagues in their article. They state that "... it [diethylpropion] has become recognized as a drug which can lead to tolerance, dependence, abuse, and psychotic manifestations..." and quote four references to support their statement. All but one reference refers to a single case, while the remaining reference describes two cases. Thus in the 10 years during which diethylpropion has been widely available only five cases of dependence have been reported; all of these cases had previously abused amphetamine. This, I would suggest, hardly indicates that diethylpropion is particularly likely to produce serious psychological dependence in the very great majority of overweight patients for whom it is prescribed.—I am, etc.,

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Brand Names

SIR,—I write in support of your leading article on brand names (30 March, p. 781). If it had ever been shown that the administration of halothane was associated in some patients with jaundice and more than one firm had been producing halothane, it would have been very important to know whether the incidence of jaundice was related to a particular method of manufacture. To specify a brand name in a patient's notes gives more information than using a B.P. name.—I am, etc.,

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Long-term Corticosteroid Treatment of Asthma

SIR,—Dr. K. Maunsell and her colleagues (16 March, p. 661) have emphasized some of the dangers of long-term steroid therapy in asthma and the importance of keeping a maintenance dose as low as possible. As your leading article (10 February, p. 329) pointed out, this can only be done if patients are followed up regularly with objective measurement of their ventilatory function. The experience of this general practice confirms Dr. G. F. B. Birdwood's belief (9 March, p. 640) that regular measurements of P.E.F. with the Wright peak-flow meter may reveal trends, which indicate deterioration, long before the patient himself is aware of it. Dr. J. L. Struthers (9 March, p. 639) doubts whether this is "relevant to the treatment of asthma as it really affects the asthmatics in the community." However, seeing patients with severe asthma daily, weekly, or monthly, according to their progress, is not as time-consuming as he supposes. In any case, this is amply compen-

sated by the rarity with which emergency visits are necessary.

Status asthmaticus must be one of the more common causes of emergency admission to hospital, yet in this general practice of over 4,000 patients there have been only nine occasions in the last six years when an adult asthmatic patient has been admitted as an emergency. Analysis of these nine emergency admissions shows that in four cases the episode which necessitated admission was apparently the first overt manifestation of asthma which the patient had experienced. Three emergency admissions were not for status asthmaticus (two being for spontaneous pneumothorax and one for complete obstruction of the main bronchus by a plug of aspergillus). Thus, in six years there have been only two occasions when a patient, who was already known to have severe asthma, has required emergency admission for status asthmaticus.

During the last six years a prospective study of all patients with asthma has been in progress. Twenty-eight patients have required treatment with steroids. All patients are followed up regularly and the dosage of steroid is carefully controlled by measurement of peak expiratory flow. At least one attempt is made to discontinue steroid therapy and this has been possible in nine patients. In the other 19 patients relapse occurred, despite very gradual reduction of dosage and, in several cases, injections of corticosteroids. In those patients who require continuous steroids the dose is kept as low as possible, the aim being not to achieve complete reversal of their airway obstruction but rather to find that dose which just suppresses their symptoms of asthma. In many patients the maintenance dose of prednisone is 4-7 mg. per day, apart from temporary increases for exacerbations, and only five patients required a dose greater than 10 mg. per day.

It is important to recognize that chronic asthma may become unaccountably refractory to a dose of steroid which previously has suppressed it satisfactorily. Usually such refractory periods are of short duration, but in some patients it proves impossible to revert to the previous maintenance dose. Although Dr. Maunsell and her colleagues found that in general there was no tendency for the effect of steroids to diminish with prolonged treatment, this certainly does occur in some individual patients.—I am, etc.,

IAN GREGG.

London S.W.15.

Deaths from Asthma

SIR,—If the physical outlet of an emotional disturbance is blocked by an effective suppressor—that is, a corticosteroid—which also has the delayed effect of increasing mortality, the mortality first falls and then rises slowly; or it may fall and then stay level if the pressure to have asthma from the bottled-up emotional disturbance is balanced by the lowered mortality from the corticosteroids. When less effective suppressors (the pressurized aerosols) which have an acute mortality are introduced a few years later the death rate will rise immediately. Children will be most affected, because their parents will assiduously administer the suppressive agents not knowing that their emotional

relationship with their children is the most common cause of the asthma.

When the public and the medical profession realize that asthma is a symptom of a cry for emotional help, and that it can be entirely relieved by giving the necessary assistance and desensitizing the patient when there is an allergy, the suppressive agents will be used with sufficient discrimination to allow their effectiveness to be realized advantageously.—I am, etc.,

Plymouth,
Devon.

ALEX FORBES.

Pelvic Examination

SIR,—The letters on the subject of pelvic examination (30 March, p. 839) indicate that the left lateral position is a kinder and quite satisfactory alternative to the "patient on her back and her legs supported [?] restrained] by a nurse or in stirrups." The left lateral position is ideal for the initial examination of the unmarried or the teenager, or for demonstrating the signs of prolapse, but it has no advantage over the dorsal position in other cases, and is much less satisfactory for teaching undergraduates to examine the pelvis of the female.

The technique described of the patient's legs being supported by nurse or stirrups has surely been generally abandoned as unnecessary, the exception being under operating conditions in theatre or for induction of labour.

In outpatient clinics or in ward beds the patient can lie on her back covered from chest to knees by a sheet. If, on request, she flexes her knees, places her heels together, and allows her knees to fall widely apart, her pelvis can be examined digitally or per speculum without her being further uncovered. This last point needs to be emphasized in the training of doctors and gynaecologists, for I regret to say I frequently see patients exposed from the waist down to facilitate pelvic examination. It seems as if the examiner believes that his complete lack of embarrassment removes the possibility of the patient feeling embarrassment.—I am, etc.,

Glasgow.

J. A. MCGARRY.

Ventilation Equipment

SIR,—We think readers should be informed or reminded, whichever applies, that despite assertions that the Ambu-E valve cannot be assembled incorrectly it is possible to reassemble this valve in the wrong way.

One of us was recently given an Ambu bag for ventilation of a patient who was being transferred from one ward to another. He was greatly confused when he found that he could not maintain ventilation smoothly. Expiration was only possible if the face mask was lifted between breaths, because the apparatus was functioning as a to-and-fro system without the absorber. The reason why was not immediately obvious, but later inspection showed that the rubber valve normally positioned at the outlet of the bag had been put over the expiratory port, thus completely stopping escape of gases through the normal channel. The patient could only

breathe out into the bag, which had of course refilled meantime.

Inspection of a valve will reveal that the rubber flap-valve within it easily and neatly slips on to the expiratory port, and the mistake could occur in any department where staff unused to the mechanics of such things are expected to wash and clean the bag after its occasional use.—I am, etc.,

MURRAY P. KELLY.

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Measuring Blood-flow in Dialysis

SIR,—An adequate blood-flow is essential for effective haemodialysis. Measurement of the blood-flow along the arterial and venous blood lines connecting the patient to the artificial kidney is customarily performed by timing the progress of an air bubble along a fixed distance and calculating the flow rate from a graph. Inaccuracies arise if the tubing is not horizontal and the flexible plastic tubing is difficult to maintain at a constant distance between two fixed points for measurement.

This can be remedied by the use of a simple device consisting of a wooden plank with a measured distance marked out on it. The plastic blood lines are held in position along these distances by a series of "Terry" clips, and to ensure that the board is horizontal during measurement a spirit level is screwed on to the device. For compactness and convenience the length of tubing can be doubled back along the known distance so that the device can be made portable for use in home dialysis. This apparatus is easily made for a cost of under 10s.—I am, etc.,

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Oral Lichen Planus and Betamethasone

SIR,—It may be of interest to know the results of following up the patients treated with oral Betnovate, reported upon earlier (13 January, p. 86). These are as follows:

Remained healed	13
Recurrence	2
Continuing to take Betnovate ...	2
Partial improvement maintained ..	1
Lost to follow-up	12
	30

Of the 12 that failed to attend again two were severely ill patients and two lived in distant parts of the country. The two patients who had recurrence of lesions were both young (that is, 20 and 21 years), but in neither case was the recurrence severe enough to cause complaints. These results are gratifying but somewhat surprising to me in that I would not have expected so minute a dosage of a corticosteroid to have so persistent an effect on what must be regarded as something more than a mere local lesion.

May I also point out a possible source of misunderstanding in my article? The trial was concerned only with betamethasone-17-valerate (Betnovate, Glaxo), and it is this