use at present into our practice office to accommodate these wonderful new folders.

Is it too late to try and reverse this crazy decision and to continue using the old faithful red and blue envelopes?—I am, etc.,

D. JARRATT

Coventry

SIR,—May I express the deep concern of four doctors in group general practice over the proposed changes in medical records in general practice from the present ECs 5 and 6 to the larger A4 international size paper as notified in circular ECN 946?

It is stated that this system will require at least twice the floor storage space of the present system. We look aghast at the expense both to us and to the country. This money would be put to better use in treating patients. We are in much greater need of old people's accommodation, day care centres, and psychiatric facilities than of redesigned medical records for G.P.s

The compilers of ECN 946 have excelled themselves. It appears to be necessary to inform the reader of the commercial availability of small mobile steps for the receptionist to reach the top shelf in a lateral filing system and that "consideration may be given to using . . . systems in which the tiers of shelves can be separated or approximated by manual pressure." By all means let us "obviate the nuisance caused by the noise of the typewriters." We pray that officialdom may be blessed with a sense of humour.

We protest strongly, and see no valid argument for altering the present general practice medical record system to be "in line with the generality of hospital and local authority health service records" if, in fact, the latter be in line. We hope that if there is sufficient outcry from the G.P.s this futile bureaucratic exercise might be dropped.—I am, etc.,

H. C. I. BYWATER

Lingfield, Surrey

Drug Data Sheets

SIR,—Dr. N. V. Edwards (28 April, p. 245) urges that data sheets issued to practitioners under the provisions of the Medicines Act 1968 should be standardized. I am writing to assure him that this will be achieved by the permanent provisions of the operative regulations.

When the permanent provisions in the regulations are fully in force data sheets will take the form either of a card, of a size which will be suitable for filing in the same boxes as are used for the present medical card, or of an entry in a compendium. The information about a medicinal product will, in either case, be given in the same order and in a standard format. At present the regulations permit for a short period the use of a variety of temporary data sheets while companies are arranging the printing of standard data sheets.

The background to this situation is that the Medicines Commission felt strongly that it would be more satisfactory for practitioners to receive a single book containing entries relating to all the products promoted to them than to receive separate sets of loose data sheets from each company concerned. The Act, however, made data sheets

obligatory from a date six months after licensing became generally effective—that is, 1 March 1973—and it did not appear possible to produce such a book by that date. The Commission felt that if no special provisions were made most companies would, in fact, produce loose data sheets and be unwilling to participate in a joint compendium and therefore recommended that temporary provisions be made. Having regard to the constraints of the legal provisions and the time available, the temporary provisions were framed so as to permit the use of existing documents or of non-standard documents which could rapidly be prepared.

Doctors may wish to know that the Association of British Pharmaceutical Industry is preparing and publishing a joint compendium of data sheets. This will contain information about some 1,500 medicinal products that are promoted by about 80 companies, some of which are not members of the association.—I am, etc.,

R. E. TRINGHAM

Department of Health and Social Security,
Medicines Division,
London E.C.2

Coeliac Disease in the West of Ireland

SIR,—The finding of a high incidence of coeliac disease in the West of Ireland reported by Dr. M. Mylotte and his colleagues in Galway (24 March, p. 703) is of the greatest interest not only to paediatricians and gastroenterologists, but to all who are interested in human biology, as an example of evolutionary change taking place in a relatively stable population.

The high incidence of a genetically determined lethal disease points towards the recent introduction of a new factor in the environment of the population concerned. As the change is selectively disadvantageous to certain genotypes, these will be gradually eliminated from the population unless the heterozygote has a selective advantage over both homozygotes leading to a balanced polymorphism such as found with the sickle-cell gene and the gene for favism in populations exposed to infection with falciparum malaria.

Cereals were the first plants selected for cultivation in the temperate regions. All are annuals with a vegetative cycle lasting for a few months, and the distribution of cereals is determined by temperature and humidity. Wheat and rye are the only cereals which are easy to store and transport in these latitudes. Wheat does not require much water although moderate quantities are needed at certain stages in its growth. Optimum conditions obtain with rain in the spring and relative drought in the summer, but it does not grow in climates which are too damp or rainy in the summer, whether it be that of maritime temperate countries like Ireland or the warm wet tropics or those with the rains of the monsoon. For these climatic reasons bread wheats were not cultivated in the West of Ireland and wheaten flour did not appear in the diet of that population until supplies became available from overseas after the catastrophic famine produced in the 1840s by potato blight.

It is not surprising, therefore, to find a high incidence of coeliac disease where wheat has not been consumed long enough to

eliminate the susceptible genes from the gene pool of the population concerned. For the same reason one would expect a relatively high incidence of coeliac disease in the highlands of Scotland and mountains of Wales, but a much lower incidence in south-east England, where wheat has been cultivated for over two millennia.

The West Irish population studied by the Galway workers would seem to be an ideal one for determining the incidence of other genes because it is a stable and relatively undisturbed population. In a previous communication¹ I suggested that determination of the incidence of coeliac disease and that of dermatitis herpetiformis in a given population would provide crucial evidence in favour or against the view that dermatitis herpetiformis is a manifestation of coeliac disease. The West Irish population would seem to be a model for the testing of this hypothesis.—I am, etc.,

E. J. MOYNAHAN

Guy's Hospital,
London S.E.1

¹ Moynahan, E. J., *British Medical Journal*, 1970, 4, 559.

SIR,—We were interested to read the paper by Dr. M. Mylotte and others (24 March, p. 703) showing that the incidence of coeliac disease presenting in childhood in the West of Ireland is 1 in 597 and overall may be as high as 1 in 303. These estimates are approximately 6-20 times those previously made for the incidence in Scotland, England, and Wales, but similar to that in an early study on Toronto children.¹ Why there should be these differences is not clear; the existence of largely asymptomatic coeliac relatives in family studies makes any estimate of the real incidence in the general population difficult. Nevertheless, on the data available the increased incidence of biopsy-proved coeliac disease in the West of Ireland seems real. As the authors point out, the differences in the genetic make-up of the various communities may be relevant. Genetic factors certainly seem to be implicated in the aetiology of coeliac disease both on account of the significant familial incidence and of the altered distribution of HLA antigens in this disease.²⁻⁴ It would be interesting to know the distribution of these antigens in the population of the West of Ireland.

The importance of environmental factors is more difficult to evaluate. Dr. Mylotte and his colleagues wondered whether early feeding of wheat cereals might be relevant but considered that there was no evidence to support this. Certainly mixed feeding is being introduced at a progressively earlier age, when the enzymatic and immunological mechanisms of the gut may not be fully developed. Thus in a study of normal infants in Dudley, Worcestershire, Shukla *et al.*⁵ showed that approximately 95% of infants were introduced to solids (presumably usually gluten-containing) before the age of 13 weeks, but in addition they pointed out that early cow's milk feeding was universal. Visakorpi and Immonen¹ postulated a relationship between cow's milk and gluten, and it could well be that the combined effect of the early exposure of the child to both these substances is more relevant than the timing of exposure to gluten itself.

One question emerges which merits serious study by the paediatricians; should children,