The data relating to medicines are in the companies, and in information about either case, as are card, regulations are under bureaucratic humour.

Let the medical record practice line with mated of shelves facilities It medical records We to notified system. We notified general practitioners to use the present 48 BRITISH MEDICAL 946?

The complaint 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 reception to reach the top shelf in a lateral filing system and that "consideration be given to ... systems in which the tiers of shelves 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 officiadom may be blessed with a sense of humour.

We protest strongly, and see no valid argument for altering the present general practice in stating that this system 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.,

Drug Data Sheets

Sin.—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 proprietary products 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 continuing system. It was recommended that temporary provisions be made. Having regard to the constraints of the legal provisions and the time available, the temporary provisions were limited to a stipulation that 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.,

H. C. I. BYWATER

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Coeliac Disease in the West of Ireland

Sin.—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 history, 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 favaism 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. Wild 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 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 communication I suggested that the 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

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24 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. M. 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 practiced in Ireland at an earlier age, when the enzymatic and immunochemical mechanisms of the gut may not be fully developed. Thus in a study of normal infants in Dudley, Worcestershire, Shukla et al.2 showed that approximately 95% of infants were introduced to solids (presumably usually gluten-containing) before the age of 13 weeks, in contrast to the age among infants in this country where milk feeding was universal. Visakorpi and Taronen25 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,